DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

September 25, 2026

Julie Ewing
State Medicaid Director
Division of Integrated Healthcare
Department of Health & Human Services
PO Box 143101
Salt Lake City, UT 84114

Dear Director Ewing:

The Centers for Medicare & Medicaid Services (CMS) is making conforming changes to Utah's "Utah Medicaid Reform 1115 Demonstration" demonstration (Project Numbers 11-W-00145/8 and 21-W-00054/8) to align with recent changes to Medicaid and Children's Health Insurance Program (CHIP) statutes, regulation, and policy.

Public Law 119-21, which CMS refers to as the Working Families Tax Cut (WFTC) legislation, made changes to the Medicaid and CHIP provisions of the Social Security Act (the Act), including eligibility and financing changes. CMS has issued regulations and guidance implementing and interpreting many of the Medicaid and CHIP provisions of the WFTC legislation. Some of these statutory and related regulatory changes will affect this demonstration. Therefore, in this action, CMS making conforming changes to the Utah Medicaid Reform 1115 Demonstration during this demonstration period.

Specifically, in this action:

- Effective January 1, 2027, we are determining not applicable section 1902(e)(14)(L) of the Act (added by section 71107 of the WFTC legislation) with respect to certain individuals affected by the demonstration through June 30, 2027.
- We are changing the demonstration special terms and conditions (STCs) to conform with sections 1903(v)(5) and 2107(e)(1)(R) of the Act (added and amended, respectively, by section 71109 of the WFTC legislation) and guidance related to those sections of the Act; these changes are effective October 1, 2026, through June 30, 2027.
- Effective January 1, 2027, we are changing the demonstration STCs to conform with sections 1902(a)(34) and 1905(a) of the Act, as amended by section 71112 of the WFTC legislation, until June 30, 2027.
- Effective January 1, 2027, we are changing the demonstration STCs to conform with section 1902(xx) of the Act (added by section 71119 of the WFTC legislation), and regulations and guidance implementing and interpreting that section of the Act, through June 30, 2027.

Unless renewed or amended, all authorities granted to operate this demonstration will expire on June 30, 2027.

The conforming changes to the STCs are authorized under STC 3.3, titled "Changes in Medicaid and CHIP Law, Regulation, and Policy," which provides that the state must, within the timeframes specified in federal law, regulation, or policy statement, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during the demonstration approval period. Under STC 3.3, CMS may amend the STCs to reflect such changes without requiring the state to submit an amendment. We consider the not applicable of section 1902(e)(14)(L) to be a conforming change permissible under STC 3.3 because it will help to avoid noncompliance with certain newly applicable requirements for a limited period of time, as further explained below.

CMS has determined that this action for the Utah Medicaid Reform 1115 Demonstration is likely to assist in promoting the objectives of the Medicaid and CHIP statutes by aligning this section 1115 demonstration with new statutory requirements applicable to the Medicaid and CHIP programs and with how CMS has interpreted and implemented those requirements in regulations and guidance. Moreover, this action will provide Utah with additional time to operationalize changes to comply with section 1902(e)(14)(L) of the Act, given its concurrent work to unwind existing expanded continuous eligibility authority in the demonstration for individuals who are also subject to section 1902(e)(14)(L) of the Act while implementing the community engagement requirements for these individuals, as described in section 1902(xx) of the Act (added by section 71119 of the WFTC legislation). The effective dates of these actions are intended to align with the implementation timelines of these new statutory requirements.

This section 1115(a) demonstration action is subject to the limitations specified in Attachment M below, which is appended to the demonstration's STCs, as changed and restated in our approval on January 16, 2026. Attachment M makes conforming changes to the demonstration's not applicables and STCs as further specified therein, and governs any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The changes in Attachment M of this letter should be considered as part of the broader set of STCs that were approved on January 16, 2026, for the Utah Medicaid Reform 1115 Demonstration and will be incorporated into the full STCs at any future approval action for this demonstration.

Program Integrity

As part of this action, CMS would like to remind the state about program integrity obligations. States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid and CHIP laws and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX and Title XXI of the Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity, including processes to identify, investigate, and refer suspected fraud and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid and CHIP services, including referrals to law enforcement, when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

Extent and Scope of Changes

Section 71107 – Eligibility redeterminations

Section 1902(e)(14)(L) of the Act, added by section 71107 of the WFTC legislation, requires states to conduct renewals of eligibility once every six months (instead of once every 12 months) for two groups of beneficiaries whose financial eligibility is determined using MAGI methodologies. First, this requirement applies to almost all individuals enrolled under the state plan in the Medicaid adult group described at section 1902(a)(10)(A)(i)(VIII) of the Act. Second, this requirement applies to almost all individuals described in section 1902(a)(10)(A)(i)(VIII) of the Act who are enrolled in coverage "under a waiver" of the state plan that provides coverage equivalent to minimum essential coverage (MEC) to all individuals described at section 1902(a)(10)(A)(i)(VIII) of the Act. The requirements of section 1902(e)(14)(L) of the Act apply to redeterminations of eligibility scheduled on or after January 1, 2027. On March 6, 2026, CMS issued State Medicaid Director Letter #26-001 which offers implementation guidance to states on this new requirement.[1]

Section 71107 implementation concurrent with expanded continuous eligibility wind down

CMS has approved expenditure authority for expanded continuous eligibility in several demonstrations, including the Utah Medicaid Reform 1115 Demonstration. This authority provides Medicaid and CHIP expenditures for continued benefits for certain individuals who would have otherwise lost coverage due to a change in circumstance. On July 17, 2025, CMS issued a Dear Colleague letter indicating that CMS does not anticipate approving new requests for expanded continuous eligibility or renewing existing section 1115 demonstration authority for expanded continuous eligibility, beyond what is required or available under the Medicaid and CHIP statutes, as applicable.[2] CMS has provided technical assistance to assist states as they begin upgrading eligibility systems, notifying beneficiaries, and conducting an orderly phase out of expanded continuous eligibility where it has been approved under section 1115 demonstration authority.

In the Utah Medicaid Reform 1115 Demonstration, certain individuals who currently qualify for expanded continuous eligibility will also be subject to the requirements of section 1902(e)(14)(L)

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd26001.pdf
[2] https://www.medicaid.gov/resources-for-states/downloads/contin-elig-ltr-to-states.pdf

of the Act. Utah will need to complete eligibility system upgrades to begin conducting eligibility redeterminations in accordance with requirements of section 1902(e)(14)(L) of the Act at the same time that Utah is working on beneficiary notices and returning to regular renewal timeframes resulting from the wind-down of the demonstration authority for expanded continuous eligibility. Therefore, in order to ensure that the state has adequate time to operationalize both sets of changes in an orderly fashion, CMS is specifying the new eligibility redetermination requirements in section 1902(e)(14)(L) as Not Applicable. This Not Applicable authority takes effect on January 1, 2027, and will not exceed the end date of the current demonstration period, June 30, 2027.

Section 71109 – Alien Medicaid eligibility

Beginning October 1, 2026, sections 1903(v)(5) and 2107(e)(1)(R) of the Act, as added and amended, respectively, by section 71109 of the WFTC legislation, generally limit federal financial participation (FFP) for medical assistance (Medicaid) and child or pregnancy-related health assistance (CHIP), with limited exceptions, to U.S. citizens and U.S. nationals, lawful permanent residents (LPRs), Cuban/Haitian entrants, and Compact of Free Association (COFA) migrants.

Section 1903(v)(5) of the Act describes three exceptions to these FFP limitations: (1) care and services necessary for the treatment of an emergency medical condition as described in section 1903(v)(3) of the Act, (often referred to as "emergency Medicaid"), per section 1903(v)(2) of the Act; (2) full Medicaid and CHIP coverage provided to lawfully residing children and pregnant women under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) 214 option, per section 1903(v)(4) of the Act, applicable to CHIP through a cross reference at section 2107(e)(1)(Q) of the Act; and (3) Health Services Initiatives (HSIs), which are programs that are designed to improve the health of low-income children, authorized under section 2105(a)(1)(D)(ii) of the Act. Utah elected the CHIPRA 214 option for Medicaid coverage of lawfully residing children and CHIP coverage of lawfully residing children.

On April 8, 2026, CMS issued State Health Official (SHO) letter #26-001, which provides policy and operational guidance to states related to implementation of the changes made by section 71109 of the WFTC legislation.[3] On August 17, 2026, CMS issued a letter to Utah describing CMS's determination that continuing previously approved policies in section 1115 demonstrations that authorize federal matching funds for expenditures for services furnished to individuals who will be subject to the FFP limitations in section 1903(v)(5) of the Act would not be likely to promote the objectives of the Medicaid or CHIP statutes, as applicable and as modified by the WFTC legislation.[4] In this action, CMS is making conforming changes to align with section 1903(v)(5) of the Act to the STCs of the demonstration. These changes, which are further described below, are expected to protect program integrity, ensure accurate eligibility determinations, and ensure proper claiming of FFP.

Aligning section 1115 eligibility policies with section 71109 changes

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[3] https://www.medicaid.gov/federal-policy-guidance/downloads/sho26001.pdf
[4] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/Utah_71109_Letter_08.17.26.pdf

The Utah Medicaid Reform 1115 Demonstration STCs currently include references to historical noncitizen eligibility requirements for individuals for whom, beginning October 1, 2026, under the statutory changes made by section 71109 of the WFTC legislation, the state is no longer able to claim FFP, unless an exception applies. The demonstration's STCs regarding coverage for these individuals are consistent with historical statutory requirements, but do not align with the new FFP limitations in section 1903(v)(5) of the Act. Therefore, CMS is taking action to ensure the demonstration STCs are compliant with section 1903(v)(5) of the Act. Specifically, CMS is making conforming changes to STC 4.3 to remove and align language regarding noncitizens with the new statutory restrictions on FFP. With this conforming change, CMS is also removing duplicative references to eligibility requirements (e.g., state residency) that apply to the demonstration. These references are unnecessary because all Medicaid and CHIP requirements expressed in law, regulation, and policy statement continue to apply unless expressly waived or identified as not applicable in the demonstration.

Aligning section 1115 expanded continuous eligibility authorities with section 71109 changes

As discussed above, CMS has approved several demonstrations under the authority of section 1115(a) of the Act that provide expenditure authority for expanded continuous eligibility.

CMS clarified in SHO Letter #26-001 that states must apply the FFP limitations under section 1903(v)(5) of the Act for the following: 1) children in a continuous eligibility period under the state plan or section 1115 demonstrations under section 1902(e)(12) of the Act; 2) individuals covered during a period of continuous postpartum coverage under the state plan or section 1115 demonstrations under section 1902(e)(16) of the Act; and 3) individuals receiving authority for an expanded continuous eligibility period under the terms of a section 1115 demonstration. For Medicaid applicants and current Medicaid beneficiaries who are not U.S. citizens or U.S. nationals, LPRs, Cuban/Haitian entrants, or COFA migrants and are not lawfully residing children eligible under the state's election of the CHIPRA 214 option, FFP remains available for emergency Medicaid coverage for such individuals in accordance with section 1903(v)(5) of the Act beginning October 1, 2026, and for the remainder of the expanded continuous eligibility period.

In this action, consistent with its August 17, 2026, letter to Utah, CMS is making conforming changes to reflect that populations receiving expanded continuous eligibility under section 1115(a)(2) expenditure authority in the Utah Medicaid Reform 1115 Demonstration are subject to these new requirements beginning October 1, 2026. Specifically, CMS is adding subsection (f) to STC 6.7 to affirm that the FFP limitation under section 1903(v)(5) of the Act is applicable to Utah's expanded continuous eligibility authority in the Utah Medicaid Reform 1115 Demonstration.

Section 71112 – Reducing state Medicaid costs

Effective January 1, 2027, sections 1902(a)(34) and 1905(a) of the Act are amended by section 71112 of the WFTC legislation to require states to shorten the retroactive eligibility period for any individual who has been determined to be eligible and enrolled under the state plan in the Medicaid adult group described at section 1902(a)(10)(A)(i)(VIII) of the Act to one month prior

to the month of application (section 1902(a)(34)(A) of the Act). For all other individuals eligible under the state plan, the retroactive eligibility period will be limited to two months prior to the month of application (section 1902(a)(34)(B) of the Act).

Utah's Adult Expansion Population and Targeted Adults authorized under section 1115(a)(2) demonstration expenditure authorities are neither eligible nor enrolled under the state plan. As such, the changes in section 71112 of the WFTC legislation would not automatically apply to these Utah demonstration populations. However, CMS generally treats Utah's Adult Expansion Population and Targeted Adult section 1115(a)(2) demonstration expenditure authorities as substantially equivalent to the state plan Medicaid adult group described at section 1902(a)(10)(A)(i)(VIII) of the Act and applies all requirements under the Medicaid program that would apply to the population if it were covered under state plan authority in that group. To help ensure the fiscal sustainability of the Medicaid program, the WFTC legislation limited the length of retroactive coverage for individuals in the Medicaid adult group to only one month prior to the month of application. Therefore, to align with CMS's historic approach to this expansion population and the requirements in all other states that have state plan authority for the Medicaid adult group, Utah's Adult Expansion Population and Targeted Adults will be limited to up to one month of retroactive coverage prior to the month of application. To effectuate this conforming change, CMS is adding section 1902(a)(34)(B) of the Act to the list of Title XIX Requirements Not Applicable to this demonstration and making a one-month retroactive eligibility period (like the one in section 1902(a)(34)(A) of the Act) applicable for individuals determined eligible for and enrolled under the section 1115(a)(2) demonstration expenditure authority for the Adult Expansion Population and the Targeted Adult group in Utah's demonstration. Under these changes, the state will make available one month of retroactive eligibility for individuals in the Adult Expansion Population or the Targeted Adult group.

Section 71119 – Requirement for states to establish Medicaid community engagement requirement for certain individuals

In this letter, CMS is making conforming changes to the terms of Utah's demonstration to align with section 1902(xx) of the Act (added by section 71119 of the WFTC legislation) and the interim final rule with comment period (IFC) implementing section 1902(xx) of the Act issued in the June 3, 2026, Federal Register (91 FR 33348).[5] Section 1902(xx) of the Act and the IFC require that, beginning no later than January 1, 2027, "applicable individuals" (as defined at section 1902(xx)(9)(A)(i) of the Act) demonstrate, as a condition of their Medicaid eligibility, community engagement (as specified in 42 CFR 435.552) for one to three consecutive months (as specified by the state) before their month of application. Additionally, enrolled applicable individuals must demonstrate community engagement for a number of months specified by the state either between renewals or, if elected by the state, between more frequent verifications of community engagement, as a condition of continued eligibility. Applicable individuals are deemed to demonstrate community engagement for a month if, during such month, they meet the criteria for a mandatory exception or, if elected by the state, an optional short-term hardship exception. Certain individuals who qualify as "specified excluded individuals" (as defined at

[5] https://www.federalregister.gov/documents/2026/06/03/2026-11094/medicaid-program-community-engagement-requirement-for-certain-individuals

section 1902(xx)(9)(A)(ii) of the Act) are not applicable individuals and are not subject to the community engagement requirement.

Aligning section 1115 expanded continuous eligibility authorities with section 71119 requirements

The expanded continuous eligibility expenditure authority in the Utah Medicaid Reform 1115 Demonstration affects populations that include applicable individuals and lists several circumstances which, should they occur during an applicable individual's designated expanded continuous eligibility period, would necessitate that the individual's Medicaid eligibility be terminated or redetermined, as appropriate. In this action, CMS is adding an applicable individual's failure to demonstrate community engagement to the list of exceptions to expanded continuous eligibility periods in STC 6.7d. Section 1902(xx)(10) of the Act prohibits a waiver of the community engagement requirement under section 1902(xx) of the Act in a section 1115(a) demonstration. Beginning January 1, 2027, (or earlier if elected under the state plan) applicable individuals must demonstrate (or be deemed to demonstrate) community engagement at their next renewal. An applicable individual who does not demonstrate (or is not deemed to demonstrate) community engagement at this time will have their Medicaid eligibility terminated, provided they are not eligible under a different eligibility group.

Applicability of section 1902(xx) of the Act to certain individuals covered through section 1115(a)(2) expenditure authority

CMS determined that Utah's demonstration provides coverage to populations using section 1115(a)(2) expenditure authority that generally meets the criteria for applicable individuals at section 1902(xx)(9)(A)(i)(II) of the Act and at 42 CFR 435.551(b). In this action, CMS is making a conforming change in STC 4.3.f.iv. and STC 4.3.h. to indicate that the community engagement requirement applies to applicable individuals who are applicants for or beneficiaries enrolled in coverage under the Utah Medicaid Reform 1115 Demonstration section 1115(a)(2) expenditure authorities for the Adult Expansion Population and the Targeted Adult group. Utah is required to implement the community engagement requirement for the specified demonstration populations in Utah's demonstration not later than January 1, 2027. Implementation of community engagement in section 1115 demonstrations must be consistent with all applicable regulations.

The state is required to comply with section 1902(xx) of the Act and implementing regulations with respect to the populations of applicable individuals in the demonstration. In Utah's community engagement state plan amendment (SPA) submission, Utah will be asked to specify that it operates a demonstration that has applicable individuals eligible and enrolled in coverage authorized only by expenditure authority under section 1115(a)(2) of the Act.

Clarifying minimum essential coverage designations

Section 1902(xx)(9)(A)(i) of the Act and 42 CFR 435.551 define applicable individuals to include certain individuals who are not eligible for or enrolled in the Medicaid adult group under the state plan, and who are otherwise eligibility to enroll or are enrolled in a demonstration

project under section 1115(a)(2) of the Act that provides coverage that meets MEC requirements. As part of its work related to implementation of section 1902(xx) of the Act, CMS is reviewing currently authorized section 1115 demonstrations that provide eligibility for medical assistance under section 1115(a)(2) expenditure authority, and making MEC determinations applicable to each population. CMS is also reviewing previous MEC determinations to ensure they are up to date. In some instances, coverage for a population using section 1115(a)(2) demonstration expenditure authority was previously designated as MEC but no longer meets the standards described in section 5000A(f)(1)(A) of the Internal Revenue Code due to changes to the demonstration.

As part of this effort, CMS determined that individuals who are eligible for and enrolled in coverage under the section 1115(a)(2) expenditure authorities for Demonstration Populations III and V in the Utah Medicaid Reform 1115 Demonstration do not receive MEC. Therefore, in this action, CMS is adding a new STC that indicates that the Demonstration Populations III and V do not receive MEC through the Utah Medicaid Reform 1115 Demonstration.

Section 71120 – Modifying cost sharing requirements for certain expansion individuals under the Medicaid program

Beginning October 1, 2028, section 1916(k) of the Act, added by section 71120 of the WFTC legislation, will require states to impose cost sharing on certain services (not to exceed $35 for any care, item, or service) for specified individuals. This requirement applies to individuals whose family income exceeds 100 percent of the federal poverty level (FPL) and who are either: enrolled under the state plan in the Medicaid adult group under section 1902(a)(10)(A)(i)(VIII) of the Act; or are described in section 1902(a)(10)(A)(i)(VIII) of the Act who are enrolled "under a waiver" of the state plan that provides coverage equivalent to MEC to all individuals described in section 1902(a)(10)(A)(i)(VIII) of the Act. Section 1916(k) also exempts primary care, mental health care services, substance use disorder services, federally qualified heath center (FQHC), rural health clinic, and certified community behavioral health clinic services from cost sharing for this population, in addition to the previously existing exemptions. Aggregate out-of-pocket costs for all individuals in the family cannot exceed 5 percent of the family income.

CMS is still determining the applicability of this provision to section 1115 demonstrations and will provide more information about potential applicability to the Utah Medicaid Reform 1115 Demonstration at a future date.

Budget Neutrality

There are no changes to budget neutrality or allotment neutrality for this action.

Monitoring and Evaluation

The state is required to conduct systematic monitoring and evaluation in accordance with the demonstration STCs and to incorporate, as appropriate, the conforming changes specified in this letter and attachment into these activities. Monitoring and evaluation should identify and describe any observed changes in metrics or outcome measures, including relevant context, as

well as associated operational updates. In addition to other required content, these activities—including required deliverables and monitoring calls—should address any anticipated or actual challenges, risks, and program integrity considerations related to clarification of the applicability of the WFTC legislation and implementation of the conforming changes in this letter and attachment.

Other Information

This action for the demonstration project is conditioned upon compliance with the previously approved expenditure authorities and STCs (as modified as stated in this letter and Attachment M) which set forth in detail the nature, character and extent of anticipated federal involvement in the project. In addition, this action is subject to CMS receiving written acceptance within 30 days of the date of this letter. Your project officer is Julia Buschmann, who is available to answer any questions concerning your section 1115 demonstration. Ms. Buschmann's contact information is as follows:

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Email: Julia.Buschmann@cms.hhs.gov

If you have questions regarding this action, please contact Sarah Aker, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Sarah.Aker@cms.hhs.gov.

Sincerely,

Dan Brillman
Deputy Administrator, CMS
Director, Center for Medicaid and CHIP Services

Enclosure

cc: Lee Herko, State Lead, Medicaid and CHIP Operations Group

Attachment M
CONFORMING CHANGES TO SPECIAL TERMS AND CONDITIONS

This Attachment M makes conforming changes to the STCs that were approved on June 30, 2022, and amended and restated on January 16, 2026, as follows. Language CMS is newly adding is in red text. Language CMS is removing is in red text and struck through.

Edits to Not Applicable List: Section 71107 implementation in demonstrations with expanded continuous eligibility authorities.

Title XIX Requirements Not Applicable to the Demonstration Eligible Populations

8. Frequency of Eligibility Renewals **Section 1902(e)(14)(L)**

To enable Utah to complete an orderly transition from expanded continuous eligibility policy by allowing the state to defer implementation of six-month renewals for individuals in the Targeted Adults population who are covered by expanded continuous eligibility as otherwise required under section 1902(e)(14)(L) of the Act until the end of the currently approve demonstration period, June 30, 2027.

Edits to Not Applicable 2: Reducing state Medicaid costs by updating retroactive eligibility as described in section 71112

Title XIX Requirements Not Applicable to the Demonstration Eligible Populations

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

a. To permit the state not to provide retroactive eligibility for individuals in Demonstration Populations III and V.
b. To permit the state not to provide retroactive eligibility for individuals receiving family planning services and family planning related services.
c. To allow the state to provide one month of retroactive eligibility for individuals in the Adult Expansion Population or the Targeted Adult group.

Edits to STC 4.3: Aligning section 1115 eligibility policies with section 71109 changes and specifying section 71119 applicable individuals in the demonstration

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

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

five percent of the household's countable income. Individuals must also be a U.S. citizen, national, or individual who has satisfactory immigration status for full Medicaid benefits, pursuant to sections 1137(d) and 1902(a)(46)(B) of the Act, and for whom federal financial participation is available pursuant to section 1903(v)(5) of the Act.

c. Demonstration Population V consists of adults age 19 through 64 with countable gross family income above 133 percent of the FPL up to and including 200 percent of FPL, ~~are U.S. citizens or qualified non- citizen , are resident(s) of Utah,~~ do not qualify for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and would otherwise be eligible as a member of Demonstration Population III (except that the eligible individual or custodial parent/caretaker is able to enroll in COBRA continuation coverage based on any qualifying event rather than a qualifying ESI plan, and that COBRA-eligibles are not subject to the requirement that an employer subsidize at least 50 percent of the premium cost for the employee's health coverage). Individuals must also be a U.S. citizen, national, or individual who has satisfactory immigration status for full Medicaid benefits, pursuant to sections 1137(d) and 1902(a)(46)(B) of the Act, and for whom federal financial participation is available pursuant to section 1903(v)(5) of the Act.
d. …
e. …
f. The Targeted Adults are comprised of adults, ages 19-64, with incomes at zero percent of the FPL (effectively five percent of the FPL with the five percent disregard) and no dependent children. The state is required to comply with all requirements specified in section 1902(xx) of the Act and 42 CFR 435.550 through 435.563, with respect to this population of applicable individuals in the demonstration. Targeted adults must ~~who~~ meet one of the following additional criteria:
g. …
h. Adult Expansion Population is comprised of adults, ages 19 through 64, who are not Current Eligibles, ~~who are U.S. citizens/qualified non-citizens, are residents of Utah,~~ and have household income at or below 133 percent of the FPL. Individuals must also be a U.S. citizen, national, or individual who has satisfactory immigration status for full Medicaid benefits, pursuant to sections 1137(d) and 1902(a)(46)(B) of the Act, and for whom federal financial participation is available pursuant to sections 1903(v)(4) or 1903(v)(5) of the Act. To remain eligible for Medicaid, beneficiaries in this eligibility group who have access to ESI are required to enroll in a qualified ESI plan, as defined by the state. The state is required to comply with all requirements specified in section 1902(xx) of the Act and 42 CFR 435.550 through 435.563, with respect to this population of applicable individuals in the demonstration.
i. …
j. …

Edits to STC 5.2(a): Clarifying minimum essential coverage designations

STC 5.2(a)(i). Minimum Essential Coverage (MEC). The Utah Medicaid Reform 1115 Demonstration includes coverage of a limited benefits package for Demonstration Populations III and V, as described in STC 5.2. Consequently, the coverage available to these populations

through this demonstration is not recognized as minimum essential coverage (MEC) with respect to enrollees, consistent with the guidance set forth in the State Health Official Letter #14-002, issued by CMS on November 7, 2014.

Edits to STC 6.7(d): Aligning section 1115 expanded continuous eligibility authorities with section 71119 requirements

STC 6.7(d): The state will provide continuous benefits for a period of 12 months to the Targeted Adults. Changes during this period will not affect a beneficiary's benefits with the exception of the following reasons:

i. Moving out of state;
ii. Death;
iii. Determined eligible for another Medicaid eligibility category;
iv. Fraud; or
v. Client request.
vi. Beginning January 1, 2027, the individual is an applicable individual who does not demonstrate, or is not deemed to demonstrate, community engagement under section 1902(xx) of the Act and 42 CFR 435.550 through 435.563.

Edits to STC 6.7: Aligning section 1115 expanded continuous eligibility authorities with section 71109 changes

STC 6.7(f): Expanded Continuous Eligibility for Noncitizens Ineligible for FFP. For current Medicaid beneficiaries in an expanded continuous eligibility period, beginning October 1, 2026, the state must apply the FFP limitations under section 1903(v)(5) of the Act. FFP is limited to payment for emergency Medicaid coverage during the remainder of the expanded continuous eligibility period for such Medicaid beneficiaries who are not U.S. citizens or nationals, Lawful Permanent Residents (LPRs), Cuban/Haitian entrants, or Compact of Free Association (COFA) migrants and are not eligible as a child who is lawfully residing in the U.S. under Utah's election of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) 214 option in accordance with section 1903(v)(4) of the Act.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

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

TITLE: Utah Medicaid Reform 1115 Demonstration

AWARDEE: Utah Department of Health and Human Services

All Medicaid and Children's Health Insurance Program (CHIP) requirements expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning November 13, 2025, through June 30, 2027, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

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

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

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

TITLE: Utah Medicaid Reform 1115 Demonstration

AWARDEE: Utah Department of Health and Human Services

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

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

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

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

4. **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.

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

6. **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).

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

8. **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.

9. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness.** Expenditures for services furnished to eligible individuals age 21 through 64 who receive treatment for a serious mental illness (SMI) and who are short-term residents in facilities that meet the definition of an IMD.

10. **Expenditures Related to Fertility Preservation for Beneficiaries Diagnosed with Cancer.** Expenditures for fertility preservation provided to eligible individuals with an active diagnosis of cancer which puts them at risk for sterility or iatrogenic infertility as described in STC 5.10.

11. **Expenditures Related to In Vitro Fertilization and Genetic Testing Services.** Expenditures for in vitro fertilization and genetic testing services for qualifying individuals as described in STC 5.11.

12. **Expenditures for Pre-Release Services**. Expenditures for pre-release services, as described in section 13 of these STCs, furnished to individuals who meet qualifying criteria in STC

13.3 for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration Initiative under this demonstration.

13. **Expenditures for Pre-Release Administrative Costs.** Capped expenditures for payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions, as is detailed in STC 13.12, which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903, to the extent such activities are authorized as part of the Reentry Demonstration Initiative.

14. **Dental Services.** Expenditures for dental services provided to all Medicaid-eligible adults and children as well as Medicaid-eligible pregnant and postpartum women.

15. **Health-Related Social Needs (HRSN) Services.** Expenditures for allowable HRSN services not otherwise covered that are furnished to individuals who meet the qualifying criteria as described in Section 12. This expenditure authority is contingent upon compliance with Section 14, as well as all other applicable STCs.

16. **Health-Related Social Needs Services Infrastructure.** Expenditures for allowable HRSN administrative and infrastructure costs not otherwise covered under section 1903 of the Act, as described in section 12 of the STCs.

17. **Expenditures for Non-Medical Transportation (NMT).** Expenditures for NMT described in STC 12.20.

18. **Expenditures for Continuous Eligibility for State Plan Benefits For the Full Pregnancy and 12-Month Period:** Expenditures for pregnant and postpartum individuals to be continuously eligible without regard to changes in circumstances through the end of the 12-month extended postpartum eligibility period as set forth in STC 4.3(i).

19. **Family Planning Services and Family Planning Related Services.** Expenditures for providing Medicaid eligibility for family planning services and family planning related services, limited to:

    Women and men age 18 and older with family income at or below 185 percent of the FPL (using MAGI methodology which includes a 5 percent FPL income disregard) who are not in a public institution and are not otherwise enrolled in Medicaid or the Children's Health Insurance Program (CHIP), as described in STC 5.12.

<u>Title XIX Requirements Not Applicable to the Demonstration Eligible Populations</u>

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

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

Section 1902(a)(17)

a. To enable the state to vary the amount, duration, and scope of services offered to individuals by demonstration group, with the exception of Former Foster Care Youth from another state to whom state plan services will be provided.
b. To enable the state to vary the amount, duration, and scope of services to individuals in the Targeted Adults, blind, aged, and disabled expenditure populations.
c. To enable the state to include additional benefits, such as behavioral health, case management, and health education not otherwise available, to Medicaid beneficiaries who are enrolled in a managed care delivery system.
d. To enable the state, through December 31, 2023, to vary the amount, duration, and scope of services offered to individuals in the Adult Expansion Population demonstration, based on whether the individual is a custodial parent/caretaker or not a custodial parent/caretaker.
e. To enable the state to provide a benefit package consisting only of ESI and COBRA premium subsidies to Populations III and V.
f. To enable the state to provide fertility treatment as described in STC 5.10 for beneficiaries diagnosed with cancer.
g. To enable the state to provide in vitro fertilization and genetic testing services as described in STC 5.11.
h. To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.
i. To the extent necessary to allow the state to offer HRSN services and to vary the amount, duration, and scope of HRSN services covered for a subset of beneficiaries, depending on beneficiary needs as determined by the application of qualifying criteria, as specified in Section 12 of the STCs.
j. To enable the state to provide a benefit package consisting only of family planning services and family planning-related services, as described in STC 5.12.

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

a. To permit the state not to provide retroactive eligibility for individuals in Demonstration Populations III and V.
b. To permit the state not to provide retroactive eligibility for individuals receiving family planning services and family planning related services.

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

a. To enable the state to provide differing types of managed care plans in certain geographical areas of the state for Title XIX populations affected by this demonstration.
b. To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.
c. To enable the state to provide housing and home environment interventions without

room and board, short-term recuperative care, and short-term rental assistance services on a less-than statewide basis, per the phase-in schedule described in STC 12.11.

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

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

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

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

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

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

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

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

Title XXI Expenditure Authorities

Under the authority of section 1115(a)(2) of the Act as incorporated into Title XXI by section 2107(e)(2)(A), state expenditures described below, shall, for the period of this demonstration, July 1, 2022 through June 30, 2027, and to the extent of the state's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the state's Title XXI plan. All requirements of Title XXI will be applicable to such expenditures for Demonstration

Population VI, described below, except those specified below as not applicable to these expenditure authorities.

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

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

Title XXI Requirements Not Applicable to Children's Health Insurance Program (CHIP) Expenditure Authorities for Demonstration Population VI and Current Eligible CHIP Children

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

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

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

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

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

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

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

To the extent necessary to permit AI/AN children who are in all CHIP populations affected by this demonstration, and whose benefits are limited to premium assistance, to be charged

premiums and/or cost sharing by the plans in which they are enrolled.

5. Benefit Package Requirements **Section 2103**

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

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

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

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

TITLE: **Utah Medicaid Reform 1115 Demonstration**

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

1. PREFACE

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

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

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

Attachment A.	SUD Implementation Plan
Attachment B.	SMI/SED Implementation Plan
Attachment C.	Non-Traditional Benefit Package
Attachment D.	Traditional Benefit Package
Attachment E.	Modified Adjusted Gross Income (MAGI) Conversion Table
Attachment F.	Claiming Methodologies
Attachment G.	Reentry Demonstration Initiative Implementation Plan *[reserved]*
Attachment H.	Reentry Demonstration Initiative Reinvestment Plan *[reserved]*
Attachment I.	Protocols for HRSN Infrastructure and HRSN Services
Attachment J.	HRSN Implementation Plan *[reserved]*
Attachment K.	Provider Payment Rate Increase Assessment – Attestation Table
Attachment L.	Postpartum Proxy Methodology
Attachment M.	Evaluation Design

2. PROGRAM DESCRIPTION AND OBJECTIVES

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

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

The demonstration offers ESI (Demonstration Population III), or Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) (Demonstration Population V) premium subsidies for state qualified insurance plan. Individuals, their spouses, and their children, ages 19 through 26, who have household incomes above 133 percent of the FPL up to and including 200 percent of the FPL are eligible to enroll in the ESI or COBRA programs. In addition, Children's Health Insurance Program (CHIP) eligible children with household income up to 200 percent of the FPL can elect ESI or COBRA premium subsidies as an alternative to direct coverage, provided the ESI or COBRA coverage meets the minimum benefit requirements. The state provides dental wrap around benefits through direct CHIP coverage if dental is not offered in the child's ESI or COBRA plan.

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

The demonstration also authorizes dental benefits for all beneficiaries who are ages 21 and over, children, and pregnant or postpartum women. In addition, all Medicaid beneficiaries, age 21 through 64, have access to Medicaid services while residing in an institution for mental diseases (IMD) for SUD or serious mental illness (SMI) short-term residential stays. The demonstration also provides full state plan coverage for former foster care youth who were enrolled in Medicaid upon "aging out" of foster care in another state or tribe and are now applying for Medicaid as a resident in Utah.

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

On January 8, 2025, CMS approved coverage of a HRSN services and expanded dental services to all Medicaid-eligible adults. As part of this approval, CMS has authorized payments for allowable infrastructure costs related to implementation of the HRSN initiative. CMS also approved expenditure authority for the state to provide non-medical transportation (NMT) to and from HRSN services for beneficiaries who meet HRSN criteria. Lastly, CMS authorized an increase in the upper age limit for fertility preservation services for individuals diagnosed with cancer; the upper age limit increased from 40 years of age to 50 years of age.

On November 13, 2025, CMS approved coverage for family planning services and family planning related services for adults. CMS also approved authority for the state to provide extended postpartum coverage to individuals enrolled in Medicaid for the period of time up to 12 months from the last day of an individual's pregnancy. Lastly, CMS approved coverage for dental services for children and pregnant or postpartum women enrolled in Medicaid. These individuals will receive these services through the fee-for-service (FFS) delivery system, rather than through managed care plans, in partnership with the University of Utah School of Dentistry and their associated statewide provider network.

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

- Provide health care coverage for low-income Utahns eligible under the demonstration who would not otherwise have access to, or be able to afford, health care coverage;
- Improve beneficiary health outcomes and quality of life;
- Lower the uninsured rate of low income Utahns;

- Provide continuity of coverage for individuals eligible under the demonstration;
- Increase access to primary care;
- Reduce uncompensated care provided by Utah hospitals;
- Reduce barriers to health care and housing, an important social determinant of health;
- Increase the utilization of preventive dental services, while reducing emergency dental procedure costs;
- Improve access to services across the continuum of care;
- Provide for better care coordination for individuals transitioning to community-based care;
- Reduce the utilization of emergency departments and inpatient hospital settings for treatment where utilization is preventable or medically inappropriate;
- Reduce the overdose death rate; and
- Improve access to fertility preservation services for Medicaid eligible individuals diagnosed with cancer, as well as access to in vitro fertilization (IVF) services for individuals diagnosed with certain genetic disorders.

3. GENERAL PROGRAM REQUIREMENTS

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

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

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

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

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made

under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality agreement for the demonstration as necessary to comply with such change as well as an allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation becomes effective, or on the last date such legislation was required to be in effect under the law, whichever is sooner.

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

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

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

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

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

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

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

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

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

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

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

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

outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

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

d. Transition and Phase-out Procedures. The state must comply with all applicable notice and fair hearing requirements found in 42 CFR 435.917 and 42 CFR part 431 subpart E. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination, 42 CFR 435.916. For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

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

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

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

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

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

3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to applying to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates. For substantial modifications to the ABP in this demonstration, the state must follow the public notice requirement set forth in 42 CFR 440.386.

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

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

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

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

4. ELIGIBILITY

4.1. **Eligibility Criteria.** Mandatory and optional Medicaid state plan populations derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws

and regulations in accordance with the Medicaid state plan, except as expressly not applied and as described in these STCs.

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

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

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

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

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

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

plan, and that COBRA-eligibles are not subject to the requirement that an employer subsidize at least 50 percent of the premium cost for the employee's health coverage).

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

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

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

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

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

    i. Be chronically homeless, defined as:

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

        2. An individual living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for a total of six months within a 12-month period; and has a diagnosable substance use disorder or serious mental health disorder. At the option of the state, these criteria may be expanded to include individuals with a

diagnosable developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability;

3. An individual who is a victim of domestic violence who is living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter; or
4. An individual currently living in supportive housing who has previously met the definition of chronically homeless as specified in paragraphs (i)(1), (i)(2), or (i)(3), above.

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

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

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

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

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

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

h. Adult Expansion Population is comprised of adults, ages 19 through 64, who are not Current Eligibles, who are U.S. citizens/qualified non-citizens, are residents of Utah, and have household income at or below 133 percent of the FPL. To remain eligible for Medicaid, beneficiaries in this eligibility group who have access to ESI are required to enroll in a qualified ESI plan, as defined by the state.

i. The Extended Postpartum Coverage population is comprised of women who are eligible for Medicaid during their pregnancy.

    i. The state will extend postpartum coverage for individuals from the end of the state plan 60-day postpartum period to the end of the 12th month following the end of the pregnancy.

    ii. To be eligible for continuous extended postpartum coverage, individuals must be enrolled in any Medicaid eligibility group while pregnant (including during a period of retroactive eligibility). Individuals who are eligible for extended postpartum coverage will remain enrolled continuously within their eligibility group regardless of changes in circumstances (except for changes in state residency, if the individual requests voluntary termination, or the individual is deceased) from pregnancy through the duration of the extended 12-month postpartum period.

    iii. The state will conduct any required redetermination or renewal of eligibility at the end of the extended postpartum period consistent with 42 CFR 435.916. This includes determining Medicaid eligibility on all bases consistent with 42 CFR 435.916 prior to determining an individual ineligible. Individuals determined eligible on another basis at the end of the postpartum period will be moved to the appropriate group at that time. Individuals determined ineligible for Medicaid on all bases will be provided advance notice of termination in accordance with 42 CFR 435.917 and 42 CFR Part 431, Subpart E, and assessed for potential eligibility for other insurance affordability programs in accordance with 42 CFR 435.916.

    iv. Postpartum Coverage for the Adult Group. The state has submitted to CMS a proxy methodology for state expenditures to qualify for the newly eligible FMAP under section 1905(y) of the Act, consistent with requirements provided in 42 CFR 433.206(d). This methodology has been approved by CMS and is incorporated as Attachment L to these STCs. The proxy methodology identifies the proportion of claimed expenditures for beneficiaries receiving post-partum benefits who are reasonably estimated to meet the definition of newly eligible under section 1905(y)(2)(A) of the Act

for whom enhanced newly eligible FMAP may be claimed, and the proportion claimed for beneficiaries who do not meet this definition for whom the regular FMAP must be claimed.

j. The Family Planning and Family Planning Related population is comprised of adults, ages 18 and older, who are not in a public institution.

5. BENEFITS

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

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

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

Long Term Care	Not covered
Transportation Services	Ambulance (ground and air) for medical emergencies only (non-emergency transportation, including bus passes, is not covered)
Dental	Dental services are not covered, with exceptions.

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

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

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

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

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

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

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

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

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

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

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

i. For ESI plans –

1. Children = $180 per enrollee per month with state wrap around dental benefits,
2. Children = $200 per enrollee per month if the plan provides dental benefits comparable to those offered through direct state coverage,

ii. For COBRA plans –

1. Children = $180 per enrollee per month with state wrap around dental benefits,
2. Children = $200 per enrollee per month if the plan provides dental benefits comparable to those offered through direct state coverage.

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

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

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

5.5. **Dental Benefit.** All adults who are enrolled in Medicaid, as well as Medicaid-eligible children and pregnant and postpartum women will receive dental benefits that are defined in the Utah Medicaid Provider Manual, *Dental, Oral Maxillofacial, and Orthodontia Services*.

5.6. **Targeted Adults.** Beneficiaries enrolled in this eligibility category will receive full Medicaid state plan benefits.

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

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

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

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

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

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

parameters of services authorized in the currently approved Medicaid State Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. Mandatory ESI Enrollees. Beneficiaries in this eligibility group that are eligible to enroll in a qualified ESI plan (as described in STC 4.3(h)), are required to enroll in that plan and will be reimbursed for the full amount of the beneficiary's share of the monthly premium cost of the qualified ESI plan. In order to ensure the beneficiary receives Medicaid benefits, wrap-around benefits will be provided through a fee-for-service (FFS) delivery system.

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

a. Psychoeducational services (mental health rehabilitation);

b. Personal services;

c. Respite care; and

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

5.10. **Fertility Preservation for Individuals Diagnosed with Cancer.** Fertility preservation services are available for beneficiaries undergoing gonadotoxic cancer treatments, or other medically necessary treatment, that is expected to render them permanently infertile. Cost sharing requirements for this benefit will not differ from those under the state plan. Reimbursement for cryopreservation storage is covered as a single payment for five years. Additional 5-year storage increments may only be requested for members that retain eligibility.

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

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

ii. The beneficiary is post-pubertal and younger than 50 years of age;

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

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

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

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

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

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

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

their eligibility for Medicaid.

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

i. Services provided under this benefit require prior authorization.

ii. Investigational or experimental procedures will not be covered.

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

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

d. **Monitoring, Reporting, and Evaluation.** The monitoring, reporting, and evaluation of this benefit will be subject to the same requirements as the overall demonstration, as described in Sections 16 (Monitoring and Reporting Requirements) and 19 (Evaluation of the Demonstration) of these STCs. The state will follow CMS guidance to ensure the Evaluation Design is amended to provide a rigorous evaluation of this component of the demonstration.

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

a. **Eligibility.**

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

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

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

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

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

dystrophy.

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

   i. Genetic testing services for individuals that satisfy the requirements in STC 5.11(a);

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

   iii. In vitro fertilization services for individuals that satisfy the requirements in STC 5.11(a).

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

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

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

d. **Monitoring, Reporting, and Evaluation.** The monitoring, reporting, and evaluation of this benefit will be subject to the same requirements as the overall demonstration, as described in Sections 16 (Monitoring and Reporting Requirements) and 19 (Evaluation of the Demonstration) of these STCs. The state will follow CMS guidance to ensure the Evaluation Design is amended to provide a rigorous evaluation of this component of the demonstration.

5.12. **Family Planning Services and Family Planning Related Services.**

Family Planning Services. Individuals eligible under this demonstration will receive family planning services and supplies as described in section 1905(a)(4)(C) of the Act. Family planning services and supplies are reimbursable at the 90 percent Federal matching rate and are limited to those services and supplies whose primary purpose is family planning to prevent or delay pregnancy. The specific family planning services provided under this demonstration are as follows:

a. Comprehensive family planning preventive visits based on nationally recognized clinical guidelines that must have a primary focus and diagnosis of family planning,

which includes counseling, education, and initiation or management of contraceptive methods.

b. FDA-approved methods of contraception;

c. Screening for sexually transmitted infection (STI) or sexually transmitted disease (STD) during a family planning visit, Pap smears, and pelvic exams.
Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood counts, and pregnancy tests. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program, or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.

d. Drugs, supplies, or devices related to family planning services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements, subject to the national drug rebate program requirements;

e. Contraceptive management, patient education, and counseling; and

f. Sterilization procedures and devices, the office visits or physical exams related to and necessary for sterilization or long-acting reversible contraception, laboratory testing necessary to complete a sterilization or long-acting reversible contraception insertion, and approved prescription medication to treat anxiety and pain in relation to the sterilization procedure. The covered procedures are vasectomies, salpingectomy, tubal occlusions, and tubal ligations, which must meet the requirements of 42 CFR 441, Subpart F. All prescription medications must be directly related to the sterilization procedure and align with the State's preferred drug list.

Family Planning Related Services. Individuals eligible under this demonstration will also receive family planning related services and supplies, defined as those services provided as part of or as follow-up to a family planning visit for diagnosis and treatment pursuant to a family planning visit, such as contraceptive counseling, and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. Examples of family planning related services and supplies include:

g. Treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/diagnosed during a screen pursuant to a routine or periodic family planning visit. A follow-up visit or encounter for the treatments, such as drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines, may be covered;

h. STI/STD diagnosis and treatment pursuant to a family planning visit, such as contraceptive counseling; and

i. FDA-approved vaccination for Human Papillomavirus (HPV).

6. ENROLLMENT AND IMPLEMENTATION

6.1. General Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.6. **Enrollment in Dental Benefits.** There is no separate enrollment process required for Medicaid-enrolled individuals to receive dental services through this demonstration.

6.7. **Targeted Adults Enrollment.**

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

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

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

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

   i. Moving out of state;

   ii. Death;

   iii. Determined eligible for another Medicaid eligibility category;

   iv. Fraud; or

   v. Client request.

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

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

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

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

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

    ii. Returning Medicaid beneficiaries will have their previous managed care plan reinstated if it has been less than two years since they were enrolled in managed care. If it has been more than two years or if their previous managed care plan is no longer available for enrollment, their pending assignment will be based on the "round robin" method, after taking into consideration the beneficiary's history with a primary care provider.

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

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

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

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

ii. Beneficiaries with presumptive eligibility;

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

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

v. Adult Expansion Population beneficiaries mandatorily enrolled in ESI.

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

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

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

7. COST SHARING

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

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

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

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

8. DELIVERY SYSTEMS

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

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

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

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

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

8.6. **Dental Services.**

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

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

ii. The contracted entities must guarantee access statewide.

9. FEDERAL MEDICAL ASSISTANCE PERCENTAGE

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

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

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

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

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

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

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

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

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

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

10. SUBSTANCE USE DISORDER

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

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

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

SUD Benefit	Medicaid Authority	Expenditure Authority
Early Intervention (Screening, Brief Intervention and Referral to Treatment)	State plan (Individual services covered)	
Outpatient Therapy	State plan (Individual services covered)	

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

10.2. **SUD Implementation Plan.** The state's SUD Implementation Plan, initially approved for the period from November 1, 2017 through June 30, 2022, remains in effect for the approval period from July 1, 2022 through June 30, 2027, and is affixed to the STCs as Attachment A. Any future modifications to the approved SUD Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral.

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

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

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

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

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

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

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

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

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

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

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

health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan also identifies areas of SUD health IT ecosystem improvement.

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

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

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

d. The SUD Health IT Plan addresses how the state's PDMP enhances ease of use for prescribers and other state and federal stakeholders.[2] This also includes plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan describes ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions— prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

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

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

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

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

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

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

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

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

h. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Monitoring Reports (see STC 14.5).

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

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

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

11. SERIOUS MENTAL ILLNESS PROGRAM AND BENEFITS

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

11.2. **SMI/SED Implementation Plan.** The state's SMI/SED Implementation Plan, initially approved for the period from December 16, 2020 through June 30, 2022, remains in effect

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

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

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

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

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

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

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

   v. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based

screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);

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

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

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

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

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

iv. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers);

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

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

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

ii. Commitment to implementation of the SMI/SED Financing Plan described in STC 11.4;

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

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

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

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

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

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

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

Plan, and was included as a section of the SMI/SED Implementation Plan (see STC 11.2) to develop the infrastructure/capabilities of the state's health IT infrastructure.

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

The state monitors progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Monitoring Report (see STC 14.5).

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

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

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

Components of the Health IT Plan include:

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

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

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

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

11.4. **SMI/SED Financing Plan.** As part of the SMI/SED Implementation Plan referred to in STC 11.2, the state submitted a financing plan for approval by CMS. The SMI Financing Plan is incorporated into the STCs as part of the Implementation Plan in Attachment B and, may only be altered with CMS approval. Components of the SMI/SED Financing Plan include:

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

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

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

11.5. **Availability of FFP for the SMI/SED Services Under Expenditure Authority #11**. FFP is only available for services provided to beneficiaries during short term stays in an IMD to receive acute care for a primary diagnosis of SMI or SED. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving covered services in an IMD. Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at

the mid-point assessment, the state may only claim FFP for services furnished to beneficiaries during IMD stays of up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days—or 45 days, as relevant.

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

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

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

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

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

12. HEALTH-RELATED SOCIAL NEEDS

12.1. **Health-Related Social Needs (HRSN) Services.** The state may claim FFP for expenditures for certain qualifying HRSN services identified in STC 12.2 and Attachment I, subject to the restrictions described below. Expenditures are limited to expenditures for items and services not otherwise covered under Title XIX, but consistent with Medicaid demonstration objectives that enable the state to continue to increase the efficiency and quality of care. All HRSN interventions must be evidence-based and medically appropriate for the population of focus based on clinical and social risk factors. The state is required to align clinical and health-related social risk criteria across services and with other relevant, non-Medicaid social support agencies, to the extent possible and appropriate. The HRSN services may not supplant any other available funding sources such as housing supports available to the beneficiary through other local, state, or federal programs. The HRSN services will be the choice of the beneficiary; a beneficiary can opt out of HRSN services anytime; and the HRSN services do not absolve the state or its managed care plans, as applicable, of their responsibilities to make payment for other covered services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on a beneficiary's receipt of HRSN services. The state must submit additional details on covered services as outlined in STC 12.10 (Service Delivery) and Attachment I.

12.2. **Allowable HRSN services**. The state may cover the following HRSN services:

a. Housing Interventions, including:

i. Housing supports without room and board, including:

1. Pre-tenancy navigation services (e.g., finding and securing housing).

2. One-time transition and moving costs other than rent, to assist with identifying, coordinating, securing, or funding one-time necessary services and modifications to help a person establish a basic household (e.g., security deposit, application and inspection fees, utilities activation fees and payment in arrears as necessary to re-establish utility service (capped at a total of six months of total arrear and prospective payments), movers, relocation expenses, pest eradication, cooking supplies, and the purchase of household goods and furniture). Allowable utilities include water, garbage, sewage, recycling, gas, electric, internet, and phone services. This does not include clothing.

3. Tenancy and sustaining services (e.g., eviction prevention, tenant rights education).

ii. Home remediations that are medically necessary, including, for example, air filtration devices, air conditioning, ventilation improvements, humidifiers, refrigeration for medication, carpet replacement, mold and/or pest removal, and/or housing safety inspections.

iii. Home/environmental accessibility modifications, including, for example, wheelchair accessibility ramps, handrails, and grab bars.

iv. Episodic housing interventions with clinical services with room and board, limited to a clinically appropriate amount of time, including:

1. Short-term recuperative care, where integrated, clinically oriented recuperative or rehabilitative services and supports are provided for individuals who require <u>ongoing monitoring and continuous access to medical care</u>.

2. Short-term post-transition housing (e.g., post-hospitalization), where integrated, clinically oriented rehabilitative services and supports are provided, but <u>ongoing monitoring of the individual's condition by clinicians is not required</u>.

v. Room and board-only supports (also referred to as “rent-only” supports or interventions), limited to a clinically appropriate amount of time, including:

1. Short-term rental assistance with room alone or with room and board together, without clinical services included in the rental assistance payment.

12.3. **HRSN Intervention Duration and Frequency.**

a. Housing interventions with room and board.

i. Housing interventions that are classified as episodic interventions, as described in STC 12.2(b)(iv) may be covered for a qualifying beneficiary, as medically appropriate, up to a combined 6 months per rolling year. For purposes of this demonstration, rolling year is defined as a continuous 12-month period with the start date beginning when the beneficiary begins receiving the service.

ii. Housing interventions that are classified as room and board-only support, as described in STC 12.2(b)(v), may be covered for a qualifying beneficiary up to a combined 6 months per household per demonstration period.

iii. For each of these 6-month caps, coverage will be permitted in one or more spans or episodes, as long as the total duration remains under the cap for the rolling year or demonstration period. CMS will also apply a total combined cap of 6 months for all types of HRSN housing interventions with room and board (including episodic interventions and room and board-only supports), per beneficiary, in any 12-month period. However, if a beneficiary is considered to have received room and board-only support because that intervention was covered for another member of the beneficiary's household as specified in STC 12.3(b), the beneficiary still may receive up to 6 months of coverage for episodic interventions in the same 12-month period without violating this STC.

b. The state will define other HRSN service duration limitations in Attachment I, subject to CMS approval as indicated in STC 12.19.

12.4. **Excluded Services.** Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

a. Construction (bricks and mortar) except as needed for approved medically necessary home modifications specified in STC 12.2;

b. Capital investments;

c. Room and board outside of specifically enumerated care or housing transitions or beyond 6 months, except as specified in STC 12.2 and 12.3;

d. Research grants and expenditures not related to monitoring and evaluation;

e. Services furnished to beneficiaries for which payment is not available under the inmate payment exclusion in the matter following the last numbered paragraph of section 1905(a) of the Act except case management of HRSN services provided as part of an approved reentry demonstration initiative;

f. Services provided to individuals who are not lawfully present in the United States;

g. Expenditures that supplant services and/or activities funded by other local, state and/or federal governmental entities;

h. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

i. Any other projects or activities not specifically approved by CMS as qualifying for demonstration coverage as a HRSN item or service under this demonstration.

    i. For all HRSN housing interventions with room and board, the following setting exclusions apply: Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space.

12.5. **HRSN Infrastructure.**

a. The state may claim FFP for expenditures for infrastructure investments to support the development and implementation of HRSN services, subject to STC 12.3. This FFP will be available for the following activities:

    i. Technology – e.g., electronic referral systems, shared data platforms, electronic heath record (EHR) modifications or integrations, screening tool and/or case management systems, licensing, databases/data warehouses, data analytics and reporting, data protections and privacy, and accounting and billing systems.

    ii. Development of business or operational practices – e.g., developing policies, procedures and workflows, training and technical assistance, and administrative activities to support or expand HRSN operations.

    iii. Workforce development – e.g., recruiting and hiring, salary and fringe benefits for staff, necessary certifications, cultural competency training, trauma-informed training, developing and training staff on new policies and procedures, and training materials.

    iv. Outreach, education, and interested parties convening – e.g., design and production of outreach and education materials, translation, obtaining community input, and interested parties convening and community engagement activities.

b. The state may claim FFP for HRSN infrastructure expenditures for no more than the annual amounts outlined in Table 5. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years, not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 5. Annual Limits of Allowable Total Computable Expenditures for HRSN Infrastructure

	DY21	DY22	DY23	DY24	DY25	Total
Total Computable Expenditures	$0	$0	$4,150,000	$16,600,000	$12,450,000	$33,200,000

c. Infrastructure expenditures will receive the FFP match for applicable administrative costs for the expenditure

d. The infrastructure funding is separate and distinct from payments for delivery of HRSN services. The state must ensure that HRSN infrastructure expenditures described in STC 12.5 are not included in HRSN service payments (including capitation payments, as applicable) and that there is no duplication of payments to entities providing or administering HRSN service benefits.

e. The state may not claim any FFP in HRSN infrastructure expenditures until Attachment I: HRSN Infrastructure Protocol is approved, as described in STC 12.9. Once approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the beginning of when the demonstration expenditure authority for HRSN infrastructure was approved.

f. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

12.6. **Covered Populations.** Expenditures for HRSN services may be made for the populations of focus specified in Attachment I, consistent with this STC. To qualify to receive coverage for HRSN services, individuals must be Medicaid (or Medicaid demonstration)-eligible and have a documented medical/clinical need for the services and the services must be determined medically/clinically appropriate, as described STC 12.1, to address the documented need. Medical appropriateness must be based on clinical and health-related social risk factors. This determination must be documented in the beneficiary's care plan or medical record. Additional detail, including the clinical and other health related-social needs criteria, is outlined in Attachment I. Attachment I, the HRSN Service Matrix, describes the full list of clinical and social risk factors the state anticipates incorporating into Attachment I over the course of the demonstration at the time of the demonstration approval of the expenditure authority for HRSN services. While Attachment I reflects the full list of clinical and social risk factors the state is authorized to implement, the state is not required to implement all of the clinical and social risk factors outlined in Attachment I. Additionally, the state can later include additional clinical and social risk factors in compliance with STC 12.7 and 12.8.

12.7. **Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications for HRSN Services.** The state must submit, for CMS approval, a Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications to CMS no later than 90 days after approval of the HRSN expenditure authority. The protocol must include, as appropriate, a list of the HRSN services and service

descriptions, the criteria for defining a medically appropriate population of focus for each service, the process by which those criteria will be applied including care plan requirements and/or other documented processes, and provider qualification criteria for each service. Any changes to the initial scope of clinical and social risk factors reflected in Attachment I must be effectuated through the process indicated in STC 12.8. The state must resubmit a revised protocol if required by CMS feedback on the initial submission. The state may not claim FFP for HRSN services until CMS approves the initial protocol. Once the initial protocol is approved, the state can claim FFP in expenditures for HRSN services retrospectively to the date of approval of the expenditure authority for HRSN services. The approved protocol will be appended to the STCs as Attachment I.

If the state adds new HRSN services beyond those specified in STC 12.2 through a demonstration amendment, the state must also submit revisions to the Protocol to CMS no later than 90 days after the approval of the amendment to the demonstration. The Protocol revisions must include a list of the new services and service descriptions provided through all delivery systems applicable, the criteria for defining a medically appropriate population of focus for each new service, the process by which those criteria will be applied including service plan requirements and/or other documented processes, and provider qualification criteria for each new service. This revised protocol must comply with applicable STCs.

Specifically, the protocol must include the following information:

a. A list of the covered HRSN services (not to exceed those allowed under STC 12.2), with associated service descriptions and service-specific provider qualification requirements.

b. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary qualifications, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.

c. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may determine the service to be medically appropriate.

    i. Plan to identify medical appropriateness based on clinical and social risk factors.

    ii. Plan to publicly maintain these clinical and social risk criteria to ensure transparency for beneficiaries and other interested parties.

d. A description of the process for developing care plans based on assessment of need.

    i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening.

    ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma informed, as appropriate.

12.8. **Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services:**

a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in Attachment I. Certain changes to the state's service offerings and qualifying criteria, within what CMS has approved in Attachment I, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN service or qualifying criteria :

i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.

ii. The state must provide public notice.

iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.

b. In addition to the requirements in (a) above, if the state seeks to implement additional clinical and/or social risk factors than what are included in approved Attachment I, the state must follow the process below to update the protocol:

i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and/or social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing so would not require an increase to the amount of the state's HRSN expenditure authority in Table 12.

ii. The state must receive CMS approval for the updated protocol prior to implementation of changes under this STC 12.8(b).

iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process outlined in this STC 12.8(b). This restriction is not applicable to the process and scope of changes outlined in STC 12.8(a).

12.9. **HRSN Infrastructure Protocol.** The state must submit, for CMS approval, an HRSN Infrastructure Protocol to CMS no later than 90 days after approval of the expenditure authority for HRSN infrastructure expenditures. The protocol must include the state's proposed uses of HRSN infrastructure funds. The state must resubmit the revised protocol as may be required by CMS feedback on the initial submission. The protocol may be updated as details are changed or added. The state may not claim FFP for HRSN infrastructure expenditures until CMS approves the protocol. Once the protocol is approved, the state can

claim FFP in HRSN infrastructure expenditures retrospectively to the date of approval of the expenditure authority for HRSN infrastructure. The approved protocol will be appended to the STCs as Attachment I: HRSN Infrastructure Protocol. If the state adds new HRSN services through a demonstration amendment, the state must submit revisions to the Protocol to CMS no later than 90 days after approval, if required based on changes to expenditures for HRSN infrastructure to support the newly added HRSN services. The revisions must include a list of proposed uses of HRSN infrastructure funds, if different than previously submitted.

Specifically, the protocol(s) must include the following information: Proposed uses of HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.

12.10. **Service Delivery.** HRSN services will be delivered through the FFS) delivery system.

a. HRSN services will be paid on a FFS basis when those HRSN services are provided to beneficiaries through the Medicaid FFS.

b. In accordance with STC 12.1, CMS expects the state to have appropriate claims data associated with each HRSN service. This is necessary to ensure appropriate fiscal oversight for HRSN services as well as monitoring and evaluation. This is also critical to ensure appropriate documentation for claims payment. Therefore, CMS requires that, for HRSN services delivered in a FFS delivery system, the state must clearly document the name and definition of each HRSN service as well as the coding used on claims data. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology codes that identify each HRSN service. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 12.15. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on the delivery of HRSN services through FFS.

12.11. **Phased In Implementation of HRSN Services.** As further discussed in the state's Implementation Plan as required in STC 12.19, the state will phase in HRSN service(s) on the following schedule: housing/home environment interventions without room and board will be available to the TAM population upon approval and will expand to additional populations on July 1, 2025; short-term recuperative care will be available once the state has secured no more than two qualified providers to deliver the service; short term rental assistance will be available no sooner than January 1, 2026 for a single urban county and, over the subsequent two years, will be available statewide.

12.12. **Compliance with Federal Requirements.** The state shall ensure HRSN services are delivered in accordance with all applicable federal statutes and regulation.

12.13. **Person Centered Plan.** The state shall ensure there is a person-centered service plan for each beneficiary receiving HRSN services that is person-centered, identifies the beneficiary's needs and individualized strategies and interventions for meeting those needs, and developed in consultation with the beneficiary and the beneficiary's chosen support network, as appropriate. The service plan must be reviewed and revised as appropriate at least every 12

months, when the beneficiary's circumstances or needs change significantly, or at the beneficiary's request.

12.14. **Conflict of Interest.** The state shall ensure appropriate protections against conflicts of interest in HRSN service planning and delivery, including by ensuring that appropriate separation of service planning and service provision functions is incorporated into the state's conflict of interest policies.

12.15. **HSRN Rate Methodologies.** For FFS payment methodologies and/or rates, the state must comply with the payment rate-setting requirements in 42 CFR Part 447, as though a state plan amendment were required, to establish any payment rate and/or methodology for HRSN services as approved under demonstration expenditure authority 16. The state must conduct state-level public notice under 42 CFR 447.205 prior to the implementation of the applicable FFS payment rates or methodologies for HRSN and maintain documentation of these FFP payment rates or methodologies on its website described in 42 CFR 447.203. The state may receive FFP for HRSN service expenditures authorized under this demonstration upon implementation of the FFS payment rates and/or methodologies for which it has conducted prior public notice and may begin claiming for this FFP (for dates of service no earlier than the effective date of approval for the relevant expenditure authority) no earlier than the date of submission of the payment rates and/or methodology to CMS for approval. However, any FFS payments to providers or claims for FFP prior to CMS approval of the payment rate or methodology must be reconciled to the ultimately approved FFS payment rate and/or methodology within one year of CMS's approval. All requirements for timely filing of claims for FFP continue to apply.

For managed care payments and rates (including capitation rates, non-risk payments, and state directed payments), the state must comply with all federal requirements, including those in 42 CFR Part 438 and these STCs. As applicable, the state must also notify CMS at least 60 days prior to intended implementation if it intends to direct its managed care plans on how to pay for HRSN services (i.e., state directed payments).

All rates/payment methodologies for HRSN services, for both FFS and managed care delivery systems, must be submitted to CMS for review and approval, including but not limited to fee-for-service payments as well as managed care capitation rates, any state directed payments that require prior written approval, and non-risk payments, as outlined in the STCs. For all payment methodologies and/or rates, for both FFS and managed care delivery systems, in addition to submitting the payment rates and/or methodology, the state must also submit all supporting documentation requested by CMS, including but not limited to how the rates and/or methodology were developed, state responses to any public comments on the rates and/or methodology (when applicable), and information about Medicaid non-federal share financing.

12.16. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding for ongoing social services related to housing and housing transition supports for the duration of the demonstration, not including one-time or non-recurring funding. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the HRSN

Implementation Plan required by STC 12.19 that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 14.5, with any justifications, including declines in available state resources, necessary to describe the findings, if the level of state funding is less than the comparable amount of the pre-demonstration baseline.

12.17. **Partnerships with State and Local Entities.** To ensure that expenditures for HRSN services under this demonstration do not supplant any other available funding sources available to the beneficiary through other local, state, or federal programs, the state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authorities) to assist beneficiaries in obtaining non-Medicaid funded housing supports, if available, upon the conclusion of temporary demonstration payment for such supports, in alignment with beneficiary needs identified in the beneficiary's care plan, as appropriate. The state will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 14.5, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Monitoring Reports.

12.18. **Provider Payment Rate Increase.** As a condition of approval of the HRSN services expenditure authority, the state must comply with the provider rate increase requirements in Section 18 of these STCs.

12.19. **HRSN Implementation Plan.**

a. The state is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs. The state must submit the MOE information required by STC 12.15 no later than 90 calendar days after approval of demonstration expenditure authority for HRSN services. All other Implementation Plan requirements outlined in this STC must be submitted no later than 9 months after the approval of demonstration expenditure authority for HRSN services. The Implementation Plan shall be submitted to CMS but does not require CMS approval. CMS will ensure it is complete and contains sufficient detail for purposes of on-going monitoring. The state may update the implementation plan

as initiatives are changed or added, with notification to CMS. The Implementation Plan will be appended as Attachment I.

b. At a minimum, the Implementation Plan must provide a description of the state's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need to repeat any information submitted to CMS under the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services; however, as applicable, the information provided in the two deliverables must be aligned and consistent.

c. The Implementation Plan must include information on, but not limited to, the following:

    i. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services interested parties to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation;

    ii. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries);

    iii. Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, qualification and consent to receive HRSN services, screening, referrals, and service provision;

    iv. A plan for tracking and improving the share of demonstration beneficiaries in the state who are eligible and enrolled in federal, state, and local housing assistance programs, relative to the number of total eligible demonstration beneficiaries in the state (including those who are eligible but unenrolled);

    v. An implementation timeline and considerations for demonstration evaluation that may be impacted by the timeline (e.g., in the case of a phased rollout of HRSN services), to facilitate robust evaluation designs;

    vi. Information as required per STC 12.16 (MOE); and

vii. Information as required per STC 12.17 (Partnerships with State and Local Entities).

12.20. **Non-Medical Transportation.** Non-medical transportation[4] (NMT) services may be provided to Medicaid beneficiaries eligible for HRSN services to and from HRSN services authorized under this demonstration. The HRSN services must be described in the beneficiary's care plan.

a. All NMT must be provided in alignment with the technical specifications, and safeguards required for NMT authorized under 1915(c) waiver or under 1915(i) state plan authorities.

13. REENTRY DEMONSTRATION INITIATIVE

13.1. **Overview of Pre-Release Services and Program Objectives.** This component of the demonstration will provide coverage for pre-release services up to 90 days immediately prior to the expected date of release to certain individuals who are inmates residing in state prisons, county jails, or youth correctional facilities (hereinafter "correctional facilities") as further specified in the STCs below. To qualify for services covered under this demonstration, individuals residing in correctional facilities must be eligible for Medicaid or as determined pursuant to an application filed before or during incarceration, and must have an expected release date no later than 90 days as further specified in the STCs below.

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

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

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

[4] Non-Medical Transportation is defined as transportation services offered in order to enable participants to gain access to 1915(c) waiver-coverable activities, community services, and resources, as specified by the beneficiary's care plan. NMT may be provided to receive HRSN services.

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

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

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

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

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

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

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

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

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 13.1;

b. Have been determined eligible for Medicaid; and

c. Have an expected release date within 90 days.

13.4. **Scope of Pre-Release Services**. The pre-release services authorized under the Reentry Demonstration Initiative include the following services to be detailed in the implementation plan required under STC 13.10. The state may provide these services in-person or, as-needed, through telehealth.

a. The covered pre-release services are:

i. Case management to assess and address physical and behavioral health needs, and health-related social needs;

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

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

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

v. Diagnostic services, including laboratory and radiology services, and treatment services in addition to those identified in STC 13.4(a)(ii);

vi. Prescribed drugs, in addition to those identified in STCs 13.4(a)(ii) and 13.4(a)(iii), and medication administration;

vii. Family planning services and supplies;

viii. Services provided by community health workers;

ix. Peer support services;

x. Treatment for Hepatitis C; and

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

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

13.5. **Participating Correctional Facilities**. The pre-release services will be provided at correctional facilities, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to the State Medicaid Agency's approval of a facility's readiness, according to the implementation timeline described in STC 13.9. States must be mindful of and ensure the policies, procedures, and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the Reentry Demonstration Initiative.

13.6. **Participating Providers**.

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

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

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

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

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

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

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

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

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

b. The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 13.3

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

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

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

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

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

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

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

13.10. **Reentry Demonstration Initiative Implementation Plan**. The state is required to submit a Reentry Demonstration Initiative Implementation Plan in alignment with the expectations outlined in the State Medicaid Director Letter (#23-003 Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated). As such, the implementation plan will identify for each milestone, as well as each associated action, what the state anticipates to be the key

implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the Reentry Demonstration Initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be incorporated into the STCs as Attachment G titled "Reentry Demonstration Initiative Implementation Plan," and may be revised only with CMS approval.

CMS will provide the state with a template to support developing of the Implementation Plan.

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

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

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

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

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

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

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

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

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

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

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

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

a. The Reentry Demonstration Initiative Planning and Implementation Program will provide expenditure authority to fund supports needed for Medicaid pre-release application and suspension/unsuspension planning and purchase of certified electronic health record (EHR) technology to support Medicaid pre-release applications In addition, Reentry Demonstration Initiative planning and implementation funds will provide funding over the course of the demonstration to support planning and IT investments that will enable implementation of the Reentry Demonstration Initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning among the State Medicaid

Agency and Qualified Applicants listed in STC 13.12(d) below. The specific use of this funding will be proposed by the qualified applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the correctional facility) and must be properly cost-allocated to Medicaid. These allowable expenditures may include the following:

i. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the Reentry Demonstration Initiative population with Medicaid application and enrollment for demonstration coverage. This includes the development of electronic interfaces for Qualified Applicants listed in STC 13.12(d). to communicate with Medicaid IT systems to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with Qualified Applicants listed in STC 13.12(d), in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

ii. **Hiring of Staff and Training.** Expenditures for Qualified Applicants listed in STC 13.12(d). to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medicaid enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

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

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

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

vi. **Additional Activities to Promote Collaboration**. Expenditures for additional activities that will advance collaboration among Utah's Qualified Applicants in STC 13.12(d). This may include conferences and meetings convened with the agencies, organizations, and other stakeholders involved in the initiative.

vii. **Planning**. Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying individuals who are potentially eligible for Medicaid; (2) assisting with the completion of a Medicaid or CHIP application; (3) submitting the Medicaid or CHIP application to the county social services department or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

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

b. The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 6. In the event that the state does not claim the full amount of FFP for a given demonstration year as defined in STC 15.12, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 6. Annual Limits of Total Computable Expenditures for Reentry Demonstration Initiative Planning and Implementation Program

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

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

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

14. MONITORING AND REPORTING REQUIREMENTS

14.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 ($5M) per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

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

b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps the state has taken to address such issues, and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

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

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

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables

will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

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

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

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

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

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

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

14.5. **Monitoring Reports.** The state must submit one Annual Monitoring Report each demonstration year (DY) that is due no later than 180 calendar days following the end of the DY. The state must submit a revised Annual Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. CMS will make on-going determinations about reporting frequency under the demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. See 42 CFR 431.420(d)(1)-(2).

The Annual Monitoring Report will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Monitoring Report must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and must be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. Per 42 CFR 431.428, the Annual Monitoring Report must document any policy or administrative difficulties in operating the demonstration. The Annual Monitoring Report must provide sufficient information to document key

operational and other challenges, underlying causes of challenges, and how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Annual Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The performance metrics will provide data to demonstrate the state's progress towards meeting the demonstration's goals and any applicable milestones. Per 42 CFR 431.428, the Annual Monitoring Report must document the impact of the demonstration on beneficiaries' outcomes of care, quality and overall cost of care, and access to care, as applicable. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. The Annual Monitoring Report must provide detailed information about deviations from CMS's applicable metrics technical specifications, relevant methodology, plans for phasing in metrics, and data or reporting issues for applicable metrics, in alignment with CMS guidance and technical assistance.

The state and CMS will work collaboratively to finalize the list of metrics to be reported on in the Annual Monitoring Report. The demonstration's monitoring metrics must cover categories to include, but not be limited to, eligibility, utilization of services, quality of care and health outcomes, and grievances and appeals. The state must report these metrics for all demonstration populations. Demonstration monitoring reporting does not duplicate or replace reporting requirements for other authorities, such as Home and Community Based Services and Managed Care authorities.

In addition, the state is expected to report monitoring metrics for the following demonstration initiative(s), as described below and per applicable CMS guidance:

i. For the SUD and SMI/SED component(s), the state's monitoring must cover metrics in alignment with CMS guidance and the demonstration's milestones as outlined in the SUD State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMD #17–003) and the SMI/SED SMDL dated November 13, 2018 (SMDL #18-011).

ii. For the Reentry demonstration initiative, the state must report on metrics that track implementation progress and milestones. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 13.4, provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional

facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in the Annual Monitoring Report narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

iii. For the HRSS and HRSN components of the demonstration, the state must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations.

For the HRSN initiatives, in alignment with STC 12.17, the state must additionally monitor and provide narrative updates on its progress in building and sustaining its partnership with existing housing agencies to leverage their expertise and existing housing resources instead of duplicating services. Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as SNAP and WIC) for which they are eligible. The Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol for Other Policies on the implementation of infrastructure investments tied to the HRSN initiatives.

As applicable, if the state, health plans, or health care providers will contract or partner with organizations to implement the demonstration, the state must use monitoring metrics that track the number and characteristics of contracted or participating organizations in specific demonstration programs, and corresponding payment-related metrics; these metrics are specifically relevant for the state's HRSN initiatives.

The reporting of these monitoring metrics may also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography) and by demonstration component, as appropriate. Subpopulation reporting can support identifying any gaps in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population.

c. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Annual Monitoring Report must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress

of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

14.6. **SUD, SMI/SED, and Reentry Mid-Point Assessment.** The state must contract with an independent entity (herein referred to as the Independent Assessor) to conduct an independent SUD Mid-Point Assessment and SMI/SED Mid-Point Assessment by June 30, 2025, and a Reentry Mid-Point Assessment by June 30, 2027. This timeline will allow for the Mid-Point Assessment to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning, and execution of the Mid-Point Assessment, the state must require that the Independent Assessor consult with key stakeholders such as, representatives of managed care organizations (MCO), health care providers, beneficiaries, community groups and other key partners.

a. The state must require that the assessor provide a Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations, and any recommendations. If requested, the state must brief CMS on the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

b. Elements of the Mid-Point Assessment must include:

i. An examination of progress toward meeting each milestone and timeframe approved in the Implementation Plan;

ii. A determination of factors that affected achievement on the milestones and performance metric gap closures to date;

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

iv. For milestones or targets identified by the Independent Assessor as at medium to high risk of not being met, recommendations for adjustments in the state's Implementation Plan, or to pertinent factors that the state can influence that will support improvement.

14.7. **Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan

may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS might withdraw an authority, as described in STC 3.10, if metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals and desired directionality, and the state has not implemented corrective action, and the circumstances described in STC 3.10 are met. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

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

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

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim or Summative Evaluation Reports stipulated in 19.7 and 19.8, respectively.

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

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

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

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 14.1.

14.9. **Monitoring Calls.** CMS will convene, no less frequently than quarterly, monitoring calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operations and implementation which align with the state's demonstration monitoring reports, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, eligibility and access, and progress on evaluation activities.

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

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

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

15. GENERAL FINANCIAL REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its

implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

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

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

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

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

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

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

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

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

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

15.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 14.2. This report must include:

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

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

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

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

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

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

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

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

15.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 16:

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

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

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

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

15.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart (table 7) provides a master list of MEGs defined for this demonstration.

Table 7: Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Current Eligibles	Main Budget Neutrality	X		X	See Expenditure Authority #1
Adult Expansion Population	Hypo	X		X	See Expenditure Authority #7
Mandatory ESI for Adult Expansion	Hypo	X		X	See Expenditure Authority #8
Targeted Adults	Hypo	X		X	See Expenditure Authority #5
Dental – Targeted Adults	Hypo	X		X	See Expenditure Authority #14
Dental – Blind & Disabled Adults	Hypo	X		X	See Expenditure Authority #14
Dental - Aged	Hypo	X		X	See Expenditure Authority #14
Dental Services	Hypo	X		X	See Expenditure Authority #14
Dental Services – Comprehensive	Hypo	X		X	See Expenditure Authority #14
Former Foster Care Youth From Another State	Hypo	X		X	See Expenditure Authority #4
SUD	Hypo	X		X	See Expenditure Authority #6
SMI	Hypo	X		X	See Expenditure Authority #9
ESI/COBRA	Hypo	X		X	See Expenditure Authority #2 and #3
In Vitro Fertilization and Genetic Testing Services	Hypo	X		X	See Expenditure Authority #11
Fertility Treatment for Individuals Diagnosed with Cancer – Male	Hypo	X		X	See Expenditure Authority #10
Fertility Treatment for Individuals Diagnosed with Cancer – Female	Hypo	X		X	See Expenditure Authority #10
Cryopreservation	Hypo	X		X	See Expenditure Authority #10
Reentry Initiative Services	Hypo	X		X	See Expenditure Authority #12

Table 7: Master MEG Chart					
Reentry Initiative Non-Services	Hypo		X	X	See Expenditure Authority #13
HRSN Services	SHAC		X	X	See Expenditure Authority #15
HRSN Infrastructure	SHAC		X	X	See Expenditure Authority #16
HRSN NMT	Hypo	X		X	See Expenditure Authority #17
Extended Postpartum Coverage	Hypo	X		X	See Expenditure Authority #18
Family Planning Services and Family Planning Related Services	Hypo	X		X	See Expenditure Authority #19

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

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

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

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

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section 16, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in section 16, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

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

Table 8: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	Detailed Description	Exclu sions	CMS-64.9 Line(s) To Use	How Expend. Are	MAP or ADM	Report Member	MEG Start Date	MEG End Date

Table 8: MEG Detail for Expenditure and Member Month Reporting								
				Assigned to DY		**Months (Y/N)**		
Current Eligibles	See Expenditure Authority #1	N/A	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	12/31/2023
Adult Expansion Population	See Expenditure Authority #7	N/A	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	Y	7/1/2022	6/30/2027
Mandatory ESI for Adult Expansion	See Expenditure Authority #8	N/A	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027
Targeted Adults	See Expenditure Authority #5	N/A	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027
Dental – Targeted Adults	See Expenditure Authority #14	N/A	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	3/31/2025
Dental - Blind & Disabled Adults	See Expenditure Authority #14	N/A	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	3/31/2025
Dental - Aged	See Expenditure Authority #14	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	3/31/2025
Dental Services	See Expenditure Authority #14	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of service	MAP	Y	4/1/2025	12/31/2025
Dental Services –	See Expenditure	N/A	Follow CMS-64.9 Base	Date of Service	MAP	Y	1/1/2026	6/30/2027

Table 8: MEG Detail for Expenditure and Member Month Reporting								
Comprehensive	Authority #14		Category of Service Definitions					
Former Foster Care Youth From Another State	See Expenditure Authority #4	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027
SUD	See Expenditure Authority #6	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027
SMI	See Expenditure Authority #9	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027
ESI/COBRA	See Expenditure Authority #2 & #3	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027
In Vitro Fertilization and Genetic Testing Services	See STC 5.11	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	MAP	Y; Each member month represents one user of the service in a given month	2/29/2024	6/30/2027
Fertility Treatment for Individuals Diagnosed with Cancer – Male	See STC 5.10	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	MAP	Y	2/29/2024	6/30/2027
Fertility Treatment for Individuals Diagnosed with Cancer – Female	See STC 5.10	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	MAP	Y	2/29/2024	6/30/2027
Cryopreservation	See STC 5.10	N/A	Follow CMS-64.10 Base	Date of Service	MAP	Y	2/29/2024	6/30/2027

Table 8: MEG Detail for Expenditure and Member Month Reporting								
			Category of Service Definitions					
Reentry Initiative Services	See Expenditure Authority #12	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	MAP	Y	7/2/2024	6/30/2027
Reentry Initiative Non-Services	See Expenditure Authority #13	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	ADM	Y	7/2/2024	6/30/2027
HRSN Services	See Expenditure Authority #15	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	ADM	Y	7/1/2025	6/30/2027
HRSN Infrastructure	See Expenditure Authority #16	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	ADM	Y	7/1/2025	6/30/2027
HRSN NMT	Expenditures for non-medical transportation for HRSN services	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	ADM	Y	7/1/2025	6/30/2027
Extended Postpartum Coverage	See Expenditure Authority #18	N/A	Follow standard CMS-64.9 Category of Service Definition	Date of Service	MAP	Y	1/1/2026	6/30/2027
Family Planning Services and Family Planning Related Services	See Expenditure Authority #19	N/A	Follow standard CMS-64.9 Category of Service Definition	Date of Service	MAP	Y	1/1/2026	6/30/2027

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

Table 9: Demonstration Years

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

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

15.14. **State Reporting for the Continuous Eligibility FMAP Adjustment.** 97.4 percent of expenditures for "newly eligible" individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) shall be claimed at the "newly eligible" FMAP rate as defined in 42 CFR 433.10(c)(6), unless otherwise adjusted as described in STC 15.13 above. The state must make adjustments on the applicable CMS-64 waiver forms to claim the remaining 2.6 percent or other applicable percentage of expenditures for individuals defined in 42 CFR 433.204(a)(1) at the state's regular Title XIX FMAP rate.

15.15. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in section 18. CMS will provide technical assistance, upon request.[5]

[5] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained

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

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

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

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

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

15.18. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated

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Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 15.18.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

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

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

    ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

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

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

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

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

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

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

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

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

16. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

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

16.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 7, Master MEG Chart and Table 8, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

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

16.4. **Main Budget Neutrality Test**. The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal

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

Table 10: Main Budget Neutrality Test

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

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

16.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

16.6. **Hypothetical Budget Neutrality Tests.**

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

Table 11a. Hypothetical Budget Neutrality Test 1								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**
Adult Expansion Population	PC	Both	4.7%	$651.40	$682.02	$714.07	$747.63	$782.77
Mandatory ESI for Adult Expansion	PC	Both	5.3%	$266.22	$280.33	$295.19	$310.84	$327.31
Targeted Adults	PC	Both	5.5%	$1,177.22	$1,242.97	$1,310.28	$1,382.35	$1,458.38
*PC = Per Capita; Agg = Aggregate								

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

Table 11b. Hypothetical Budget Neutrality Test 2								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**
Dental – Targeted Adults	PC	Both	5.3%	$40.57	$42.72	$44.98	—	—

Dental – Blind & Disabled Adults	PC	Both	4.8%	$21.08	$22.09	$23.15	—	—
Dental – Aged	PC	Both	3.4%	$34.00	$35.16	$36.36	—	—
Dental Services	PC	Both	5.9%	—	—	$19.64	$20.80	—

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

Table 11c. Hypothetical Budget Neutrality Test 3								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**
Former Foster Care Youth from Another State	PC	Both	5.2%	$1,679.32	$1,766,64	$1,858,51	$1,955.15	$2,056.82

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

Table 11d. Hypothetical Budget Neutrality Test 4								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**

SUD	PC	Both	5.2%	$4,468.94	$4,701.32	$4,945.79	$5,202.97	$5,473.52

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

Table 11e. Hypothetical Budget Neutrality Test 5								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**
SMI	PC	Both	5.3%	$14,998.93	$15,793.87	$16,630.95	$17,512.39	$18,400.55

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

Table 11f. Hypothetical Budget Neutrality Test 6								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**
ESI/COBRA	PC	Both	5.2%	$247.15	$260.00	$273.52	$287.74	$302.70

g. **Hypothetical Budget Neutrality Test 7: HRSN NMT.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 7. MEGs that are

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

Table 11g. Hypothetical Budget Neutrality Test 7								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**
HRSN NMT	PC	Both	5.2%	—	—	—	$8.58	$9.03

h. **Hypothetical Budget Neutrality Test 8: Fertility Preservation Services for Individuals Diagnosed with Cancer and In Vitro Fertilization and Genetic Testing.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 8. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 8 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 11h. Hypothetical Budget Neutrality Test 8								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**
Fertility Treatment for Individuals Diagnosed with Cancer – Male	PC	Both	5.3%	—	$500	$526.50	$554.40	$583.79
Fertility Treatment for Individuals Diagnosed with Cancer – Female	PC	Both	5.3%	—	$9,375.00	$10,042.46	$10,574.71	$11,135.17

Cryopreservation	PC	Both	5.3%	—	$500	$526.50	$554.40	$583.79
In Vitro Fertilization and Genetic Testing Services	PC	Both	5.0%	—	$7,421.38	$7,814.71	$8,228.89	$8,665.02

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

Table 11i: Hypothetical Budget Neutrality Test 9								
MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 21	DY 22	DY 23	DY 24	DY 25
Reentry	PC	Both	5.7%	—	—	$1,028.19	$1,086.80	$1,148.74
Reentry Non-Services	Agg	Both	N/A	—	—	$2,847,829.00	$4,271,743.50	$4,271,743.50

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

Table 11j: Hypothetical Budget Neutrality Test 10

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 21	DY 22	DY 23	DY 24	DY 25
Extended Postpartum Coverage	PC	Both	5.7%	—	—	—	$820.27	$867.03

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

Table 11k: Hypothetical Budget Neutrality Test 11								
MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 21	DY 22	DY 23	DY 24	DY 25
Family Planning Services and Family Planning Related Services	PC	Both	5.2%	—	—	—	—	$42.92

l. **Hypothetical Budget Neutrality Test 12: Dental Services – Comprehensive.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 12. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as

"WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 12 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 11l: Hypothetical Budget Neutrality Test 12								
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21**	**DY 22**	**DY 23**	**DY 24**	**DY 25**
Dental Services – Comprehensive	PC	Both	5.1%	—	—	—	$39.24	$41.24

16.7. **Supplemental HRSN Aggregate Ceiling (SHAC) Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in Section 14), CMS considers these expenditures to be "supplemental HRSN aggregate ceiling (SHAC)" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, SHAC expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped SHAC expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent SHAC Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the SHAC Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state's SHAC spending exceeds the Capped SHAC Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped SHAC.

16.8. **SHAC Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the SHAC Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the SHAC Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the SHAC Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 12: SHAC Budget Neutrality Test								
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21**	**DY 22**	**DY 23**	**DY 24**	**DY 25**
HRSN Services	Agg	Both	N/A	—	—	—	$94,157,357	$94,157,357
HRSN Infrastructure	Agg	Both	N/A	—	—	$4,150,000	$16,600,000	$12,450,000

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

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

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

Table 13: Main Budget Neutrality Test Mid-Course Correction Calculations		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY21	Cumulative budget neutrality limit plus:	2.0 percent
DY21 through DY22	Cumulative budget neutrality limit plus:	1.5 percent
DY21 through DY23	Cumulative budget neutrality limit plus:	1.0 percent
DY21 through DY24	Cumulative budget neutrality limit plus:	0.5 percent
DY21 through DY25	Cumulative budget neutrality limit plus:	0.0 percent

17. EVALUATION OF THE DEMONSTRATION

17.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f). This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration's operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 14.1.

17.2. **Independent Evaluator.** The state must use an independent entity (herein referred to as the Independent Evaluator) to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The Independent Evaluator must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

17.3. **Evaluation Design**. The state must submit, for CMS comment and approval, an Evaluation Design with implementation timeline, no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be developed in accordance with the STCs and applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time services, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

The state is strongly encouraged to use the expertise of the Independent Evaluator in the development of the Evaluation Design. The Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 17.7 and 17.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component, unless otherwise agreed upon by the state and CMS. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. The amendment components of the Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

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

17.5. **Evaluation Questions and Hypotheses.** Consistent with the STCs and applicable CMS guidance, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as eligibility and various measures of access, utilization, costs, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of demonstration and other applicable services. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include the

Consumer Assessment of Health Care Providers and Systems (CAHPS), the Medicaid and CHIP Core Sets of Health Care Quality measures, commonly referred to as the Child and Adult Core Sets, the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum (NQF).

The state must develop robust evaluation questions and hypotheses related to each demonstration initiative, and per applicable CMS guidance. Specifically:

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

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

c. Evaluation hypotheses for the HRSS and HRSN components of the demonstration must focus on areas such as assessing the effectiveness of the HRSS and HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on the prevalence and severity of beneficiaries' social needs and the provision of and beneficiary utilization of HRSS and HRSN services. Furthermore, the HRSN evaluation must include analysis of how the initiatives affect utilization of preventive and routine care; utilization of and costs associated with potentially avoidable, high-acuity health care; utilization of hospital and institutional care; and beneficiary physical and mental health outcomes.

   Hypotheses must be designed to help understand, in particular, the impacts of the HRSN services provided in the demonstration on beneficiary health outcomes and experience. In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access to and, quality of care, or health outcomes at the individual, population, and/or community level.

   The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing supports any other type of allowable HRSN services, change over time in concert with new Medicaid funding toward those services. In addition, in light of how demonstration HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiative must include a cost analysis

to support developing comprehensive and accurate cost estimates of providing such services. Evaluation of the HRSN initiative is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

d. For the Adult Expansion and employer-sponsored insurance (ESI) demonstration components, the state must analyze coverage, access to primary care, avoidance of inappropriate care utilization, reductions in uncompensated care, and health outcomes.

e. For the other components of the demonstration, the state must—as applicable—develop and test hypotheses in alignment with program goals that support analyzing demonstration effects on enrollment rates, uninsurance rates, access to primary care, access to mental health care, rates of emergency department visits (emergent and non-emergent), and access to dental services. The evaluation must also provide an assessment of the state's process for winding down the Current Eligibles population, and any potential lessons thereof.

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

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

   The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they

develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

g. Hypotheses for the family planning services and family planning related services component of the demonstration must focus on the impact of the demonstration in helping eligible beneficiaries access family planning services and family planning related services. Hypotheses must include, but not be limited to, outcomes such as beneficiary access to and utilization of family planning services (e.g., percentage of beneficiaries who utilized any contraception by method effectiveness) and family planning related services, and maternal health and birth outcomes (e.g., unintended pregnancies, teen birth rates, and the rate of preterm and low birthweight births).

h. Hypotheses for the extended postpartum care component of the demonstration must cover outcomes related to primary and preventive care utilization, maternal and infant health, and if applicable, treatment for behavioral health.

As part of its evaluation efforts, the state must also conduct an overall demonstration cost assessment to include, but not limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey or interviews to assess, for instance, beneficiary understanding of the demonstration policy components and beneficiary experience with access to and quality of care. To better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—and barriers to—implementation, the state is strongly encouraged to undertake a robust process/implementation evaluation. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state may collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography). Such stratified data analyses can provide a fuller understanding of gaps in access to and quality of care and health outcomes, as well as help inform how the demonstration's various policies support improving outcomes.

17.6. **Evaluation Budget**. A budget for the evaluations must be provided with the Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses

and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

17.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). The draft Interim Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

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

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

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. When applying for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment. If the state does not request an extension for the demonstration, the Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

17.8. **Summative Evaluation Report.** The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft Summative Evaluation Report, if any.

b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

17.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

17.10. **State Presentations for CMS**. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, or the Summative Evaluation Report.

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

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

18. PROVIDER RATE REQUIREMENTS

18.1. The provider payment rate increase requirements described hereafter are a condition for the HRSN expenditure authorities, as referenced in expenditure authorities 16 and 17.

18.2. As a condition of approval and ongoing provision of FFP for the HRSN expenditures over this demonstration period of performance, DY 23 through the fifth full demonstration year following the effective date of this amendment, the state will in accordance with these STCs analyze, increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates, by at least two percentage points in the ratio of Medicaid to Medicare provider rates for one of the service categories that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state's

Medicaid fee-for-service program or only Medicaid managed care, the state shall only be required to increase provider payments for the delivery system for which the ratio is below 80 percent. If the state's average Medicaid rates already equal or exceed 80 percent of Medicare in any of these three categories for either FFS or managed care, then the state is not subject to a provider rate increase requirement in that service category and delivery system, but the state must at least sustain rates for such categories at existing levels for the remainder of the demonstration period.

a. Subject to CMS approval, in the event that the state cannot implement a rate increase by the end of this limited period of performance (DY23 through DY 25) as otherwise authorized in STC 18.2, which is due to the HRSN expenditure authority being approved in the middle of the current period of performance, and if HRSN expenditure authority is subsequently approved by CMS for a demonstration extension period, then the state will implement the rate increase no later than the amount of time allowed by STCs 18.9, 18.10, and 18.11 as applicable to the state, beginning from this demonstration effective date into the subsequent period of performance.

18.3. The state may not decrease provider payment rates for other Medicaid or demonstration covered services to make state funds available to finance provider rate increases required under this STC (i.e., cost-shifting).

18.4. The state will, for the purpose of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increases as may be required under this section, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health care services.

18.5. No later than 90 days of the demonstration effective date, and if the state makes fee for service payments, the state must establish and report to CMS the state's average Medicaid to Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

a. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the state and the service category as noted in the following sources:

i. For primary care and obstetric care services in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3); AND

ii. For behavioral health services (the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3)); OR

b. Provide to CMS for approval for any of the three services categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

i. Service codes must be representative of each service category as defined in STC 18.4;

ii. Medicaid and Medicare data must be from the same year and not older than 2019.

iii. The state's methodology for selecting the year of data, determining Medicaid code-level utilization, the service codes within the category, geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

18.6. To establish the state's ratio for each service category identified in STC 18.4 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

a. The average fee-for-service ratio as provided in STC 18.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the State pay providers based on state plan fee-for-service payment rate schedules); or

b. The data and methodology for any or all of the service categories as provided in STC 18.5(b) using Medicaid managed care provider payment rate and utilization data.

18.7. In determining the ratios required under STC 18.5 and 18.6, the state may not incorporate fee-for-service supplemental payments that the state made or plans through December 31, 2029, to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR § 438.6(a) and 438.6(d).

18.8. If the state is required to increase provider payment rates for managed care plans per STC 18.2. and 18.6, the state must:

a. Comply with the requirements for state directed payments in accordance with 42 CFR 438.6(c), as applicable; and

b. Ensure that the entirety of a two-percentage point increase applied to the provider payments rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

18.9. For the entirety of the third full demonstration year following the effective date of this amendment through the fifth full demonstration year following the effective date of this amendment, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY 23, and such rate will be in effect on the first day of the third full demonstration year following the effective date of this amendment. A required payment rate increase shall apply to all services in a service category as defined under STC 18.4.

18.10. If the state uses a managed care delivery system for any of the service categories defined in STC 18.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from the third full demonstration year following the effective date of this amendment, through the fifth full demonstration year following the effective date of this amendment, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 23 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment increase shall apply to all services in a service category as defined under STC 18.4.

18.11. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of the third full demonstration year following the effective date of this amendment (or, as applicable, the first day of the first rating period that starts in the third full demonstration year following the effective date of this amendment), the state will provide an alternative effective date and rationale for CMS review and approval.

18.12. Utah will provide the information to document the payment rate ratio required under STC 18.5 and 18.6, via submission to the Performance Metrics Database and Analytics (PMDA) portal for CMS review and approval.

18.13. For demonstration years following the first year of provider payment rate increases, if any, Utah will provide an annual attestation within the State's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, in the previous year.

18.14. No later than 90 days following the demonstration effective date, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 18.5 and 18.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment K.

Table 14. Utah HRSN Related Provider Payment Increase Assessment – Attestation Table.

The reported data and attestations pertain to HRSN related provider payment increase requirements for

the demonstration period of performance DY 23 through the fifth full demonstration year following the effective date of this amendment.		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-Service ratio**	**Medicaid Managed Care to Medicare Fee-for-Service Ratio**
Primary Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 18.5(a) or STC 18.5(b)]	[insert approach, either ratio derived under STC 18.6(a) or STC 18.6(b), insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
Obstetric Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 18.5(a) or STC 18.5(b)]	[insert approach, either ratio derived under STC 18.6(a) or STC 18.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
Behavioral Health Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 18.5(a) or STC 18.5(b)]	[insert approach, either ratio derived under STC 18.6(a) or STC 18.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
In accordance with STCs 18.1 through 18.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in the service category in each delivery system, as applicable to the state's Medicaid or demonstration service delivery model, if for that delivery system the ratio is both the lowest ratio among the three and below 80 percent. Such provider payment increases for each service will be effective beginning on the first day of the third full year following the effective date of this amendment, and will not be lower than the highest rate for that service code in DY 23 plus a two-percentage point increase relative to the rate for the same or similar		

Medicare billing code through at least the fifth full demonstration year following the effective date of this amendment.

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 18.6(b) will be based on Medicaid managed care provider payment rate and utilization data.

[Select the applicable effective date, must check either a. or b. below]
☐a. The effective date of the rate increases is the first day of the third full demonstration year following the effective date of this amendment and will be at least sustained, if not higher, through the fifth full demonstration year following the effective date of this amendment.
☐b. Utah has a biennial legislative session that requires provider payment approval, and the timing of that session precludes the state from implementing the payment increase on the first day of the third full demonstration year following the effective date of this amendment. Utah will effectuate the rate increases no later than the CMS approved date of January 1, 2027, and will sustain these rates, if not made higher, through the fifth full demonstration year following the effective date of this amendment.

Utah *[insert does or does not]* make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, as necessary to comply with the HRSN STCs, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*].

Utah *[insert does or does not]* include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, as necessary to comply with the HRSN STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 20.7 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than [*insert date*].

Per STC 18.2(a), in the event that the state cannot implement a rate increase by the end of this limited period of performance (DY23 through the fifth full demonstration year following the effective date of this amendment) and if HRSN expenditure authority is subsequently approved by CMS for a demonstration extension period, then the state will implement the rate increase no later than period of time allowed by STC 18.9, 18.10, or 18.11, as applicable, beginning from this demonstration effective date into the subsequent period of performance. If the state intends to use this flexibility, the state will provide to CMS for CMS approval its plan to use this flexibility. ☐a. The state will increase provider payment rates by the end of this demonstration period and will sustain use of these rate increases during the demonstration extension period. ☐b. The state will not increase the provider payment rates by the end of this demonstration period and will use this flexibility to increase the provider payment rates during the next demonstration extension period. The state will provide CMS with its timeline for implementing these provider rate increases in the event that the HRSN expenditure authority is extended into a subsequent demonstration period. Proposed start date for provider rate increase: *[Provide date]*
If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 18.8, I attest that necessary arrangements will be made to assure that 100 percent of the two-percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
Utah further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 18.
I, *[insert name of SMD or CFO (or equivalent position)] [insert title],* attest that the above information is complete and accurate. [*Provide signature*_____*] [Provide date*_____*] [Provide printed name of signatory]*

Attachment A: SUD Implementation Plan

State of Utah SUD 1115 Waiver Implementation Plan

Division of Medicaid and Health Financing
Utah Department of Health

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Overview

The Utah Department of Health (DOH) was created in 1981 to protect the public's health by preventing avoidable illness, injury, disability and premature death; assuring access to affordable, quality health care; promoting healthy lifestyles; and monitoring health trends and events. The Utah Department of Health is the designated Medicaid single state agency pursuant to Title 26, Chapter 1 of the Utah Code Annotated. The Division of Medicaid and Health Financing (DMHF) is the agency authorized to administer Utah's Medicaid program.

The Division of Substance Abuse and Mental Health (DSAMH) is authorized under Utah Code Annotated (UCA) §62A-15-103 as the single state authority in Utah. It is charged with ensuring a comprehensive continuum of substance use and mental health disorder services are available throughout the state. In addition, DSAMH is tasked with ensuring that public funds are spent appropriately.

According to the annual report from the Division of Substance Abuse and Mental Health, Department of Human Services, State of Utah, 134,764 adults in the state were classified as needing treatment for alcohol and/or drug dependence or abuse in 2015. For youth in grades 6 through 12, 11,804 are in need of treatment for drug and/or alcohol dependence or abuse. Seventy four percent (74%) of all adults treated by the public system are Medicaid eligible. If amendment # 15 (Attachment 9) is approved by CMS the percentage of adults needing SUD services who are Medicaid eligible will increase. At the same time 46% of all youth receiving treatment in the public system are Medicaid eligible.

Utah, like other states, is trying to address a significant increase in opioid use. According to a report recently published by the Utah Department of Health, from 2012-2014 Utah ranked 4th in the U.S. for drug poisoning deaths. Every month, 49 Utahans die as a result of a drug overdose.

In 2014, 32.3% of Utah adults reported using at least one prescribed opioid pain medication during the preceding 12 months, an increase of 55.3% since 2008.

Furthermore, the prevalence of Utah adults who reported using prescription opioids that had not been prescribed to them increased 77.8% from 2008 (1.8%) to 2014 (3.2%). In 2012, Utah ranked 15th highest in the nation for high-dose opioid prescribing. A number of factors have contributed to the increase and widespread availability of prescription opioids. In the early 1990s, physicians were urged to be more attentive in identifying and aggressively treating pain. In addition, the pharmaceutical industry aggressively marketed the use of prescription opioids to providers. Consequently, opioid pain relievers, such as oxycodone and hydrocodone, gained widespread acceptance. Health care professionals prescribed opioid pain relievers more frequently as part of patient care. The increase in prescription pain medication prescribing resulted in these medicines being kept in home medicine cabinets, providing in an increased opportunity for theft or misuse. Utah needs to use all available options in a continuum of care to treat this health care crisis in our state.

MILESTONE 1: Access to Critical Levels of Care for SUD Substance Use Disorder Delivery System

The Utah public mental health and substance abuse system provides an array of services that assure an effective continuum of care. Under the administrative direction of DSAMH, the counties and their local mental health authority (LMHA) are given the responsibility to provide mental health and substance use disorder services to its citizens. Counties set the priorities to meet local needs and submit an annual local area plan to DSAMH describing what services they will provide with State, Federal, and County money. State and Federal funds are allocated to a county or group of counties based on a formula established by DSAMH.

In Utah, a continuum of services has been designed to address the full spectrum of substance use problems. Treatment services are based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

Comprehensive Benefit Design

Utah administers a comprehensive evidence–based MH/SUD benefit that offers a full continuum of care. Treatment services are based on the American Society of Addition Medicine (ASAM) Patient Placement Criteria. Effective July 1, 2017, Utah added coverage for SBIRT (Screening, Brief Intervention and Referral to Treatment) as a state plan covered service.

The following table provides an overview of each ASAM level of care with current Utah Medicaid coverage along with proposed changes:

ASAM Level of Care	Title	Description	Provider	Existing Medicaid Service Y/N	New Medicaid Service Y/N
0.5	Early Intervention	Screening, Brief Intervention and Referral for Treatment (SBIRT)	Managed care or Fee for Services provider	Y as of July 1, 2017	
1	Outpatient Services	Less than 9 hours of services /week (adults); Less than 6 hours /week adolescents) for recovery or motivational enhancement therapies/strategies, MAT, TCM	DHS/OL Certified Outpatient Facilities	Y	

2.1	Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more hours /week (adolescents) to treat multi-dimensional instability, MAT, TCM	DHS/OL Certified Outpatient Facilities	Y	
2.5	Day Treatment/ Psychosocial Rehabilitation Services	20 or more hours of service/week for multi-dimensional instability, not requiring 24 hour care, MAT, TCM	DHS/OL Certified Outpatient Facilities	Y	
3.1	Clinically Managed Low-Intensity Residential Services	24 hour structure with trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment, MAT, TCM	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y	
3.3	Clinically Managed Population Specific High Intensity Residential Services	24 hour structure with trained counselors to stabilize multi-dimensional imminent danger; Less intense milieu; and group treatment for those with cognitive or other impairments unable to use fill active milieu or therapeutic community and prepare for outpatient treatment, MAT, TCM	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y	

3.5	Clinically Managed High Intensity Residential Services	24 hour care with trained counselors to stabilize multi-dimensional imminent danger and prepare for outpatient treatment, MAT, TCM	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y	
3.7	Medically Monitored Intensive Inpatient Services	24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. 16 hour/day counselor availability, MAT, TCM	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric Hospitals	Y	
4	Medically Managed Intensive Inpatient	24 hour nursing care and daily physician care for severe unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric Hospitals	Y	
OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling to maintain multidimensional stability for those with severe opioid use. MAT includes methadone, Suboxone, Naltrexone	DHS/OL Licensed OTP Maintenance Providers, Licensed Prescribers	Y	

Table Two- ASAM Criteria for Withdrawal Services

Level of Withdrawal Management	**Level**	**Description**	**Provider**	**Existing Medicaid Service Y/N**	**New Medicaid Service Y/N**
Ambulatory Withdrawal Management Without Extended on-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient Supervision	DHS/OL Certified Outpatient Facility w/ Detox Certification; Physician, licensed prescriber; or OTP for opioids	N	Y
Ambulatory Withdrawal Management with Extended On-site Monitoring	2-WM	Moderate Withdrawal management and support and supervision; at night has supportive family or living Situation	DHS/OL Certified Outpatient Facility w/ Detox Certification; Licensed Prescriber; or OTP for Opioids	Y	
Clinically Managed Residential Withdrawal Management	3.2-WM	Moderate withdrawal, but needs 24 hour support to complete Withdrawal management and increase likelihood of continuing treatment or Recovery	DHS/OL Licensed Residential Facility w/ Detox Certification; Physician, Licensed Prescriber; Ability to Promptly Receive Step-downs	N	Y

Utah currently covers the discrete individual services if an individual is eligible for Medicaid and is in residential treatment for ASAM level 3.1, 3.3, 3.5 and 3.7 levels of

care. Utah's waiver allows Medicaid to cover services provided for ASAM level 3.1, 3.3, 3.5 and 3.7 on a per diem basis for all Medicaid eligible populations in facilities with 17 or more beds. Each of the ASAM levels of care will be addressed in more detail to describe current coverage, future coverage, and a timeline for implementation of any proposed changes. In addition, the Utah Medicaid Provider Manual, Rehabilitative Mental Health and Substance Abuse Disorder Services will be updated to reflect each ASAM level of care covered by Utah Medicaid. This update will be completed by July 1, 2018.

Residential treatment

Services for Adolescents and Youth with an SUD

Access to substance abuse treatment is especially important for the millions of children who live with at least one parent who is dependent on alcohol or an illicit drug. Utah provides coverage to all children under the age of 21 for screening, vision, dental, hearing, and other medically necessary health care services to treat, correct, or ameliorate illnesses and conditions discovered, regardless of whether the service is covered in the Utah Medicaid State Plan, as required by Early and Periodic screening, Diagnostic, and Treatment (EPSDT). This benefit extends to all substance abuse treatment identified through the ASAM continuum of care, including residential and inpatient treatment.

Level of Care: 0.5 (Early Intervention)

Current State:

Utah Medicaid provides coverage for several individual services around early intervention, including smoking cessation counseling and screening, brief intervention, and referral to treatment (SBIRT). These services are available to all Utah Medicaid members without prior authorization.

Future State:

No changes are expected.

Summary of Actions Needed:

None

Level of Care: 1.0 (Outpatient Services)

Current State:

Utah Medicaid reimburses for outpatient treatment (OT) as a service available through on a fee for services basis and through Utah's Prepaid Mental Health Plans. Coverage, code and billing details can be found in the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.

https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/RehabMentalHealthSubAbuse7-17.pdf

Future State:

No changes are expected

Summary of Actions Needed:

None

Level of Care: 2.1 (Intensive Outpatient Services)

Current State:

Utah Medicaid reimburses for intensive outpatient treatment (IOT) as a service available through on a fee for services basis and through Utah's Prepaid Mental Health Plans.
Coverage, code and billing details can be found in the Utah Medicaid Provider Manual for

Rehabilitative Mental Health and Substance Use Disorder Services.
https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/RehabMentalHealthSubAbuse7-17.pdf

Future State:

No changes are expected

Summary of Actions Needed:

None

Level of Care: 2.5 (Day Treatment/Psychosocial Rehabilitation Services/ Partial Hospitalization)

Current State:

Utah Medicaid covers Day Treatment/Psychosocial Rehabilitation Services for all members as a service available through on a fee for services basis and through Utah's Prepaid Mental Health Plans. Coverage, code and billing details can be found in the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.
https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/RehabMentalHealthSubAbuse7-17.pdf

Future State:

No immediate changes are expected.

Summary of Actions Needed:

None

Level of Care: 3.1 / 3.5 (Clinically Managed Low-Intensity Residential / Clinically Managed High-Intensity Residential)

Current State:

Residential treatment for substance abuse disorders can be provided within institutions for mental disease (IMDs). An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Federal law prohibits federal financial participation (FFP) from going to IMDs for individuals aged 21 through 64. One of the primary goals of the 1115 SUD waiver is to waive this restriction and allow IMDs to provide treatment to all Utah Medicaid members, including inpatient and residential treatment.
Utah Medicaid currently covers the discrete individuals services provided to Medicaid members who are in a residential treatment facility at ASAM level 3.1 or 3.5 with no more than 16 beds.

Future State:

Utah Medicaid determined a per diem rate to pay for residential treatment for substance use disorder. Therefore upon approval of Utah's amendment to its 1115 waiver and Utah's SUD Implementation Plan, Level 3.1 (clinically managed low-intensity residential) and Level 3.5 (clinically managed high-intensity residential) will be reimbursable in a facility with 17 or more beds (IMD) for all Utah Medicaid populations (fee-for-service and managed care).
The State will reimburse residential programs based on a bundled per diem payment. The bundled rate methodology for both Level 3.1 and 3.5 residential services will initially be based around a mix of current discrete services Medicaid eligible individuals receive while in a residential treatment setting. Only facilities that have been designated by the Division of Substance Abuse and Mental Health (DSAMH) as a Level 3.1 or Level 3.5 residential facility will receive reimbursement from Utah Medicaid. The development of improved certification requirements and ASAM designation for these facilities will be addressed under a later section of the implementation plan.

Summary of Action Items:

- MMIS system modifications (including finalizing coding)
- Update the Utah provider manual, "Rehabilitative Mental Health and Substance Abuse Disorder Services" to reflect coverage based on ASAM Levels of care for 3.1, 3.3, 3.5 and 3.7.
- Provider notification and training

Action Implementation Timeline

- Develop rate methodology for residential treatment- COMPLETE
- MMIS system modifications (including finalizing coding)- November 1, 2017
- Provider notification and training- Beginning November 2, 2017
- Coverage and Reimbursement for ASAM levels of care 3.1/3.5 on a per diem basis in a facility with 17 or more beds (IMD) will be available immediately upon approval the Utah's SUD Implementation Plan.
- Update the Utah provider manual, "Rehabilitative Mental Health and Substance Abuse Disorder Services" to reflect coverage based on ASAM Levels of care for 3.1, 3.3, 3.5 and 3.7 by March 31, 2018.

Level of Care: 3.7 (Medically Monitored Intensive Inpatient / Medically Managed Intensive Inpatient) Withdrawal Management Services (Inpatient Detoxification)

Current State

Utah Medicaid currently covers the discrete individual services provided to Medicaid members who are in a residential treatment facility at ASAM level 3.7 with no more than 16 beds.

Utah Medicaid has established a methodology to pay for residential treatment for substance use disorder. Therefore upon approval of Utah's amendment to its 1115 waiver Level 3.7 (Medically Monitored Intensive Inpatient) will be reimbursable for all populations (fee-for-service and managed care).

The State will reimburse residential programs based on a bundled per diem payment. The bundled rate methodology for Level 3.7 will initially be based around a mix of current discrete services Medicaid eligible individuals receive while in a residential treatment setting.

Only facilities that have been designated by the Division of Substance Abuse and Mental Health (DSAMH) as a Level 3.7 residential facility will receive reimbursement from Utah Medicaid. The development of improved certification requirements and ASAM designation for these facilities will be addressed under a later section of the implementation plan.

Summary of Action Items:

- MMIS system modifications (including finalizing coding)
- Update provider manuals
- Provider notification and training

Action Implementation Timeline

- Develop rate methodology for residential treatment- COMPLETE
- MMIS system modifications (including finalizing coding)- November 1, 2017
- Provider notification and training- Beginning November 2, 2017
- Coverage and Reimbursement for ASAM levels of care 3.7 on a per diem basis will be available immediately upon approval the Utah's SUD Implementation Plan.
- Update the Utah provider manual, "Rehabilitative Mental Health and Substance

Abuse Disorder Services" to reflect coverage based on ASAM Levels of care for 3.1, 3.3, 3.5 and 3.7 by March 31, 2018.

Future State:
No changes are expected

Summary of Actions Needed:

None

Sub Support Service – Addiction Recovery Management Services

Current State:
Utah currently covers addiction recovery management services. Please see the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.
https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/RehabMentalHealthSubAbuse7-17.pdf

Future State:

No changes are expected
Summary of Actions Needed:

None

MILESTONE 2. Use of Evidence –based SUD Specific Patient Placement Criteria

Patient Assessments

The Utah State Division of Substance Abuse and Mental Health (DSAMH) requires that the Local Authority Substance Use and Mental Health Providers complete the following
(1) Biopsychosocial Assessment (2) ASAM Patient Placement Criteria and (3) Screening for substance use disorder, mental health and suicide risk. However, DSAMH does not require one specific multi-dimensional tool. The assessment should be ongoing, strength based, and comprehensive to identify individual strengths and needs. These requirements are found in the DSAMH Division
Directives: https://dsamh.utah.gov/pdf/contracts_and_monitoring/Divison_Directives_FY 17_Final.pdf.

In addition, Utah Administrative Rule R523-4 requires: "Assessments shall identify the individual's level of motivation for treatment and implement strategies to increase engagement and need for clinically appropriate Mental Health Disorder services and/or Substance Use Disorder services in the following modified ASAM Patient Placement Criteria dimensions:
(a) Risk of acute psychosis, intoxication/withdrawal;

(b) Biomedical conditions or complications;

(c) Emotional, behavioral, or cognitive conditions;

(d) Readiness to change;

(e) Relapse, continued use or continued problem potential; and

(f) Recovery environment.

(3) The assessment shall include relevant information on:

(a) The individual's psychosocial function, substance use including tobacco/nicotine, mental and physical health, and other factors, such as educational experiences, trauma history, cultural issues, legal involvement, and family relationships that are relevant to the purpose of the assessment;

(b) Strengths, resiliencies, natural supports, interests of the individual, and an evaluation of the individual's unique abilities;

(c) Developmental and functional levels, social, emotional, communication abilities and strengths, and independent living skills;

(d) Cognitive, social, and affective development; family, peer, and intimate relationships; trauma; current or past emotional, physical or sexual abuse; suicidality; and safety;

(e) Collateral information from other sources that are relevant to the individual's situation and provides insight into the issues in Subsection R523-4-6(2)(a) through (2)(d).

(4) The assessment shall include a diagnosis when clinically indicated.

(5) Based on the screening and the assessment, the assessor shall make recommendations regarding the needed level of care and services to address the identified clinical needs.

(6) The levels of care and array of services shall be based on the ASAM."

DSAMH conducts annual monitoring site visits to all county local authority treatment programs in which clinical records and client placement is reviewed. Our monitoring tools and reports are online at: https://dsamh.utah.gov/provider-information/contracts- monitoring/.

Retention in treatment is the factor most consistently associated with positive client outcomes. The appropriate length of a treatment varies based on the needs of the individual. However, the National Institute of Drug Addiction (NIDA) states: "Participation in residential or outpatient treatment for less than 90 days is of limited effectiveness and treatment lasting significantly longer is recommended for maintaining positive outcomes. For methadone maintenance, 12 months is considered a minimum, and some individuals with opioid use disorders continue to benefit from methadone maintenance for many years." Just like treatment for any other chronic disease, addiction treatment must be of sufficient duration to succeed. Client progress over a short period of time should not be seen as a "cure." Likewise, relapse should not be a reason to discontinue care. Programs should employ multiple strategies to engage and retain clients. Successful programs offer continuing care, and use techniques that have been proven to enhance client motivation. It is also important to recognize that multiple episodes of treatment may be necessary.

Future State:
All providers will be trained on ASAM criteria
Summary of Actions Needed:
Ongoing provider training on ASAM criteria
Action Implementation Timeline

- Provider education will continue to be provided on ASAM Criteria by the Division of Substance Abuse and Mental Health throughout 2017 and 2018

Independent Third Party

Once an eligible licensed professional completes a psychosocial assessment for individuals needing substance abuse treatment, those findings must be reviewed by an independent third party that has the necessary competencies to use the ASAM Patient Placement Criteria to assure the findings were correct.
The Division of Substance Abuse and Mental Health is responsible for monitoring and oversight of the public behavioral health system. DSAMH conducts annual, on-site monitoring of each Local Authority in the public behavioral health system. The monitoring visits are required by Utah Code and are intended to measure contract compliance, use of evidence-based practices, as well as ensure a cohesive, strategic direction for the state and to assure individuals are receiving services at the appropriate level of care.
In addition, if a Medicaid member is enrolled in a PMHP for their SUD services, the PMHP is responsible to assure the findings from a psychosocial assessment is correct for their enrollee. PMHPs may also implement utilization review in the form of prior authorization of services.
Future State:
Utah Medicaid does not currently require prior authorization for residential treatment based on ASAM Levels of Care for fee for service members. Utah Medicaid will need to establish a utilization review process based on ASAM criteria to assure that all residential placement for fee for service members are appropriate. In addition, Utah Medicaid needs to review PMHP contract language to assure this requirement is clear. Each entity will be allowed to utilize any evidence-based system for clinical guidelines that incorporates the medical criteria required for an individual to meet an ASAM level of care.
Summary of Actions Needed:

This requirement will be formalized in Medicaid policy and Managed Care contracts. Procedures need to be established and implemented for fee for service members.
Action Implementation Timeline:

- Medicaid policy will be clarified by July, 1, 2018
- PMHP contracts clarified no later than July 1, 2018.
- Utah Medicaid will establish and implement procedures to review placements for appropriate ASAM level of care for fee for service members by July 1, 2018

Milestone 3: Use of Nationally Recognized SUD-specific Program Standard to Set Provider Qualifications for Residential Treatment Facilities

Certification of Residential Facilities

Utah through the Division of Substance Abuse and Mental Health established provider qualification requirements for residential treatment providers in their licensure standards, or other guidance that mirror the description of good quality residential treatment services in the ASAM Criteria or other nationally recognized SUD-specific program standards**, https://rules.utah.gov/publicat/code/r501/r501-19.htm.**
In addition, counties that contract for residential services have detailed contracts with providers based on ASAM Criteria.

The Office of Licensing audits to these guidelines. DSAMH conducts annual monitoring site visits to Local Authorities reviewing Policy and Procedures, licensures, schedules, clinical documents. Copies of DSAMH monitoring tools and reports can be found at: https://dsamh.utah.gov/provider-information/contracts-monitoring/.

Future State:

Utah Medicaid will have a process established to certify private residential treatment facilities based on ASAM criteria who may provide services to Medicaid fee for service members.

Summary of Actions Needed:

Utah Medicaid will need to establish and implement a process to certify private residential treatment facilities based on ASAM criteria who provide services to Medicaid fee for service members. In addition, PMHP contracts language regarding this requirement should be reviewed to determine if changes to the contract to support this milestone are necessary.

Action Implementation Timeline

- Utah Medicaid will establish and implement a process to certify private residential treatment facilities based on ASAM criteria who provide services to Medicaid fee for service members no later than July 1, 2018.
- The Utah Division of Substance Abuse and Mental Health and the Office of Licensing will implement a process to certify public and private non-profit residential treatment facilities based on ASAM criteria who provide services to Medicaid fee for service members no later than December 31, 2018.
- PMHP contracts language regarding this requirement will be reviewed and modified if appropriate by July 1, 2018.
- Administrative rule making will be promulgated to support this milestone with an effective date of July 1, 2018.
- An addendum to the Utah Medicaid Provider Agreement will be implemented to gather information on ASAM levels of care provided by private residential treatment providers by March 31, 2018.

MILESTONE 4- Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment

Network Development Plan

Overall Strategy- Addiction Treatment Services Providers

Network adequacy is a critical concern for the success of the 1115 SUD waiver. DSAMH certifies all mental health and addiction providers in Utah. In addition, SUD professionals are licensed by the Utah Division of Occupational and Professional Licensing. Finally residential treatment programs are licensed by the Division of Licensing, Utah Department of Human Services.

Local Substance Abuse authorities are responsible to provide SUD treatment to the residents of their county. Community mental health centers and their contracted providers are the core of public SUD services in Utah. The DSAMH monitors the Local authorities to assure appropriate access to care for county residents. In addition, the DMHF and DSMH are working with several private non-profit residential treatment providers to expand their capacity to provide treatment to Medicaid members in need of residential treatment. The state anticipates there will be at least 240 residential treatment beds available by July 1, 2018. DSAMH also prepared an inventory of additional residential treatment providers across the state who can provide treatment if the need arises.

The DSAMH works closely with the Local Mental Health and Substance Abuse Authorities to ensure

there are a sufficient number of providers in the community to provide access to outpatient services. In addition, HSAG, Utah Medicaid contracted external quality review organization (EQRO) also conducts an assessment of the adequacy of provider networks for Medicaid contracted managed care entities. The Local MH/SA Authorities contract with Utah Medicaid as PIHPs or PAHPs pursuant to Utah's 1915(b) Prepaid Mental Health Waiver.

Future State:

The inventory of providers prepared by DSAMH does not identify providers by ASAM level of care nor identify if the provider is accepting new patients. The State may have a total of 240 residential treatment beds from private non-profit providers by July 1, 2018.

Summary of Actions Needed:

The DSAMH provider inventory needs to be updated to identify providers by ASAM level of care and whether or not providers are accepting new patients.
DMHF and DSAMH will continue to work together to assure Medicaid members in need of SUD treatment services have access to care.

Action Implementation Timeline:

- DSAMH will update their provider inventory referred to above to include information on the providers at each ASAM level of care and whether or not the provider is accepting new patients by September 2018.
- DMHF and DSAMH will meet on an annual basis to evaluate the adequacy of access to SUD providers for the entire continuum of care on an annual basis beginning May 2018.

Program Integrity Safeguards

Utah Medicaid complies with all required provider screening and enrollment requirements as outlined in *42 CFR 455, Subpart E*.

Risk-Based Screening

Each provider is subject to pre-enrollment screening. Providers are categorized by risk level - limited, moderate, or high - using the Centers for Medicare & Medicaid Services (CMS) guidelines for risk determination. The risk level assignment of an individual provider may be increased at any time as a result of a payment suspension, an overpayment, Office of Inspector General (OIG) exclusion within the past 10 years, or at the discretion of the State pursuant to Utah Administrative Code R. In these instances, the provider is notified by the State, and the new risk level will apply to processing enrollment-related transactions. Providers who are enrolling (including changes of ownership) or revalidating are screened according to their assigned risk levels. Providers assigned to the high-risk category are required to pass a national fingerprint-based criminal background check in order to enroll or remain enrolled with the Utah Medicaid. All individuals who have at least 5% ownership or controlling interest in the enrolling business entity are required to have criminal background checks. The requirement also applies to individual practitioners who have been assigned to the high-risk category. The criminal background check requires affected individuals to submit to fingerprinting. When fingerprints are taken, a confirmation number is provided. Individuals being fingerprinted should be sure to record the confirmation number, as they will need this information when completing the IHCP provider enrollment application. Individuals who have had fingerprint-based federal criminal background checks for the IHCP within the last six months do not need to repeat the process for a new enrollment; the confirmation number of the prior fingerprinting is acceptable, as long as it was conducted within six months of submission. Individuals are responsible for the cost of the fingerprinting. It is important to follow instructions carefully, or it may be necessary to be fingerprinted.
Utah Medicaid may deny or terminate an individual's or entity's eligibility to participate as a Medicaid provider in the state of Utah if the agency finds that the provider or a person owning, directly or indirectly, at least 5% of the enrolling/enrolled entity has been convicted of any offense (including guilty pleas and adjudicated pretrial diversions) that the agency determines is inconsistent with the best

interest of Utah Medicaid members or the Medicaid program. The following list includes examples of offenses that may demonstrate that a provider is not eligible for participation. This list is not exhaustive. Felony crimes against persons, such as murder, rape, assault, and other similar violent crimes.

- Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other crimes of criminal neglect, misconduct, or fraud
- A criminal offense that may subject members to an undue risk of harm
- Sexual misconduct that may subject members to an undue risk of harm
- A crime involving a controlled substance
- Abuse or neglect of a child or adult
- A crime involving the use of a firearm or other deadly weapon
- Crimes directly related to the provider's ability to provide services under the Medicaid Program

In addition, Utah Medicaid may implement administrative sanction against a provider who abuse or improperly apply the program pursuant to Utah Administrative Code R414- 22.

Provider Revalidation

The Centers for Medicare & Medicaid Services (CMS) requires state Medicaid programs to revalidate provider enrollments at intervals not to exceed every five years. The CMS revalidation requirement for durable medical equipment (DME) and home medical equipment (HME) providers, including pharmacy providers with DME or HME specialty enrollments, is more frequent, at intervals not to exceed every three years.

Utah Medicaid providers receive notification letters when it is time to recredential their enrollments. Notification with instructions for revalidating are sent 90 and 60 days in advance of the revalidation deadline. Notices are mailed to the Service Location address indicated on the provider's service location profile. Providers with multiple service locations must revalidate the enrollment of each service location. Providers that fail to submit revalidation paperwork in a timely manner will be disenrolled from participation in Utah Medicaid.

After disenrollment, the provider will need to submit a new Utah Medicaid Provider Enrollment Application and all Documents to reenroll with Utah Medicaid.

Disenrollment with subsequent re-enrollment may result in a gap in the provider's eligibility.

Provider Agreements

Before participating with Utah Medicaid, all substance abuse providers must have a signed Provider Agreement with Utah Medicaid pursuant to *42 CFR 431.107*. All providers on a PMHPs provider panel must also be enrolled directly with the Utah Medicaid program. In addition the provider is credentialed by the plan and enter into a contract with the PMHP.

Billing and Compliance Issues

As part of the Provider Agreement, providers agree to disclose information on ownership and control, information related to business transactions, information on changes in ownership, and information on persons convicted of crimes. In addition to DMHF, the Utah Office of Inspector General for Medicaid Services has responsibility for overseeing the integrity of all Medicaid payments issued by the State for services on behalf of all Medicaid-eligible beneficiaries as well as referring cases of suspected fraud to the Utah Office of the Attorney General, Medicaid Fraud Control Unit. Additionally, each of Utah Medicaid MCEs are contractually obligated to have administrative procedures that detail the manner in which each will detect fraud and abuse, including the operation of special investigation units (SIUs). The MCE SIUs meet regularly with the OIG and MFCU address program integrity issues. The MCEs are also contractually obligated to provide reports to Utah Medicaid on their activities.

Providers can find out how to enroll with Utah Medicaid at
https://medicaid.utah.gov/become-medicaid-provider

Benefit Management

All Utah ACOs and PMHPs are required by contract to provide the same benefits as Utah's fee for service Medicaid program in accordance with Article 4 of the contract.

Future State:

No changes are expected.

Summary of Actions Needed:

None

MILESTONE 5: Implementation of Comprehensive Strategies to Address Prescription Drug Abuse and Opioid Use Disorders

Level of Care: OTS (Opioid Treatment Services)

Current State:

Utah Medicaid currently provides coverage for opioid treatment program (OTP) services, including the daily administration of methadone. Methadone programs are licensed by the Department of Human Services. Methadone is only administered by licensed clinics, which bill Utah Medicaid directly on a fee for service basis for any Medicaid member, even those enrolled in managed care. Methadone is a carved out service for managed care.

Methadone providers are enrolled as Utah Medicaid Providers or as an ordering, prescribing, or referring provider in accordance with Section 6401 of the Patient Protection and Affordable Care Act.

Utah Administrative Rule R523-4 requires that "All individuals with alcohol and/or opioid disorders shall be educated and screened for the potential use of medication-assisted treatment." In addition, the DSAMH Directives require that, "

Local Substance Abuse Authority treatment programs . . .

ii. Evaluate all clients who are opioid or alcohol dependent for the use of Medication Assisted Treatment (MAT) within the first 10 days of services and document the results of the assessment. Educate the client about MAT options; when clinically indicated and the client is amenable:

a. Include the use of MAT in the treatment plan, and

b. Either provide MAT as part of the treatment, or

c. Refer the individual for MAT.

Some Local Authority Residential Providers have a physician in their program that can provide MAT (Buprenorphine) to contracted residential treatment providers. In addition, they coordinately closely with the Utah State Opioid Treatment Providers who provide MAT to residential programs on or off site.

In Utah, the illegal use of prescription drugs has reached epidemic proportions.

- An average of 21 Utahns die as a result of prescription opioids (pain killers) each month
- Opioids contribute to approximately three out of four drug overdose deaths
- The number of prescription opioid deaths decreased from 301 in 2014 to 278 in 2015

Over the last decade, prescription pain medications have been responsible for more drug deaths in Utah than all other drugs combined. However, coordinating with multiple partners and focusing prevention and intervention efforts has resulted in Utah seeing a decrease in opioid related deaths by

7.6% in one
year https://www.health.utah.gov/vipp/pdf/RxDrugs/PrescribingPracticeInUtah.pdf. DSAMH collaborates with the Department of Health to increase access to naloxone, a drug that reverses opiate overdose, and to increase efforts to prevention abuse and misuse. Following the Strategic Prevention Framework, prevention efforts include coalition work, changing laws, and strategic use of evidence-based prevention programs. DSAMH has been actively involved in numerous state initiatives designed to reduce the impact of opioid abuse:

- Use Only As Directed (UOAD) began in 2007 in collaboration with the Utah Department of Health, Department of Human Services, Law Enforcement, and private industry. This statewide campaign focuses on safe use, storage, and disposal of prescription medications. Since 2013, Intermountain Healthcare has been an active partner. In August 2016, Intermountain Healthcare and UOAD launched a new campaign at McKay Dee Hospital, showing that every day, 7,000 prescriptions are filled in Utah.

- The Center for Disease Control released a revised set of Prescriber Guidelines in 2016. The guidelines outline appropriate prescribing protocols in an effort to decrease the over prescribing of opioids for non-cancer incidences.
- Take Back Events—semi-annual event collecting thousands of pounds of unused and expired medications.

Successful treatment may include:

- Detoxification (the process by which the body rids itself of a drug)
- Behavioral counseling, medication (for opioid, tobacco, or alcohol addiction)
- Evaluation and treatment for co-occurring mental health issues such as depression and anxiety with long-term follow-up to prevent relapse.

In 2016 Utah published a comprehensive report, "Opioid Prescribing Practices in Utah." This report was a partner publication of the Utah Department of Health and
Utah Department of Commerce, Division of Occupational and Professional Licensing. The following Utah Department of Health programs contributed to this report: Center for Health Data and Informatics, Department of Technology Services, Executive Director's Office, Health Informatics Program, Office of Health Care Statistics, and Violence and Injury Prevention Program. The report outlines Utah's efforts to establish prescribing guidelines consistent with the CDC Guidelines. The report can be found at: https://www.health.utah.gov/vipp/pdf/RxDrugs/PrescribingPracticeInUtah.pdf

A range of care with a tailored treatment program and follow-up options can be crucial to success. Treatment should include both medical and mental health services as needed.
Follow-up care may include community- or family-based recovery support systems. Medication Assisted Treatment (MAT) is a safe and effective strategy for reducing opioid use and the risk of overdose. Currently, there are three MAT medications approved by the FDA for the treatment of opioid dependence: methadone, buprenorphine and naltrexone. These medications are used in combination with counseling and behavioral therapies, to provide a "whole-patient" approach. People may safely take medications used in MAT for months, years, several years, or even a lifetime. Plans to stop a medication must always be discussed with a doctor. Methadone works by changing how the brain and nervous system respond to pain. It lessens the painful symptoms of opiate withdrawal and blocks the euphoric effects of opioids. By law, methadone used to treat opiate-use disorder can only be dispensed through an Opioid Treatment Programs (OTP) certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), regulated by the Drug Enforcement Agency (DEA), Licensed by Department of Human Services and accredited by one of the major healthcare accreditation entities. There are 14 OTP providers in the State of Utah. Utah's OTP's provide safe and effective treatment that includes regular counseling sessions, drug testing, and medication assisted treatment and recovery support. In 2015, 3,495 individuals sought assistance at the OTP clinics in Utah.

Buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed or dispensed in physician offices, significantly increasing treatment access. Like methadone, buprenorphine suppresses and reduces cravings for the abused drug. Buprenorphine is prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs. SAMHSA has developed an online prescriber locator: samhsa.gov/medication-assistedtreatment/ physician-program- data/treatmentphysician-locator.

Strategies to Address Prescription Drug Abuse / Opioid Use Disorder

DSAMH assisted in passing Legislation related to Naloxone education and distribution. DSAMH also works closely with the Utah Department of Health (UDOH), Utah Naloxone and other stakeholders to increase access to Naloxone. DSAMH has provided funding to the Department of Public Safety, the Utah Department of Corrections and the Utah Department of Health for projects related to naloxone training, purchase and distribution.

DSAMH will also provide funding to the University of Utah's Utah Naloxone Project. Information about this project can be found at: http://www.utahnaloxone.org/. In addition, DSAMH will provide funds to support 13 local Naloxone training and distribution entities contracted with UDOH. In addition, the 2018 DSAMH Directives includes the following requirement: "Local Substance Abuse Authority treatment programs shall provide Naloxone education, training and assistance to individuals with opioid use disorders and when possible to their families, friends, and significant others." DSAMH will monitor to ensure this requirement is met during annual site visits.

Prior Authorization Criteria

Utah Medicaid's prior authorization criteria for pharmacy can be found on the Utah Medicaid website at https://medicaid.utah.gov/pharmacy/prior-authorization

Prescribing Guidelines

DSAMH participated with the UDOH and the Utah Medical Association (UMA) in the development of the Utah Clinical Guidelines on Prescribing Opioids published in 2008. DSAMH worked again with UDOH and the UMA to update these guidelines in 2016.

ADDITIONAL INFORMATION

Weber Human Services (WHS) and Davis

Behavioral Health received funding from Intermountain Healthcare to provide medication assisted treatment and counseling for individuals with opioid dependence from prescription drugs that may have also led to current heroin use. Since its beginning, 120 clients have been served in the Opioid Community Collaborative. Currently, in Salt Lake County, a pilot project was legislatively funded in FY15 offering clients coming out of jail or prison with the option of using Vivitrol in coordination with treatment. Salt Lake County Behavioral Health Services launched this project in September 2015 and has served 205 clients to date. The average length of stay in the program is 3-4 months.

Salt Lake County anticipates ongoing growth and increased participation and length of stay in the program. Syringe Exchange Programs (SEP) also known as syringe services programs (SSPs), needle exchange programs (NEPs), and needle-syringe programs (NSPs), are community-based programs that provide access to sterile needles and syringes free of charge. The programs also facilitate safe disposal of used needles and syringes. SEPs are an effective component of a comprehensive, integrated approach to HIV and hepatitis C prevention among people who inject drugs. Most SEPs offer other prevention materials and services, such as HIV/HCV education; overdose prevention, including Naloxone distribution; referral to substance abuse treatment programs; and counseling and testing for HIV and hepatitis C.

Syringe exchange programs became legal in Utah in 2016, the day Utah Governor Gary Herbert signed House Bill 308 into law. The bill went into effect May 2016, and states that agencies in Utah "may operate a syringe exchange program in the state to prevent the transmission of disease and reduce morbidity and mortality among individuals who inject drugs and those individuals' contacts." HB 308 does not fund syringe exchange programs in Utah, it only provides guidelines and reporting

requirements and follows the restrictions of federal funding.
Naloxone (Narcan®) is a life-saving prescription medication used as an antidote to opioid overdose. Naloxone has mainly been used in the past in the hospital or by emergency medical personnel. However, Naloxone kits are now available for patients to use for emergency treatment of overdoses at home. In 2016, the executive director of the Utah Department of Health signed a statewide standing order allowing to dispense Naloxone, without a prior prescription, to anyone at increased risk of experiencing or witnessing an overdose. Through this standing order, anyone can purchase Naloxone without a prescription. DSAMH has worked to provide Naloxone kits and training to first responders, as well as all Adult Probation & Parole agents, and individuals in the community.

Drug Courts

Individuals with a substance use disorder are disproportionately represented in our criminal justice system. Evidence indicates that approximately 80% of individuals in the criminal justice system meet the definition of substance use involvement and between one-half to two-thirds meet diagnostic criteria for substance abuse or dependence.
Drug courts are special court dockets designed to treat individuals with substance use disorders and provide them the tools they need to change their lives. The drug court judge serves as the leader of a multidisciplinary team of professionals, which commonly includes a program coordinator, prosecuting attorney, defense attorney, probation or community supervision officer, and treatment representatives. Drug Courts provide an alternative to incarceration. Eligible participants for these programs have a moderate-to-severe substance use disorder, are charged with non- violent, drug-related offenses, such as possession or sale of a controlled substance, or another offense caused or influenced by drug use, such as theft or forgery to support a drug addiction, and who are at substantial risk for reoffending, commonly referred to as high-risk and high-need offenders. To effectively work with this population, Drug Courts provide intensive supervision and treatment services in a community environment. Successful completion of the program results in expunged charges, vacated or reduced sentences, or rescinded probation.
DSAMH funds 45 drug courts throughout the state of Utah; 25 adult felony drug courts, 15 family dependency drug courts, and 5 juvenile drug courts. In fiscal year 2016, Utah's drug court program served 2084 individuals, the majority of whom participated in the adult felony drug court program. DSAMH and partner agencies (the Administrative Office of the Courts and the Department of Corrections) work to improve quality assurance and monitoring processes of the program. In addition to conducting annual site visits and biennial certifications of the courts, DSAMH has partnered with the National Center of State Courts to conduct process and outcome evaluations at select Utah Drug Courts, once completed new performance measurements will be developed and implemented throughout the state to help insure best practice standards are followed.

Future State:

Utah Medicaid will implement a coverage policy to limit opioid prescriptions for dental procedures to 3 days without prior authorization

Summary of Actions Needed:

Draft policy and administrative rule
Submit rule for public comment
Publish policy and notify providers and pharmacies

Action Implementation Timeline

- Draft policy and rule by March 1, 2018
- Notify providers and pharmacies in June and July 2018 Medicaid Information Bulletin
- Implement coverage policy that limits opioid prescriptions for dental procedures to three (3) days by July 1, 2018.

Milestone 6 Improved Care Coordination and Transitions between Levels of Care

Transitions of Care

Current State

Appropriate management of transition of care is critical to the success of the individual in overcoming their SUD. Several of Utah's residential treatment providers also provide a full continuum of outpatient SUD services.

Future State:

Utah will add an addendum to the Utah Provider agreement for enrolled residential treatment providers that outlines a specific requirement that the provider is responsible to assure appropriate transitions of care either by providing this service directly or coordinating the provision of this service with another provider.

Utah plans to amend the Utah Provider Manuals for, Targeted Case Management for Individuals with Serious Mental Illness, to include Substance Use Disorder. In addition, Utah will amend the Utah Provider Manual for Hospital services. Both manuals will clearly state the requirement for residential and inpatient treatment facilities to coordinate and facilitate transition of Medicaid member to community based services and supports following a stay at a facility.

In addition, Utah will modify the language in its Prepaid Mental Health Plan (PMHP) contracts in section 10.3 Coordination and Continuity of Care to specify the same requirements as stated in revised policy.

Summary of Actions Needed:

Utah will amend provider manuals and managed care contracts.

Providers and Managed Care Contractors will need to be notified ad trained regarding the state's transitions of care requirement.

Action Implementation Timeline

- Utah will amend provider manuals and the PMHP contracts by July 1, 2018
- Providers will be notified of this change in the May, June and July 2018 Medicaid information Bulletin.

ADDITIONAL INFORMATION

Case Management

Case management is a central highlight of community mental health work, both in teams and individually working with people with mental illness and/or substance use disorders to help achieve their goals. Case Management is a mandated service in Utah, and the Local Mental Health and Substance Use Authorities are responsible to provide case management in their local areas. Case management provides four critical functions often referred to using the acronym CALM (Connecting, Advocating, Linking and Monitoring): connecting with the individual, advocating for the individual, linking and planning for services, and monitoring service provision.

Providers of case management services also provide skill development services, personal services, as well as psychosocial rehab groups. DSAMH has improved the quality of case mangers through a certification process that has proven to be successful. DSAMH is also working with the local homeless service providers to develop a certification program with basic standards for all providers serving individuals that are homeless.

DSAMH developed preferred practices for case management, including a training manual, and an exam with standards to promote, train, and support the practice of case management and service coordination in behavioral healthcare. In SFY 2016, DSAMH has certified 184 case managers compared to 176 in SFY 15, for a total of 650 certified case managers.

Crisis Intervention Team (CIT)

The Crisis Intervention Team (CIT) Program is an innovative model of community policing that involves partnerships between law enforcement, the mental health system, and advocacy groups. CIT provides law enforcement personnel with specialized crisis intervention training to assist a person experiencing a mental health or SUD crisis, which improves officer and consumer safety, and redirects individuals with mental illness from the judicial system to the health care system. This training includes a 40-hour course that is completed in a one- week session. DSAMH has partnered with CIT Utah Inc. and its board of directors to provide statewide law enforcement training and support. In this partnership, law enforcement personnel who take the 40 hour training and pass a state test will achieve the CIT certification. A total of 127 law enforcement agencies have sent representatives to the CIT Academies. For more information, visit the CIT website: CIT-Utah.com.

Certified Peer Support Specialists (CPSS)

Peer Support Specialists are adults in recovery from a substance use or mental health disorder that are fully integrated members of a treatment team. They provide highly individualized services in the community and promote client self-determination and decision-making.

CPSS also provide essential expertise and consultation to the entire treatment team to promote a culture in which each client's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, and community self- help activities. Since the program's inception, 488 individuals have been certified by DSAMH as CPSS. DSAMH currently contracts with Utah State University, Optum Health and the Salt Lake City Veteran Affairs Medical Center to provide standardized training across the state. Utah State University has developed or is developing additional special population peer support training modules for Youth- In-Transition (age 16-25), Refugee, Native American and Hispanic populations. To date, 122 CPSS have received Youth-In-Transition Training.

Trauma-informed Approach

Most individuals with substance use disorders and mental illness are also dealing with trauma. Between 34% and 53% of people with a severe mental illness report childhood physical/sexual abuse. A Center for Substance Abuse Treatment publication states that as many as two-thirds of women and men in treatment for substance abuse report experiencing childhood abuse or neglect. Child abuse, sexual assault, military combat, domestic violence, and a host of other violent incidents help shape the response of the people we serve. Adverse childhood experiences are strongly related to development and prevalence of a wide range of health problems, including substance abuse and mental illness. Over time people exposed to trauma adopt unhealthy coping strategies that lead to substance use, disease, disability and social problems, and premature mortality.

Since 2012, DSAMH embarked on several statewide efforts to implement the Trauma- Informed Approach in public and private programs, by providing training; organizational evaluation and consultation; policy implementation and partnering with local and national organizations. Some of these initiatives and training events are listed below:

1. Ongoing Organizational Evaluation,

Consultation, Training and Technical Assistance on the Trauma-Informed Approach, provided by Gabriella Grant, M.A., Director for the California Center of Excellence for Trauma-Informed Care for CABHI Grantees, Volunteers of America, DSAMH and other groups.

2. Utah Trauma Academy: October 31, November 4, 2016 for 110 public and provide providers. The Utah Trauma Academy was developed and provided by Gabriella Grant and several local trauma experts. The Utah Trauma Academy was based on the Victim Academy developed by the Office of Victims of Crimes at the Department of Justice.

3. Implementation of the Trauma-Informed Approach: DHS, DSAMH and several public and private providers have started the process for implementing a Trauma-Informed Approach in their practices.

Future State:

No changes are expected.

Summary of Actions Needed:

None

Grievances and Appeals

Utah Medicaid members and providers receive notice of any adverse action pursuant to 42 CFR 341 Part E. In addition, all managed care entities contracted with the Utah Medicaid program must comply with the grievance an appeals provisions of 42 CFR 438 Part F. Finally all state Medicaid fair hearings are conducted in accordance with Title 63G Chapter 4 Utah Code Annotated, Utah Administrative Procedures Act and Utah Administrative Code R414-4, Administrative Hearing Procedure.

https://le.utah.gov/xcode/Title63G/Chapter4/63G-4.html?v=C63G-4_1800010118000101.

https://rules.utah.gov/publicat/code/r410/r410-014.htm.

Future State:

Utah Administrative Code and internal procedures are consistent with recent changes to federal regulations.

Summary of Actions Needed:

Utah Medicaid will review 42 CFR 431 Part E and 42 CFR 438 Part F once again to assure Utah Code reflects the requirements of current federal regulation.

Action Implementation Timeline

- Utah Medicaid will conduct a review of current administrative code and federal regulations to determine any needed updates by November 30, 2017.

- Utah Medicaid will implement any necessary changes to administrative code and internal procedures by March 31, 2018

Attachment B: SMI/SED Implementation Plan

Section 1115 SMI/SED Demonstration Implementation Plan

Overview: The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and

2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are

encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

Memorandum of Understanding: The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

State Point of Contact: Please provide the contact information for the state's point of contact for the implementation plan.

Name and Title: Jennifer Meyer-Smart
Telephone Number: 385-215-4725
Email Address: jmeyersmart@utah.gov

1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	*Utah*
Demonstration name	*Utah 1115 Primary Care Network Demonstration*
Approval date	*Enter approval date of the demonstration as listed in the demonstration approval letter.*
Approval period	*Enter the entire approval period for the demonstration, including a start date and an end date.*
Implementation date	*Enter implementation date(s) for the demonstration.*

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	**Current State:** In accordance with Utah Administrative Code R432-101 Specialty Hospital, all psychiatric facilities must be licensed and certified through the Utah Bureau of Health Facility Licensing and Certification. Residential Treatment Programs are required to be licensed through the Utah Office of Licensing. **Hospitals**: Utah's Bureau of Health Facility Licensing and Certification has established licensing and certification requirements for psychiatric hospitals. Participating psychiatric hospitals will be licensed and approved by the Bureau of Health Facility Licensing and Certification.

	Through the state survey process psychiatric hospitals are required to meet 42 CFR part 482. The Division of Licensing and Certification uses the State Operations Manual survey guidelines for psychiatric hospitals. The enrollment process and requirements for psychiatric hospitals are posted on the Division's external website. **Residential Treatment Programs**: The Utah Department of Human Services, Office of Licensing licenses residential treatment programs. R501-19 details the requirements a program must meet to be licensed and includes regulations for specialized treatment services for substance abuse treatment, services for children and youth, and services for people with disabilities.
	Future Status: Utah will continue operation of current requirements for hospitals. The State will develop methodologies for enrollment of residential treatment programs that include verification of accreditation by a national accreditation association.
	Summary of Actions Needed: The Medicaid Provider Enrollment process will be updated to require submission of verification of accreditation by a national accreditation association. In addition, all necessary system program changes needed in order to enroll residential treatment programs with the appropriate identifier. (Timeline: 6-12 months)

Prompts	Summary
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	**Current Status:** Currently the Utah Department of Health Facility Licensing, Certification, and Resident Assessment may conduct administrative inspections on a routine basis for any licensed facility. **Hospitals:** R432-3-4 requires: (1) The Department (Utah Department of Health Facility Licensing, Certification, and Resident Assessment) or its designee may, upon presentation of proper identification, inspect each licensed health care facility or agency as necessary to determine compliance with applicable laws, rules and federal regulations. (2) Each licensed health care facility or agency must: (a) allow authorized representatives of the Department immediate access to the facility or agency, including access to all staff and patients; and (b) make available and permit photocopying of facility records and documents by, or on behalf of, the Department as necessary to ascertain compliance with applicable laws, rules and federal regulations. Copies become the responsibility and property of the Department. In addition, current state law allows for on site, unannounced visits to ascertain compliance with licensure requirements **Residential Treatment Center:** Utah code states: 62A-2-118. Administrative inspections. (1) The office may, for the purpose of ascertaining compliance with this chapter, enter and inspect on a routine basis the facility of a licensee. (2) Before conducting an inspection under Subsection (1), the office shall, after identifying the person in charge: (a) give proper identification; (b) request to see the applicable license; (c) describe the nature and purpose of the inspection; and (d) if necessary, explain the authority of the office to conduct the inspection and the penalty for refusing to permit the inspection as provided in Section 62A-2-116. (3) In conducting an inspection under Subsection (1), the office may, after meeting the requirements of Subsection

	(2): (a) inspect the physical facilities; (b) inspect and copy records and documents; (c) interview officers, employees, clients, family members of clients, and others; and (d) observe the licensee in operation. (4) An inspection conducted under Subsection (1) shall be during regular business hours and may be announced or unannounced. (5) The licensee shall make copies of inspection reports available to the public upon request. (6) The provisions of this section apply to on-site inspections and do not restrict the office from contacting family members, neighbors, or other individuals, or from seeking information from other sources to determine compliance with this chapter.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	**Current Status:** Under Utah Administrative Code R432-101, Specialty Hospital-Psychiatric, psychiatric hospitals as well as residential treatment programs are to complete admission assessments to determine if the level of care provided is the least restrictive environment for the beneficiary. Discharge assessments are also to be performed in order to verify medical necessity and if the beneficiary no longer meets medical necessity criteria, discharge to a lower level of care should be completed. **Hospitals**: Prior to admission, Utah Medicaid's managed care plans require an assessment of the beneficiary in order to appropriately place the beneficiary. Beneficiaries may be referred to a different level of care based on the information gathered in the assessment. The managed care plans then monitor treatment of the beneficiary throughout the hospital stay to ensure that the facility is the least restrictive setting appropriate for their needs.

	Additionally, hospital must be in compliance with 42 CFR 482.30 which in part states, "The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs." Also, Utah Administrative Code R432-101-17 Admission and Discharge states: 3(a) The facility shall assess and screen all potential patients prior to admission and admit a patient only if it determines that the facility is the least restrictive setting appropriate for their needs. The pre-screening process shall include an evaluation of the patient's past criminal and violent behavior. (4) The patient shall be discharged when the hospital is no longer able to meet the patient's identified needs, when care can be delivered in a less restrictive setting, or when the patient no longer needs care. **Residential Treatment Programs:** Prior to admission in a residential treatment facility, Utah Medicaid's managed care plans require an assessment of the beneficiary to ensure the beneficiary is appropriately placed. Beneficiaries may be referred to a different level of care based on the information gathered in the assessment. The managed care plans then monitor treatment of the beneficiary throughout the residential stay to ensure that the facility is the least restrictive setting appropriate for their needs. Additionally, Utah Administrative Code R532-4-6 Standards for Substance Use and Mental Health Disorder Screening and Assessment requires that an assessment be made "prior to admission to a clinical treatment level of care" and that the assessment uses a screening instrument that "has been evaluated and found reliable and valid by the scientific community". Additionally, the assessment shall "provide the basis for a treatment plan, and establish a baseline measure for use in evaluating a patient's response to treatment".
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None
1.d Compliance with program integrity requirements and state	**Current Status:** In order to receive reimbursement under Medicaid, participating psychiatric hospitals and residential

compliance assurance process	treatment programs must be enrolled to participate in Utah Medicaid. Provider enrollment processes fully comply with 42 CFR Part 455 Subparts B&E. Utah's managed care plans have been reimbursing IMDs as an in lieu of service and are only permitted to contract with Utah Medicaid screened and enrolled providers, the State is currently screening and revalidating this provider type.
	Future Status: Continued operation of current requirements.
	Summary of Actions Needed: No action needed at this time.
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	**Current Status:** In accordance with 42 CFR 482.61, Utah Administrative Code requires both hospitals and residential treatment programs to screen and assess all beneficiaries for co-morbid conditions, including mental health disorders, suicidal ideations, physical health conditions, and substance use disorder screening. **Hospitals:** Utah Administrative Code R432-101-20 Inpatient Services requires that upon admission: (a) A physician or qualified designee shall make an assessment of each patient's physical health and a preliminary psychiatric assessment within 24 hours of admission. The history and physical exam shall include appropriate laboratory work-up, a determination of the type and extent of special examinations, tests, or evaluations needed, and when indicated, a thorough neurological exam. (b) A psychiatrist or psychologist or qualified designee shall make an assessment of each patient's mental health within 24 hours of admission. A written emotional or behavioral assessment of each patient shall be entered in the patient's record. Additionally, hospitals must comply with 42 CFR 482.62(c). "Standard: Availability of medical personnel. Doctors of medicine or osteopathy and other appropriate professional personnel must be available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available

	within the institution, the institution must have an agreement with an outside source of these services to ensure that they are immediately available or a satisfactory agreement must be established for transferring patients to a general hospital that participates in the Medicare program." **Residential Treatment Programs:** Utah Administrative Code R523-4-6 Standards for Substance Use and Mental Health Disorder Screening and Assessment, requires using screening instruments for mental health/substance use disorders. Additionally, the initial assessment is required to: (a) Determine the adult's eligibility for treatment, provide the basis for a treatment plan, and establish a baseline measure for use in evaluating a patient's response to treatment. (b) Identify comorbid medical and psychiatric conditions and diagnosis and to determine how, when and where they will be addressed; (c) Identify communicable diseases and address them as needed; (d) Evaluate the adult's level of physical, psychological and social functioning or impairment; (e) Assess the adult's access to social supports, family, friends, employment, housing, finances and legal problems; and (f) Determine the adult's readiness to participate in treatment.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None

Prompts	Summary
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	**Current Status:** According to Utah Administrative Code R432-101-11, both hospitals and residential treatment programs are required to "have a well-defined quality assurance plan designed to improve the delivery of patient care through evaluations of the quality of patient care services and resolution of identified problems". This rule further requires all providers maintain a "Plan for Patient Care Services", which is a "written plan that ensures the care, treatment, rehabilitation, and habitation services provided are appropriate to the needs of the patient population service and the severity of the disease, condition, impairment, or disability". The Plan for Patient Care services must be kept up to date and all corrective actions and meeting minutes must be presentable upon request by the State.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	**Current Status**: Both residential treatment centers and hospitals are required by Utah administrative code to have transfer and discharge policy in place in order for beneficiaries to be provided with the necessary aftercare and follow up services following discharge. **Hospital**: All Medicaid-enrolled psychiatric hospitals, including the participating IMD facilities, are required to comply with all applicable CMS Conditions of Participation (COP), including but not limited to 42 CFR 482.43, which establishes

	minimum discharge planning requirements aligned with this milestone. Additionally, Utah Administrative Code R432-101-17(4)(c) requires that, "Discharge planning shall be coordinated with the patient, family, and other parties or agencies (e.g. community-based providers) who are able to meet the patient's needs." **Residential Treatment Centers:** R501-2-6(7) Transfer and Discharge a. a discharge plan shall identify resources available to consumer. b. the plan shall be written so it can be understood by the consumer or legally responsible party. c. whenever possible the plan shall be developed with consumers participation, or legally responsible party if necessary. The plan shall include the following: 1) reason for discharge or transfer, 2) adequate discharge plan, including aftercare planning, 3) summary of services provided, 4) evaluation of achievement of treatment goals or objectives, 5) signature and title of staff preparing summary, and 6) date of discharge or transfer. d. The program shall have a written policy concerning unplanned discharge.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	**Current Status:** Utah's psychiatric hospitals and mental health residential centers provide care of the highest quality, which includes a comprehensive discharge plan. Utah's managed care plans work closely with psychiatric hospitals and mental health residential programs to ensure comprehensive discharge plans. The psychiatric hospitals and mental health residential programs, in coordination with Utah's managed care plans, assess beneficiaries' housing situations and coordinate with housing services providers when needed and available" as part of the best practices

	for care coordination. The requirement for case management and care coordination is mandated in the managed care contracts between Utah Medicaid and its contracted managed care plans.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None

Prompts	Summary
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	**Current Status:** Utah's managed care plans attempt to contact members as a follow up for all emergency departments and inpatient discharges within 72 hours. The care managers also reach out to members when they discharge from residential treatment programs to help the beneficiary arrange a follow up appointment. This effort is specifically done to improve the seven day follow up measure, but the care manager outreach will almost always happen within 72 hours
	Future Status: Utah will add specific requirements in our managed care contracts to reflect this requirement
	Summary of Actions Needed: Add this requirement to the next amendment to applicable managed care contracts Timeline: July 2021 contract amendment
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	**Current Status:** Utah is committed to preventing or decreasing ED and inpatient stays. By providing beneficiaries the proper services and interventions when needed, beneficiaries receive better care and more cost effective services. This minimizes the need for more costly services such as ED visits. Utah Medicaid recently implemented several strategies to prevent or reduce ED visits and inpatient admission in psychiatric hospitals or residential treatment programs. In the 2020 Utah General Session H.B. 32, Crisis Services Amendments was passed. H.B. 32 expanded the mobile crisis outreach team grant program, funded behavioral health receiving centers, and created the Behavioral Health Crisis Response Commission. Utah already has a statewide Crisis Line, Mobile Crisis Outreach Teams, and Assertive Community Treatment teams. These crisis services are designed to prevent ED and inpatient stays. Utah also has the Clinically Managed Residential Withdrawal Pilot. This pilot allows for beneficiaries to receive social detoxification services, also known as withdrawal management, as a covered service. Many beneficiaries that access social detoxification services are dually diagnosed with a substance use disorder and a mental health disorder. Social detoxification prevents ED and inpatient psych stays by allowing beneficiaries to have a level of care appropriate for their current needs instead of going to an ED or inpatient stay to withdraw. Additionally, beneficiaries will have case managers at the detox center to assess them and guide them into outpatient mental health services appropriate for their needs.

	Utah adopted the Crisis Now model for implementation and expansion of crisis services. In 2019, Utah established a statewide crisis line in which all crisis calls statewide are routed through one line. The Utah crisis line then serves to direct individuals into other appropriate care including warm hand offs for additional assessment to local behavioral health providers, to dispatch Mobile Crisis Outreach Teams based in communities throughout the state, or to higher levels of care when needed. As crisis stabilization services are built the crisis line will be able to provide direct referrals into those facilities as well.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None
2.e Other State requirements/policies to improve care coordination and connections to community-based care	**Current Status:** Utah Medicaid services are operated predominantly through Managed Care Plans. On January 1, 2020, Utah Medicaid implemented four new Integrated Managed Care Plans. The Utah Medicaid Integrated Care (UMIC) plans manage both physical and behavioral health benefits for the Adult Expansion population. Prior to this time, Utah had separate physical health and behavioral health plans only. The UMIC plans are able to provide more holistic care to the beneficiaries. By using integrated care, the care managers in the UMIC plans can help beneficiaries get needed care more easily and efficiently. Non-integrated care plans are unable to see the whole person. Since these plans are new to Utah, outcome data is still being gathered. However, nationally integrated care has proven to be a benefit to the beneficiary, reduced ED stays, and inpatient stays.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None

Prompts	Summary
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of	**Current Status:** In partnership with local partners, Utah Medicaid completed the initial assessment on September 30th 2020. Some important results are the lack of IMD facilities available to beneficiaries, the need to increase crisis response in rural areas, and the need to increase crisis receiving centers throughout the state. **Future Status:** Utah Medicaid commits to conducting an availability assessment annually and will discuss any improvements that need to be made in ongoing assessments and reports.

the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.	**Summary of Actions Needed:** Utah will complete the next annual assessment of the availability of mental health providers by September 30th, 2021.

Prompts	Summary
3.b Financing plan	**Current Status:** See Topic 5 for information on the State's financing plan.
	Future Status: See Topic 5 for information on the State's financing plan.
	Summary of Actions Needed: See Topic 5 for information on the State's financing plan.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	**Current Status:** Currently each organization, with inpatient and crisis stabilization beds, manages their own bed availability and capacity. Anyone seeking a bed has to inquire with each organization individually.
	Future Status: The Utah Behavioral Health Availability Platform is a search engine developed from the Juvare EMSResource© platform. Mental health inpatient bed availability will be the initial focus, followed by substance use disorder residential programs and social detoxification centers along the Wasatch front. Emergency room staff, participating inpatient units, call centers (including the University of Utah), and mobile crisis teams will be able to access the search engine, with bed availability updated twice per day. The kickoff for the platform is planned for January 2021.
	Summary of Actions Needed: Implementation of the platform – January 2021 Monitor with DSAMH the Utah Behavioral Health Availability Platform's progress. Timeline: Ongoing
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of	**Current Status:** Utah Medicaid uses InterQual Criteria, an evidence-based clinical decision support tool, to determine appropriate level of care and length of stays. Utah Medicaid requires its managed care plans by contract to use evidence based practice guidelines consistent with

care and length of stay	current standards of care. They are required to ensure decisions on utilization management are based on the best practice guidelines. Although managed care plans are already using a tool as discussed above, the contracts currently do not have a specific requirement to use an assessment tool.
	Future Status: Add to contracts for managed care plans to use a "widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay".
	Summary of Actions Needed: 1. Modify managed contracts to include a requirement that they must use a "widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay". 2. Follow up with managed care plans to ensure they are requiring the utilization of a patient assessment tool (Timeline: 6-12 months)

Prompts	Summary
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	**Current Status:** Utah Medicaid is currently working to implement a SAMHSA model of Crisis Receiving and Stabilization Services model called Utah Behavioral Health Receiving Centers. Utah Medicaid is working to add this service as part of the Medicaid State Plan.
	Future Status: Continue the State Plan amendment process. Pending CMS approval, the amendment will take affect 1/1/2021.
	Summary of Actions Needed: Follow through with needed action steps to ensure completion of the State Plan amendment process. (Timeline: 3-6 months)
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs	**Current Status:** All of Utah's county behavioral health authorities are required to ask during intake if the individual is employed, unemployed, on disability etc. This includes use of the specific question - "Are you interested in looking for work/school". If the individual answers that they are interested, there is an automatic referral to the Individual Placement and Support (IPS) Supported Employment teams. Anyone can be referred whether they want full-time, part-time, volunteer, or education. Additionally, all county behavioral health authorities have a functional assessment tool, usually given by a case manager, and generally provided within the first few treatment sessions. The needs assessment scale, usually the Daily Living Activities Functional Assessment (DLA-20). This tool reviews how well someone is functioning across multiple domains from self-care, independent activities of daily living, health practices, etc. It identifies strengths and weaknesses, and becomes part of a treatment plan with referrals to case management, skills training, peer support, day programs, and engagement of community resources when needed.

	Utah's Division of Substance Abuse and Mental Health (DSAMH) requires that treatment plans are updated regularly, reviewing goals and determining if there are new or more emergent issues that should be the focus of treatment and care. DSAMH also has the ability to audit treatment plans to ensure quality of care. DSAMH also oversees First Episode Psychosis (FEP) programming targeting individuals ages 15-26 who are experiencing the first signs of psychosis. These programs are available in four areas throughout Utah, with additional training being offered across the State. FEP services focus on a Coordinated Specialty Care (CSC) model that allows for individuals who are seeking services to receive a range of necessary services including individual therapy, family therapy, medication management, case management, and peer support services. CSC services are also provided to individuals throughout their communities to ensure their services are more accessible. All of the county-based behavioral health authorities provide early intervention services for children and youth. These services included early childhood services, school based behavioral health, and family peer support services. Each of these services allow for earlier identification and access to care for children and their families.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	**Current Status:** On January 1, 2020 Utah Medicaid implemented integrated managed care plans. These plans, called Utah Medicaid Integrated Care (UMIC), combine physical and behavioral benefits under one payor. This allows for improved case management and care coordination. By having a more complete view of a member's needs the managed care plan's care coordinators can identify earlier SED/SMI concerns that may be arising for a member. After identifying a need for intervention, the care coordinators can help a member get the proper care for their unique needs. The Utah Division of Substance Abuse and Mental Health manages early intervention services for children and

	youth. These services are provided through the Local Authority Behavioral Health system and are focused on providing early access to care in non-traditional settings. These settings include partnerships with local education agencies and other health care providers. Through partnerships with schools, the local authority system is able to improve identification of SED and provides more access to services for children earlier in life. With support of a federal grant DSAMH is implementing the Utah- Promoting Integration of Primary and Behavioral Health Care (U-PIPBHC) Program. The U-PIPBHC program will provide mental and physical health services, substance abuse treatment and psychiatric consultation. In addition, DSAMH continues to work with the Association of Utah Community Health to integrate community health center services for physical health and local behavioral health centers services.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None

Prompts	Summary
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	**Current Status:** Utah Department of Human Services (DHS) oversees the Stabilization and Mobile Response (SMR) program. This program provides children, youth, and family's specific crisis intervention and stabilization strategies. These crisis intervention and stabilization strategies help teach skills to improve family functioning, create plans that prepare for and prevent future challenges, prevent the need for out-of-home services, and equip families with ongoing resources and support in home and community based settings. SMR currently operates in two DHS regions of the state and is currently planning to expand to two more regions with the goal of becoming statewide. DHS also operates Juvenile Receiving Centers (JCR) under the Division of Juvenile Justice in twelve communities across the state in order to prevent at-risk youth from entering the justice or child welfare systems. JRCs operate in conjunction with the Division of Juvenile Justice Services' (DJJS) Youth Services Model and allow for a safe environment for adolescents to be taken when they are not appropriate for other services. Here they are assessed and referred for other services throughout the community, including those services provided by community based mental health centers.
	Future Status: DHS will continue to work to implement SMR statewide. It is anticipated that SMR will expand to the Salt Lake region by January of 2021 and into the Eastern region by mid-year 2021. The expansion into the final parts of the state will occur when funding becomes available. DHS will continue to push integration and more robust behavioral health services into Juvenile Receiving Centers. DJJS recently partnered with a local county mental health provider to integrate services into a Juvenile Receiving Center and there are plans to expand this model into other counties across Utah to continue to provide more integrated behavioral health services to youth who are accessing services through these means.
	Summary of Actions Needed: SMR will expand to the Salt Lake region by January of 2021 and into the Eastern region by mid-year 2021
4.d Other state strategies to increase earlier	**Current Status:** The Utah Department of Human Services and Division of Substance Abuse and Mental Health oversees programming to

identification/engagement, integration, and specialized programs for young people	increase early intervention strategies including preschool based programming for youth with co-occurring mental health and autism spectrum disorder needs. There are currently five programs operating throughout Utah. Each of these programs operates under different names. They provide services to youth ages 2-8 who are in need of co-occurring mental health and autism/developmental needs. Utah's Department of Human Services also uses the System of Care's High-Fidelity Wraparound (HFW) model, through this model and working with DSAMH, Utah is able to work with family advocacy and peer led organizations to provide high fidelity wraparound services and family and youth peer support services. These services are meant to provide early intervention for the youth and their families, and to help navigate the complex mental health system. Early childhood programs are also provided through Utah's Department of Child and Family Services with partnerships with local family support centers that provide mental health services and crisis nursery services. School based services are also provided in conjunction with county behavioral health authorities and schools to increase early engagement and access to services.
	Future Status: Early childhood training needs have been identified to help build out more robust mental health services and partnerships between agencies that serve children. These early childhood training needs include a consultation and competency model that will provide training to providers who serve younger children (0-5) throughout their communities. These trainings are meant for both clinical and non-clinical professionals and will increase the overall capacities throughout local communities. Ongoing efforts to increase partnerships and services with schools and Local Authorities. Currently there are partnerships with over 350 local schools throughout Utah. For the future, it is anticipated that these partnerships will continue to grow based on need in local areas with new schools being added yearly. Youth in Transition services and training opportunities are also being developed. DSAMH leads a State Youth In Transition team that meets monthly and are working on a health disparities project and creating a strategic plan.
	Summary of Actions Needed: Within the next 12 months, the Department of Human Services will enter into a contract for an early childhood competencies and consultation program that will include training for Local Authorities and their community partners.

	Within 18 months, DSAMH and the Local Authorities will continue to partner with the Utah State Board of Education and Local Education Agencies to increase the local involvement for services, including increasing access to telehealth services and in person services that will be provided in local schools. A full school based implementation manual will also be completed in that timeframe.

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
5.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	**Current Status** Utah adopted the Crisis Now model for implementation and expansion of crisis services. In 2019, Utah established a statewide crisis line in which all crisis calls statewide are routed through one line. The Utah crisis line then serves to direct individuals into other appropriate care including warm hand offs for additional assessment to local behavioral health providers, to dispatch Mobile Crisis Outreach Teams based in communities throughout the state, or to higher levels of care when needed. As crisis stabilization services are built the crisis line will be able to provide direct referrals into those facilities as well. Utah Medicaid recently added Assertive Community Treatment and Mobile Crisis Outreach Teams to the State Plan. Utah Medicaid also submitted a SPA to receive approval for bundled daily rates for services provided at a Crisis Receiving Center or a mental health residential treatment program. Utah currently either operates or is in the process of implementing several crisis services related initiatives. 1. Crisis Line: Currently any individual in Utah can access crisis services via the Utah Crisis Line, which is funded by a mix of county and state funds. 2. Mobile Crisis Outreach Team (MCOT): The four urban counties/Local Authorities in Utah have been operating MCOT teams. Seven additional rural/frontier Local Authorities will begin operating MCOT services in FY21. These are funded via a mix of state general funds, local funds, and Medicaid reimbursement. 3. Stabilization and Mobile Response (SMR)- in three regions, currently in the works to expand to one additional region, 4. Crisis Receiving Centers: Four Local Authorities will be standing up crisis receiving centers between FY 21 and

	FY23. These will be funded by state general funds with a plan to add a bundled rate to the Utah State Plan. 5. Sub-Acute.
	Future Status Utah will add Crisis Receiving Centers and mental health residential treatment as a bundled rate to the State Plan 1. Sustainable funding plan for crisis line: Plan will be submitted to the Utah Crisis Commission by Summer 2021. 2. Expand MCOT statewide: Goal of even additional rural/frontier local Authorities will begin operating MCOT services by January 1, 2021 pending sustainable funding plan approved and adopted. 3. Expand SMR statewide: Goal of SMR to be in four regions by Spring of 2021 dependent on funding. 4. Crisis stabilization centers- modified for rural areas: goal of a stepped rollout of a minimum of one center implementing services annually beginning SFY22. 5. Increased crisis prevention strategies including access to robust outpatient care/services. Ongoing in partnership with behavioral health workforce expansion plans. 6. Engagement and partnership with police dispatch to divert non-public safety calls from law enforcement into the crisis system 7. Continue to address workforce capacity through the Utah Medical Education Council. This multi stakeholder group is in the process of compiling a Mental Health Workforce Report to identify needs and gaps in the workforce
	Summary of Actions Needed 1. On January 1, 2021, pending CMS approval, Utah will add Crisis Receiving Centers and mental health residential treatment as a bundled rate to the State Plan. 2. By December 2020, Utah will finalize administrative rule governing Crisis Receiving Centers.

	3. Sustainable funding plan for crisis line: Plan will be submitted to the Utah Crisis Commission by Summer 2021. 4. Expand MCOT statewide: Goal of statewide MCOT by July 1, 2022 pending sustainable funding plan approved and adopted. 5. Expand SMR statewide: Goal of SMR to be in four regions by Spring 2021 dependent on funding. 6. Crisis stabilization centers- modified for rural areas: goal of a stepped rollout of a minimum of one center implementing services annually beginning SFY22. 7. Increased crisis prevention strategies including access to robust outpatient care/services. Ongoing in partnership with behavioral health workforce expansion plans. Ongoing. 8. Engagement and partnership with police dispatch to divert non-public safety calls from law enforcement into the crisis system. Ongoing. 9. Continue to address workforce capacity through the Utah Medical Education Council. This multi stakeholder group is in the process of compiling a Mental Health Workforce Report to identify needs and gaps in the workforce. Ongoing.
5.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified	**Current Status:** Utah currently offers a comprehensive continuum of community-based mental health services. Outpatient, partial hospitalization, and residential mental health treatment services have been part of the Utah State Plan since 1987. The state continuously monitors access to mental health services through its managed care plans, external quality reviews, and through the Utah Department of Substance Abuse and Mental Health (DSAMH). Managed care plans are required to follow 42 CFR 438.68 Network adequacy standards. In accordance with 42CFR 438.358, Utah Medicaid contracts with an external quality organization to validate the managed care plans for network

Community Behavioral Health Clinic model.	adequacy for the preceding 12 months. Utah Code 62A-15-103 assigns responsibility to DSAMH to work with the county behavioral health authorities to conduct annual program audits and reviews to ensure adequate plans and community based services are available throughout Utah. DSAMH is required to review the Local Authority Area Plans annually and audit each county behavioral health authority to these plans. In 2019, Utah Medicaid began reimbursing for the Assertive Community Treatment (ACT) model of care. Utah currently has one ACT team at SAMHSA fidelity with plans to expand to more teams. On January 1 2020, Utah Medicaid implemented four new integrated managed care plans. These plans cover both physical health behavioral health services. Through these new integrated plans, beneficiaries are able to receive care management in a more complete manner.
	Future Status DSAMH will continue to monitor county behavioral health authorities to ensure provision of mandated services including issuing Division Directives and requiring annual Area Plans as well as annual audits. DSAMH will work with key stakeholders to identify gaps in services including workforce shortages and partner on strategies to build out increased access to a continuum of community based services. DSAMH will continue to expand access to ACT services and AOT services. An additional ACT team in SLCO will launch FY21 (current year) and an AOT team will launch in Weber county
	Summary of Actions Needed 2020 Utah will finalize the Utah administrative rule governing ACT Teams. The state will require an annual plan by each Local Mental Health Authority that outlines the local plan for service delivery to high acuity clients and will provide support to build out AOT and/or ACT services when clinical need arises.

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[1] *The HIT Plan should also describe, among other items, the:* ● *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* ● *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	The State assures that it has a sufficient health IT infrastructure to achieve the goals of the demonstration. The State has an established health IT infrastructure that is based on the goal to improve interoperability across the continuum of care on behalf of all beneficiaries. The State's health IT infrastructure includes achieving goals that will improve health outcomes, facilitate access, simplify care, and reduce the overall costs of healthcare. In order to achieve these goals, the State utilizes the State Medicaid Health Information Technology Plan (SMHP), an incentive based program that encourages hospitals and providers to utilize Electronic Healthcare Technology in order to improve outcomes for beneficiaries. Currently the state utilizes the Clinical Health Information Exchange (cHIE), which has been accredited through the Electronic Healthcare Network Accreditation Commission. The cHIE is the state-designated Health Information Exchange platform that allows providers and MCOs to collect and connect patient data within one main system throughout the state of Utah. https://uhin.org/solutions/use-cases/clinical-use-cases/

[1] See SMDL #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Prompts	Summary
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	Utah confirms that the State's Behavioral Health IT Plan aligns with the State's Broader State Medicaid Health IT Plan and other State health IT plans. Utah's Prescription Drug Monitoring Program (PDMP) is called the Controlled Substance Database (CSD). Utah's CSD is part of the PMP Interconnect (PMPi), in conjunction with Appriss Health and the National Association of Board of Pharmacy that enables the secure sharing of PMP data across states and systems. InterConnect includes a 'smart hub' routing methodology and rules engine to enforce interstate sharing permissions. Utah also has a contract with Utah Health Information Network (UHIN) as part of the SUD Health IT Plan goals. Through UHIN, the cHIE is utilized by providers and managed care plans as stated above. The goal of the cHIE is to decrease over utilization of services, reduce hospital readmissions, provide quality reports, track and monitor transient patient populations, identify gaps in care, and gather data for HEDIS measures.

Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	Utah Medicaid will be in compliance with the standards set forth in 45 CFR 170 Subpart B. In addition, Utah Medicaid added this requirement as part of the July 1, 2020 amendments to the Managed Care Plan's contracts requiring the plans to implement the standards referenced in the Interoperability Standards Advisory (ISA)2 and 45 CFR 170 Subpart B by July 1, 2021.

[2] Available at https://www.healthit.gov/isa/.

Prompts	Summary
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [3] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."* [4]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	**Current State:** It is not a consistent practice to use the EHR to execute e-referrals and closed loop referrals between mental health providers.
	Future State: Describe the future state of the health IT functionalities outlined below: The future state will be determined following feedback from surveys by providers and managed care plans to determine a need for closed loop referrals. Based on the results of the survey, the State will develop a plan for closed loop referrals if determined necessary.
	Summary of Actions Needed: The State (DSAMH and UDOH) will develop a survey to assess the need for developing a standard process to conduct closed loop referrals. Once the survey has been developed, it will be distributed to the appropriate providers and managed care plans for completion. (Timeline: 18-24 months)

[3] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.
[4] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/no-wrong-door/index.html.

Prompts	Summary
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	**Current State:** As stated above, there is no current method or standard for closed loop referrals using the EHR to refer beneficiaries from an institution/hospital/clinic.
	Future State: The State will conduct a survey to determine the number of mental health providers who utilize closed loop referrals or e-referrals.
	Summary of Actions Needed: The State (DSAMH and UDOH) will develop a survey to assess the need for developing a standard process to conduct closed loop referrals. Once the survey has been developed, it will be distributed to the appropriate providers and managed care plans for completion. (Timeline: 18-24 months)
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	**Current State:** There is no current method or standard for closed loop referrals using the EHR to refer beneficiaries from physicians to community based providers.
	Future State: The State will conduct a survey to determine the number of mental health providers who utilize closed loop referrals or e-referrals.
	Summary of Actions Needed: The State (DSAMH and UDOH) will develop a survey to assess the need for developing a standard process to conduct closed loop referrals. Once the survey has been developed, it will be distributed to the appropriate providers and community based support programs for completion. (Timeline: 18-24 months)
Electronic Care Plans and Medical Records (Section 2)	

2.1 The state and its providers can create and use an electronic care plan	**Current State:** Electronic care plans are used as a means to create a plan of care for beneficiaries by providers. While it is common practice for providers to utilize an electronic care plan for treatment, there is no standardized programming or reporting established by the State. According to ONC Health IT statistics from 2017, 97% of Utah's acute care hospitals have adopted certified EHRs. In the physician community, 94% have adopted an EHR, with 85% using a certified EHR that meets the requirements for meaningful use. Almost 1200 unique providers participated in Utah's Promoting Interoperability incentive program attesting that they have adopted a certified EHR. This encompasses a wide range of providers in major health systems, mid-size clinics, FQHCs and smaller independent practices. Particularly within the major health organizations in Utah, accessing shared care plans between different health providers in the same system should be fairly simple.
	Future State: Although EHR adoption levels in Utah are quite high, the state scores much lower when it comes to sending, receiving, and integrating patient health information from outside sources in settings beyond the hospital setting. There is room for improvement in these areas and providers need to understand the benefit of sharing this information outside of the walls of their own organizations (when clinically necessary.)
	Summary of Actions Needed: Partner with UHIN to understand what options are available to the behavioral health community. Conduct outreach and education to encourage the sharing of care plans and the efficiencies that are gained when everyone is on the same page. (Timeline: 18-24 months)

Prompts	Summary
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	**Current State:** As mentioned previously, Utah has implemented Utah Medicaid Integrated Care (UMIC) to manage both physical and behavioral health for beneficiaries throughout the state. Under these managed care plans, the e-plans of care are available to all relevant providers, including behavioral health providers.
	Future State: The State will continue with the current state.
	Summary of Actions Needed: No further action needed at this time.
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	**Current State:** Currently in the Local Authority Behavioral Health system, transitions of care for youth to adult records within the agency are communicated by both EHR facilitated electronic communications and secured email. Transitions from youth systems to adults systems outside of the agency are managed via secure email.
	Future State: The State will continue with the current state.
	Summary of Actions Needed: None
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	**Current State:** Currently in the Local Authority Behavioral Health system, electronic care plans for transitions of care for youth to adult records within the agency are communicated by both EHR facilitated electronic communications and secured email. Transitions from youth systems to adults systems outside of the agency are managed via secure email.
	Future State: The State will continue with the current state.

	Summary of Actions Needed: None.

Prompts	Summary
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	**Current State:** Currently in the Local Authority Behavioral Health system transitions of care for community supports within the agency are communicated by both EHR facilitated electronic communications and secured email. Transitions of care outside of the agency are managed via secure email.
	Future State: The State will continue with the current state.
	Summary of Actions Needed: None
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	**Current State:** Currently half of the local authority providers capture individual consent electronically in a way that is accessible to the care team in order to share protected health information.
	Future State: The state will continue to assess the need for change and update Health IT functionalities as needed.
	Summary of Actions Needed: The state will require an annual plan from each of the local authority providers that includes a plan for care coordination including communicating consent and will make changes as needed. DSAMH already implements the requirements for annual plans and UDOH will work with providers to ensure this is in place. (Timeline: 6-18 months)
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the	**Current State:** Currently half of the Local Authority Behavioral Health providers utilize the cHIE and only one authority uses it to capture intake, assessment, and screening tools. However, all are able to capture within their organizations EHR.

HIT ecosystem	**Future State:** The state will continue to assess the need for change and update Health IT functionalities as needed.
	Summary of Actions Needed: The state will require an annual plan from each of the local authority providers that includes a plan for capturing intake, screening and assessment tools and will make changes as needed. DSAMH already implements the requirements for annual plans and UDOH will work with providers to ensure this is in place. (Timeline: 6-18 months)

Prompts	Summary
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	**Current State:** Telehealth technologies are available in all of the Local Authority Behavioral Health systems. These systems allow for better access to care and communication between providers for more integrated approaches. Multiple authorities involved in integrated healthcare systems also utilize telehealth technologies to ensure broader integrated care access.
	Future State: The State will continue with the current state.
	Summary of Actions Needed: None.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[5])	**Current State:** It is not a common practice for the State to collect data and identify beneficiaries that are at risk for discontinuing engagement in treatment or have stopped engaging in treatment entirely. It is also not a practice of the State to notify care teams and managers of a beneficiary's disengagement in treatment.
	Future State: The future state will be developed based on feedback from surveying enrolled Utah care providers.
	Summary of Actions Needed: The State will work with DSAMH to develop a survey to identify a target population and assess the need for developing a standard process to identify patients who are at risk of disengagement from treatment and what roles the care teams may play in re-engaging the member in treatment. Once the survey has been developed, it will be distributed to the appropriate providers and community based support programs for completion. The State will then analyze the results and develop next steps based on the data. (Timeline: 18-24 months)

[5] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

Prompts	Summary
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	**Current State:** In the Local Authority Behavioral Health system, the entire care team providing services for an individual experiencing a first episode of psychosis utilizes the EHR in accessing records to coordinate care among the team.
	Future State: The State will continue with the current state.
	Summary of Actions Needed: None
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	**Current State:** Currently no organizations in the Local Authority Behavioral Health system link children's records with parent caregiver records.
	Future State: No actions have been planned around this activity.
	Summary of Actions Needed: None
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	**Current State:** Currently all Local Authority Behavioral Health providers utilize an EHR that allows all services provided by employees of the agency which includes all types of providers, including prescriber, therapist and case management/Peer Support , etc...to capture all episodes of care of any given patient.
	Future State: The State will continue with the current state.

	Summary of Actions Needed: None

Section 3: Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.

Attachment C: Non-Traditional Benefit Package

Attachment D: Traditional Benefit Package

Attachment E: Modified Adjusted Gross Income (MAGI) Conversion Table

Attachment F: Claiming Methodologies

Attachment G: Reentry Demonstration Initiative Implementation Plan

[To be incorporated after CMS Approval]

Attachment H: Reentry Demonstration Initiative Reinvestment Plan

[To be incorporated after CMS approval]

Attachment I: Protocols for HRSN Infrastructure and HRSN Services

HRSN Infrastructure Protocol

HRSN Infrastructure. In accordance with the state's section 1115 demonstration and Special Terms and Conditions, this protocol provides additional detail on the requirements on infrastructure investments for the Health-Related Social Needs (HRSN) program, as specifically required by STC 12.9. The state's HRSN program allows qualifying Medicaid beneficiaries to receive evidence-based clinically-appropriate services. Over the course of the demonstration the state is authorized to spend up to $33,200,000 on infrastructure investments necessary to support the development and implementation of HRSN services. This protocol outlines the proposed uses of HRSN infrastructure expenditures, types of entities that will receive funding, intended purposes of funding, projected expenditure amounts and implementation timeline.

HRSN Infrastructure

I. **Implementation Timeline and Approach**

a. **Timeline for Disbursement of Infrastructure Funding**

i. The state intends to begin awarding infrastructure funds to eligible entities no sooner than April 1, 2025. The state will utilize a phased approach to disbursing infrastructure funds to ensure providers beginning their participation at different times have sufficient infrastructure and capacity.

ii. Eligible entities can apply for capacity building funding on an ongoing basis.

b. **Approach to Infrastructure Funding Applications and Disbursements**

i. The state will conduct the HRSN infrastructure application and funding disbursement activities either directly or through a contracted vendor based on experience operationalizing the HRSN Infrastructure program.

ii. Either directly or through a contacted vendor, the state will conduct the following activities:

1. Develop the infrastructure funding application and budget template
2. Conduct outreach and education to eligible entities regarding infrastructure funding opportunities
3. Review applications against minimum entity eligibility criteria
4. Review funding request budget templates to ensure compliance with requirements
5. Award infrastructure funding to eligible entities
6. Disburse funding to awarded entities

7. Monitor infrastructure funding uses amongst eligible entities to prevent fraud, waste and abuse
8. Develop reporting templates for awardees to report on funding uses
9. Review and analyze reports from awardees on funding uses

c. **Monitoring and Oversight**

i. The state will ensure that any HRSN infrastructure fund disbursements are consistent with these STCs. The state will ensure that any HRSN infrastructure funding is subject to program integrity standards, including:

1. **Participating in audit processes.** The state will conduct spot audits to ensure that infrastructure funds are being spent on permissible uses and are being documented and reported on appropriately.
2. **Taking action to address non-compliance.** The state will ensure that action is taken to address any identified non-compliance with HRSN infrastructure funding parameters. If the funding recipient has failed to demonstrate appropriate performance, the state may impose corrective actions (e.g., caps on funding, discontinuation of funding and/or recoupment of funding). The state will provide notice to any funding recipient prior to initiating corrective action.
3. **Ensuring non-duplication of funds.** Funding recipients will be required to attest to non-duplication of funding with other federal, state and local funds. The state will monitor for funding irregularities and potential duplication of funds.
4. **Monitoring for fraud, waste and abuse.** The state will actively monitor all HRSN infrastructure disbursements for instances of fraud, waste and abuse. The state will suspend and/or terminate infrastructure funding in cases of confirmed fraud, waste and/or abuse. The state reserves the right to recoup funding as necessary.

II. Eligible Entities. The following entities may be eligible to apply for and receive HRSN infrastructure funding:

a. Providers of HRSN services, including, but not limited to:

i. Tribal government and tribal providers
ii. Community-based organizations (CBOs)
iii. Social-services agencies
iv. Housing agencies and providers

v. Case management providers
vi. Child welfare providers
vii. City, county, and local governmental agencies
viii. Outreach and engagement providers

In addition, entities must meet the following minimum eligibility criteria in order to be considered eligible for the HRSN infrastructure funding. Minimum eligibility criteria may include:

a. The entity is capable of providing or supporting the provision of one or more HRSN services to Medicaid beneficiaries within the state of Utah.
b. The entity intends to contract to serve as an HRSN provider for at least one HRSN service.
c. The entity has attested to being financially stable, as defined by the state.

III. Intended Purpose and Proposed Uses of HRSN Infrastructure Funding. The state may claim federal financial participation (FFP) in infrastructure investments to support the development and implementation of HRSN services across the following domains.

a. Technology
b. Development of business or operational practices
c. Workforce development
d. Outreach, education and stakeholder convening

The State intends to provide infrastructure funding to eligible entities for the following activities:

a. Technology. Qualifying entities can leverage HRSN infrastructure funding to support a range of technology needs, including those that support closed-loop referral platforms and other community information exchange priorities.

i. Procuring IT infrastructure/data platforms/systems needed to enable, for example:
    1. Authorization of HRSN services
    2. Documentation of eligibility for HRSN services and track enrollment
    3. Closed loop referral to HRSN services
    4. Record plans of care
    5. HRSN service delivery
    6. HRSN service billing
    7. HRSN program oversight, monitoring and reporting, including for activities beyond HRSN infrastructure (e.g., reporting on HRSN services delivered, monitoring to ensure members receive the services for which they were authorized, activities to prevent fraud, waste and abuse across the HRSN program)

8. Determine eligibility for other federal, state and local programs including Supplemental Nutrition Assistance Program (SNAP) and/or Women, Infants and Children (WIC)

ii. Modifying existing systems to support HRSN
iii. Development of an HRSN eligibility/services screening tool
iv. Integration of data platforms/systems/tools
v. Onboarding to new, modified or existing systems
vi. Training for use of new, modified or existing systems

b. **Development of business or operational practices**
   i. Development of polices/procedures related to:
      1. HRSN referral and service delivery workflows
      2. Billing/invoicing
      3. Data sharing/reporting
      4. Program oversight/monitoring
      5. Evaluation
      6. Privacy and confidentiality
   ii. Training/technical assistance on HRSN program and roles/responsibilities
   iii. Administrative items necessary to perform HRSN duties and/or expand HRSN service delivery capacity (e.g., initial month of lease payments for new or an extension of existing office spaces needed to support HRSN operations)
   iv. Procurement of administrative supports to assist implementation of HRSN

c. **Workforce development**
   i. Cost of recruiting, hiring and training new staff to provide HRSN
   ii. Salary and fringe for staff that will have a direct role in overseeing, designing, implementing and/or executing HRSN responsibilities, time limited to a period of 18 months.
   iii. Necessary certifications, training, technical assistance and/or education for staff participating in the HRSN program (e.g., on culturally competent and/or trauma informed care)
   iv. Privacy/confidentiality training/technical assistance (TA) related to HRSN service delivery
   v. Production costs for training materials and/or experts as it pertains to the HRSN program

d. **Outreach, education and stakeholder convening**
   i. Production of materials necessary for marketing, outreach, training and/or education related to HRSN.
   ii. Translation of materials

iii. Planning for and facilitation of community-based outreach events to support awareness of HRSN services
iv. Planning for and facilitation of learning collaboratives or stakeholder convenings for HRSN
v. Community engagement activities necessary to support HRSN program implementation and launch (e.g., roundtable to solicit feedback on guidance documents)
vi. Administrative or overhead costs associated with outreach, education or convening directly tied to HRSN.

IV. **Projected Expenditure Amounts:** The state estimates the following infrastructure expenditure amounts by allowable use category over the course of the demonstration. The state used the annual infrastructure spending amounts articulated in the state's STCs, and an analysis of anticipated need across the state to develop the estimates below. The state anticipates that the percentage of spend permissible use categories (as illustrated in the table below) will stay relatively constant across the Demonstration Years.

Allowable Use Category	**% of Spend**	**Estimated Amount**
Technology	30%	$9,960,000
Development of Operational or Business Practices	25%	$8,300,000
Workforce Development	30%	$9,960,000
Outreach, Education and Stakeholder Convening	15%	$4,980,000
Total	**100%**	**$33,200,000**

Demonstration Year (DY)	**DY23**	**DY24**	**DY25**
HRSN Infrastructure Estimated Amounts	$4,150,000	$16,600,000	$12,450,000

HRSN Services Protocol

In accordance with the Special Terms and Conditions (STCs) of Utah's Section 1115 Demonstration, this protocol provides additional detail on the requirements for the delivery of services for the Health-Related Social Needs (HRSN) program. It outlines the covered HRSN services, a process for identifying eligible individuals, a process for determining the services medically appropriate, and a description of the process for developing care plans based on assessment of need.

1. **Member Eligibility**
   a. **Covered Populations.** The following covered populations will be eligible to receive HRSN services provided that they also satisfy the applicable clinical and social risk criteria and the HRSN service is determined to be medically appropriate:

Table 1: Covered Populations

Covered Population	Population Description	Covered Service
Recently Incarcerated Individuals	1. The individual must be released from incarceration within the past 12 months. 2. The individual must be 18 years of age or older. 3. Eligibility must be determined within 12 months of release from incarceration. 4. The individual must have received the Medicaid Justice Benefit Plan while incarcerated.	• Pre-Tenancy Navigation Services[6] • Tenancy and Sustaining Services • One-time transition and moving costs other than rent • Home accessibility modifications and remediations that are medically necessary
Adult Expansion (AE)	1. The individual must be 19-64 years old. 2. The individual must be covered under the Adult Expansion program.	• Pre-Tenancy Navigation Services • Tenancy and Sustaining Services • One-time transition and moving costs other than rent • Home accessibility modifications and remediations that are medically necessary

[6] Pre-tenancy navigation services, as well as tenancy and sustaining services, one-time transition and moving costs other than rent, and home accessibility modifications and remediations that are medically necessary were previously covered under the state's Housing Related Services and Supports (HRSS) program. These services are now covered under the HRSN program.

		• Short-Term Rental Assistance • Short-Term Recuperative Care
Targeted Adult Medicaid (TAM)	1. The individual must be 19-64 years old. 2. The individual must be covered under the Targeted Adult Medicaid program.	• Pre-Tenancy Navigation Services • Tenancy and Sustaining Services • One-time transition and moving costs other than rent • Home accessibility modifications and remediations that are medically necessary • Short-Term Rental Assistance • Short-Term Recuperative Care

b. **Medical Appropriateness.** To ensure the services are medically appropriate, the state will require that individuals identified as in need of HRSN services meet the following clinical and social risk criteria. To qualify for a HRSN service, a member must:
   i. Meet the eligibility criteria for one or more of the covered populations (described above in Section I.a);
   ii. Have at least one of the clinical risk factors. The HRSN clinical risk factors for housing are listed in the table below.
   iii. Meet the following social risk criteria: Be experiencing homelessness or at risk of homelessness, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except the annual income requirement in 24 CFR 91.5 (1)(i) ;
   iv. Meet any additional eligibility criteria and requirements that apply in connection with the specific HRSN service.

c. **Clinical Risk Factors.** In order to receive services, individuals must meet one of the clinical risk factors listed below.

Table 2: Clinical Risk Factors

Clinical Risk Factors	
HRSN Clinical Risk Factor	**Risk Factor Description**
1. Complex Behavioral	Requires improvement, stabilization, or prevention of

Health Need	deterioration of functioning (including ability to live independently without support) resulting from the presence of diagnosable substance use disorder, serious mental illness, developmental disability, cognitive impairment or behavioral impairment resulting from dementia, brain injury or other medically-based behavior condition/disorder.
2. Needs Assistance with ADLs/IADLs or Eligible for LTSS	Requires assistance with one or more activities of daily living (ADLs), one of which may be body care, verbal queuing or hands-on assistance.
3. Pregnant/Postpartum	An individual who is currently pregnant or up to 12 months postpartum.
4. Adults 65 years of age or older	An adult who is 65 years of age or over and currently has at least one of the following: ● Two or more chronic health conditions ● Social isolation placing the individual at risk for early death, neurocognitive disorders, sleep disruption, cardiovascular disease, and elder abuse ● A health condition, including behavioral health and developmental syndromes, stemming from trauma, child abuse, or neglect
5. Recent hospitalization for a Chronic Health Condition	In the last 12 months, at least 1 inpatient claim for one of the following: ● Cancer ● Diabetes ● Hypertension ● Heart Disease ● Heart Failure ● Kidney Disease ● Kidney Transplant Failure ● Liver Disease ● Multiple Sclerosis ● Necrotizing Fasciitis ● Renal Failure Utah Medicaid's Medical Director may approve additional chronic conditions on a case-by-case basis.
6. At-risk of or transitioning from ED/hospitalization or institutional care	Must have an acute medical condition that can be safely managed in a recuperative care program setting, and Medical respite care is necessary to provide the conditions to support recovery from the acute medical condition and meet one of the following:

	• Are at-risk of Emergency Department (ED), hospitalization or institutional care as determined by a qualified healthcare professional, or • Are in the ED/hospitalized, or • Are in institutional care

2. **HRSN Services**
    a. **Use of a Third-Party Contractor or Other Contracted Vendor**. The state may contract with a third-party contractor or other entity to perform service approval, care management, and other functions related to the administration of HRSN services for members covered under the FFS program. The state will work with Tribal Government on a culturally responsive and specific HRSN service delivery approach for American Indian/Alaska Native (AI/AN) members.
    b. **Providing culturally and linguistically appropriate services**. All HRSN services must be provided in a way that is culturally responsive and ensures meaningful access to language services.
    c. **Nonduplication of services**. No HRSN service will be covered that is found to be duplicative of a state or federally funded service or other HRSN service the member is already receiving.
    d. **Covered HRSN Services**. The state will cover the following HRSN services as defined in the table below:

Table 3: Covered HRSN Services

Service	Description	Eligibility Criteria
Pre-Tenancy Navigation Services	The following service includes: 1. Tenant screening and housing assessment to identify housing preferences (e.g., housing type, location, living alone or with someone else, roommate identification, type of accommodations needed, etc.) barriers to successful tenancy, identification of housing transition and retention barriers. 2. Development of an individualized housing support plan to address identified barriers and establish goals to address each issue, identification of providers/services required to meet the established goal. 3. Assistance with the housing application process, including application/documentation completion and submission. 4. Assistance with completing reasonable accommodation requests. 5. Assistance with the housing search process. 6. Identification of resources to cover housing expenses (e.g., rental application fees, security deposits, moving costs, furnishings, adaptive aids, environmental modifications, and other one-time expenses, 7. Ensuring, though coordination, that the living environment is safe and move-in ready.	Population: 1. AE; 2. TAM; or 3. Recently Incarcerated Individuals Clinical Risk Factors: At least one of the clinical risk factors 1-5 in Table 2 Social Risk Factor: Homeless or at Risk of Homelessness

	Beneficiaries with Serious Mental Illness (SMI) have access to Targeted Case Management (TCM) services under Utah's Medicaid State Plan. Targeted Adults with a serious mental illness who receive benefits on a fee for service basis and are not enrolled in a Prepaid Mental Health Plan (PMHP) will have access to Tenancy Support Services if they cannot otherwise access Targeted Case Management services. To ensure there is no duplication of services, the state will review and authorize requests for tenancy support services through the demonstration only after verifying that Targeted Case Management services are not being provided.	
Tenancy and Sustaining Services	The following service includes: 1. Development of a housing support crisis plan to identify prevention and early intervention services when housing is jeopardized. 2. Participation in planning meetings to assist beneficiaries with the development of a housing support and crisis plan to address existing or recurring housing retention barriers. 3. Assistance with completing reasonable accommodation requests. 4. Connecting beneficiaries to education and training on tenant and landlord rights, and responsibilities. 5. Providing eviction risk reduction services (e.g., conflict resolution skills, coaching, role playing, and communication strategies targeted towards resolving disputes with landlords and neighbors). a. Communicating with landlords and neighbors to reduce the risk of eviction. b. Addressing biopsychosocial behaviors that put housing at risk. through coordination and referrals to other services c. Providing ongoing case management support with activities related to household management. d. Assistance with the housing voucher/subsidy application and recertification processes.	Population: 1. AE; 2. TAM; or 3. Recently Incarcerated Individuals Clinical Risk Factors: At least one of the clinical risk factors 1-5 listed in Table 2 Social Risk Factor: Homeless or at Risk of Homelessness
One-time transition and	Services provided to assist eligible beneficiaries to secure, establish, and maintain a safe and healthy living environment.,. Services include:	Population: 1. AE; 2. TAM; or

moving costs other than rent	1. One-time purchase of essential household items and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; moving expenses; and activities to assess, arrange and procure necessary resources. Services needed to establish basic living arrangements in a community setting, including kitchen, bathroom and cleaning equipment/goods. 2. Payment of a security deposit when a member moves into a new residence and it is required for a beneficiary to obtain a lease. To address the complex social determinants of health needs of individuals enrolled in the Targeted Adult Population, the State will impose a maximum of no more than two security deposit payments per beneficiary during the five-year demonstration approval period to help individuals who have transitioned into a community-based living arrangement and subsequently lose the community residence. 3. One-time non-refundable fees including submit rental applications, a. application and inspection fees, b. utilities activation fees and payment in arrears as necessary to re-establish utility service (capped at a total of six months of total arrear and prospective payments), c. movers and relocation expenses, d. pest eradication, e. cooking supplies, and f. the purchase of household goods and furniture. Allowable utilities include water, garbage, sewage, recycling, gas, electric, internet, and phone services that are essential to the operation of the residence. Services will be furnished when determined reasonable and necessary, when identified in a member's housing support plan, and when the beneficiary is unable to secure funding/items from other sources.	3. Recently Incarcerated Individuals Clinical Risk Factors: At least one of the clinical risk factors 1-5 listed in Table 2 Social Risk Factor: Homeless or at Risk of Homelessness
Home accessibility modifications and	The provision of medically necessary home accessibility modifications and remediation services to eliminate known home-based health and safety risks and ensure the occupants' health and safety in the living environment.	Population: 1. AE; 2. TAM; or

Remediations that are medically necessary	1. Home/environmental accessibility modifications including, for example, wheelchair accessibility ramps, handrails, and grab bars. 2. Home remediations that are medically necessary, including, for example, air filtration devices, air conditioning, ventilation improvements, humidifiers, refrigeration for medication, carpet replacement, mold and/or pest removal, and/or housing safety inspections.	3. Recently Incarcerated Individuals Clinical Risk Factors: At least one of the clinical risk factors 1-5 listed in Table 2 Social Risk Factor: Homeless or at Risk of Homelessness
Short-term rental assistance	Payment for rent and/or short-term, temporary stays for up to six months in a 5-year period. Payments include: • Rent payments for apartments, single room occupancy (SRO) units, single-family homes, multi-family homes, mobile home communities, accessory dwelling units (ADUs), co-housing communities, middle housing types, trailers, manufactured homes; manufactured home lots, motel or hotel when it is serving as the member's primary residence, transitional and recovery housing including bridge, site-based, population specific, and community living programs that may or may not offer supportive services and programming. Eligible costs include: • Rent payment (past due or forward rent) • Storage fees • Renter's insurance if required by the lease • Landlord paid utilities that are part of the rent payment and not duplicative of other HRSN utility payments. Payments must only be provided in connection with dwellings that meet maintenance regulation code within the local jurisdiction for safety, sanitation, and habitability.	Population: 1. AE; or 2. TAM Clinical Risk Factors: At least two of the clinical risk factors 1-5 listed above Social Risk Factor: Homeless or at Risk of Homelessness

	Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from the demonstration. Rent/temporary housing is only available to individuals who are transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, Institutions for Mental Diseases (IMDs), residential mental health and substance use disorder facilities, or inpatient psychiatric units, correctional facilities, and acute care hospitals Room and board-only interventions are limited to a combined 6 months per household per demonstration period. All section 1115 demonstration HRSN housing interventions with room and board are limited to the global HRSN housing cap of a combined 6 months per rolling 12-month period.	
Short Term Recuperative Care (Also referred to as Medical Respite)	Short-term recuperative care where integrated, clinically oriented recuperative or rehabilitative services and supports are provided for individuals who require ongoing monitoring and continuous access to medical care. Maximum benefit period: 60 days in a 365-day period. Assessed based on a rolling year. Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from the demonstration. All section 1115 demonstration HRSN housing interventions with room and board are limited to the global HRSN housing cap of a combined 6 months per rolling 12-month period.	Population: 1. AE; or 2. TAM Clinical risk factor 6: At-risk of or transitioning from ED/hospitalization or institutional care Social Risk Factor: Homeless or at Risk of Homelessness

Short-term post transition housing	Short-term post-transition housing (e.g., post-hospitalization), where integrated clinically oriented rehabilitative services and supports are provided, but ongoing monitoring of the individual's condition by clinicians is not required. Services may include: a. Rent or lease payments for dwellings that are an individual's primary residence. Dwellings must meet local zoning guidelines and local housing and building codes for safety, sanitation, and habitability. b. Hotel or motel costs, if being used as the individual's primary residence c. Renter's insurance if required by the lease. Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from the demonstration. All section 1115 demonstration HRSN housing interventions with room and board are limited to global HRSN housing cap of a combined 6 months per rolling 12-month period.	Population: 1. AE; or 2. TAM Clinical risk factor 6: At-risk of or transitioning from ED/hospitalization or institutional care Social Risk Factor: Homeless or at Risk of Homelessness

3. **Provider Qualifications**
    a. Service providers will be required to meet the following minimum qualification requirements:
        i. Demonstrate the capacity and experience to provide HRSN services as described below:
            1. Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing.
            2. Pre-tenancy Navigation Services must be provided by Medicaid enrolled providers certified by the State per Administrative rule R523-7-4.
            3. Tenancy and Sustaining Services must be provided by Medicaid enrolled providers certified by the State per Administrative rule R523-7-4.
            4. One-time transition and moving cost providers must meet the following criteria. Entities coordinating the purchase of equipment or supplies or paying deposits or other set-up fees for Medicaid members must be enrolled Medicaid providers that are:
                a. Housing authorities,
                b. public or private not-for-profit service organizations,
                c. faith-based organizations,
                d. state or local departments and agencies,
                e. units of local governments, or
                f. homeless services providers who provide housing/homeless services to individuals and/or families who are experiencing homelessness or are at risk of becoming homeless.

        ii. **HRSN Provider Experience and Expertise:** All HRSN services providers are expected to meet certain qualifications that ensure they are capable of providing high-quality services to qualifying members as well as have culturally specific expertise to connect with members of priority populations. Qualifications may include, for example:
            1. Maintain sufficient hours of operation and staffing to serve the needs of HRSN participants.
            2. Demonstrate their capabilities and/or experience with effectively serving at least one "priority population," as determined by the state. HRSN providers may demonstrate these capabilities and/or experience through, for example:
                a. Providing letter(s) of support from community members being served or other entities in the community, describing the HRSN provider's presence in the community and impact on individual community members and/or the community as a whole.

b. Submitting an annual report or similar document that describes the HRSN provider's relevant capabilities and activities.
c. Other methods deemed appropriate by the state.
d. Demonstrate that it has qualified service delivery and administrative staff, as determined by the state.

3. The ability to comply with applicable federal and state laws.
4. The capacity to provide culturally and linguistically appropriate, responsive and trauma-informed service delivery, including by ensuring their ability to:
    a. Adhere to federal and state laws and requirements related to ensuring communication and delivery of services to Members with diverse cultural and ethnic backgrounds.
    b. Meet cultural needs of the community for whom it provides services.
    c. Provide documentation of how cultural responsiveness and trauma informed care trainings are impacting organizational policies and staff practices.
    d. Document efforts to recruit and employ staff who reflect the HRSN provider’s Medicaid population, including individuals with similar demographics, lived experience, background and language fluency to the greatest extent possible.

4. **Member Identification and Assessment of Service Need**
    a. **Member Identification.** The state will ensure individuals can be identified for HRSN services through many different pathways.
        i. The state will ensure multiple pathways for individuals to be identified as being enrolled in Medicaid, belonging to an HRSN Covered Population, and potentially having one or more HRSN Service needs. Pathways for Member identification must include:
            1. The state proactively identifying Members through a review of encounter and claims data;
            2. Contracting with HRSN Service Providers to conduct HRSN Outreach and Engagement to identify Members and make HRSN Recommendations;
            3. Engaging with and receiving HRSN Recommendations from organizations other than HRSN Service Providers (called “HRSN Connectors”); and
            4. Accepting Members’ self-referral.
        ii. The following are examples of individuals and entities that may serve as HRSN Connectors and will have a pathway to identify individuals in need of HRSN services:
            1. Private and public housing service agencies and housing providers
            2. Correctional institutions

3. Health care providers including but not limited to primary care providers, behavioral health providers, hospitals, and long-term services and supports (LTSS) providers
4. State, local, and federal agencies who engage with Medicaid members
5. Traditional health workers
6. Child welfare workers and other case managers
7. Community partners and housing agencies will be required to estimate the number of individuals they expect to serve each year with HRSN services, as well as report to the state on the actual number of individuals they do serve.

b. HRSN Requests

i. The state will provide an HRSN Request Template that contains necessary information about individuals identified with a service need for an approval decision. HRSN Connectors that recommend individuals to receive HRSN services must use the State-developed HRSN Request Template.

ii. Other information that may be documented in the HRSN Request includes confirmation of Medicaid enrollment as well as any other information regarding the individual's potential HRSN eligibility. All HRSN Recommendations must include a statement that the recommended individual desires to take part in further HRSN eligibility determination process.

iii. The transmission of the information in the HRSN Request Template to the state can occur through a variety of delivery methods including, but not limited to email, fax, mail personal delivery or any other reasonable delivery method. These pathways must be made clear and accessible to members, Community-Based Organizations (CBOs), and other potential entry points through information posted on the state's website and through other means.

5. Eligibility Determination and Services Approval

a. Upon receipt of the information regarding the individual's HRSN needs, the state will use reasonable efforts to obtain all other information necessary to determine whether the individual is eligible for HRSN.

b. If, after completing the HRSN eligibility determination and documenting all the required information in, the Member meets all of the criteria for being HRSN eligible, the state will authorize the identified HRSN Services needed as expeditiously as possible. The service approval will be based on the following criteria:

i. Confirmation that the member is enrolled in Utah Medicaid;

ii. Determination that the individual meets the eligibility criteria for one of the HRSN covered population groups;

iii. Determining what other services the individual is receiving or may be eligible to receive under Medicaid or other programs;

iv. Assessment of the individual's clinical and social needs (described above in Section I.b) that justify the medical appropriateness of the service.

c. The HRSN provider will be required to:

i. Notify the individual of approval or denial of the service and provide information about appeals and hearing rights.
    1. The HRSN provider shall notify all individuals who have undergone an HRSN Service authorization or denial as expeditiously as the circumstances require, not to exceed fourteen (14) calendar days from the date of, as applicable and appropriate, authorization or denial. The HRSN provider will follow individual preferences for methods of communication (e.g., e-mail, phone call, etc.)
    2. Individuals who are denied HRSN Services or are authorized for HRSN Services but such authorization is limited in scope, amount, or duration, have Grievance and Appeal rights.

ii. Document the approval or denial of services through the closed loop referral technology; or chosen alternative system by the referring entity, ensuring a closed loop of the referral.

iii. A determination of non-eligibility for the HRSN program will be sent by the State and include Grievance and Appeal rights.

d. HRSN service approvals shall have the duration of up to 12 months. To ensure continuity of care, an HRSN provider shall rescreen for HRSN eligibility and service needs at least 60 days before the expiration of the current service authorization and submitted to the state for eligibility redetermination as described above in items 5.a and b, at least 30 days before the expiration of the current service authorization. This process will reassess any changes in the individual's circumstances, clinical and social needs, and service utilization. Subsequent re-screenings will follow this timeline annually, or sooner if significant changes in the individual's condition or circumstances are reported.

6. Care Management and Service Plans

a. The HRSN provider will conduct care management for individuals approved for HRSN services. The care management will include:
    i. Developing the care plan with the member and review as needed;
    ii. Identifying other HRSN services the member may need and referring to alternative providers if needed;
    iii. Determining what other services the individual is receiving or may be eligible to receive under Medicaid or other programs;
    iv. Coordinating with other social support services and care management the member is already receiving or becomes eligible for while receiving the HRSN service;
    v. Conducting reassessment for services prior to the conclusion of the service; and
    vi. At a minimum, conducting a 6-month check-in to understand if HRSN services are meeting their needs, if additional/new services are needed if the service duration is longer than 6 months, or if HRSN services are duplicating other services they are receiving.

b. The case manager and the member will create the care plan for the individual to obtain the HRSN service as approved by the community partner or housing agency. The care plan will be in writing and developed with and agreed upon by the member.
    i. The care plan will include:
        1. The recommended HRSN service;
        2. The service duration;
        3. The determination that the recommended service, unit of service, and service duration is medically appropriate based on clinical and social risk factors;
        4. The goals of the service(s);
        5. The follow-up and transition plan;
        6. The care management team responsible for managing the member's HRSN services.
c. The case manager is required to have one meeting with the individual, either in person or by telephone or videoconference during the development of the care plan. If efforts to have a meeting are unsuccessful, the case manager is required to document connection attempts, barriers to having a meeting, and justification for continued provision of service.

7. Payment

a. After providing HRSN services to members who satisfy HRSN eligibility requirements, HRSN service providers will submit a claim to the state.
b. The state will reimburse HRSN service providers according to a fee schedule for HRSN services to be developed by the state.
c. The state may also pay HRSN service providers in advance for select services, with the intent of conducting a reconciliation no less than annually to ensure services were rendered.

8. Conflict of Interest

a. The state shall ensure appropriate protections against conflicts of interest in HRSN service planning and delivery, including by ensuring that appropriate separation of service planning and service provision functions is incorporated into the state's conflict of interest policies.

Attachment J: HRSN Implementation Plan

[To be incorporated after CMS approval]

Attachment K: Provider Payment Rate Increase Assessment – Attestation Table

[To be incorporated after CMS approval]

Attachment L: Postpartum Proxy Methodology

As established in SHO# 21-007 RE: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP), CMS recognizes that states may use a proxy methodology to account for the proportion of individuals covered under the extended postpartum coverage option who would otherwise be eligible for coverage in the adult group and for the newly eligible FMAP under section 1905(y) of the Act.

Utah proposes the following methodology to estimate a percentage for claiming the enhanced FMAP for Medicaid members eligible for extended postpartum coverage. The State estimates this percentage to be 9.43%. Utah proposes to apply the percentage to the entire prenatal and postpartum period as described in the Application section below.

Methodology

Time Frame and Population

The methodology uses data from members who had deliveries paid for by the Medicaid program between April 1, 2021, and March 31, 2022. Utah identified these members based on specific aid codes for pregnant women and diagnosis codes associated with delivery services. This time frame has been selected as the most representative period for analysis. During this time, Medicaid members could neither be disenrolled nor could they move to non-pregnant eligibility groups until 60 days after their pregnancy ended.

Metrics

On average, these members received prenatal care for approximately 6.27 months and postpartum care for 11.64 months, beginning the month following the delivery. Additionally, 17.53% of these members transitioned to an expansion aid group post-delivery.

Calculation

Utah arrived at the proposed 9.43% figure using the following methodology:

1. The State queried all Medicaid claims and encounters in the Medicaid data warehouse with a delivery (identifiable based on presence of ICD-10-CM code of O80* or 082*) in a given month between 4/1/2021 through 3/31/2022. This totaled 6,018 deliveries.
    a. This is data gathered while the PHE was still active. Had Utah been able to, the State would have used data from months outside of the PHE. However, Utah is constrained by the fact that Utah's Adult Expansion program began in January 2020. This was three months prior to the start of the maintenance of effort (MOE) period
    b. Utah recognizes that this data has the anomaly of the PHE, but does not have an alternative time period to measure the movement from the pregnant program to adult expansion. This time frame simulated the effect of a 12-month postpartum coverage policy due to the fact that individuals would only be disenrolled from Medicaid due to death, moving out of state, or requesting case closure.
2. Of the 6,018 deliveries, the State queried the members' new aid category four months after the delivery month.
    a. Although the MOE required Utah Medicaid to keep members eligible except under special circumstances (death, move out of state, request closure, etc.), the member could transition to other aid categories after their delivery pursuant to 85 FR 71142.

   b. Utah chose to look four months after the delivery month because the State wanted to ensure that the member in question was actually outside of the 60-day postpartum coverage period. Due to the fact that the 60-day coverage policy covered individuals through the end of the month that contained the 60th day after the end of the pregnancy, there were some end-of-month deliveries that could result in three postpartum months of coverage. This is why Utah queried the fourth month after delivery.
   c. Following this evaluation, it was found that 17.53% (1,055 members) transitioned into adult expansion categories. 41.54% transitioned to parent/caretaker relative categories, 39.37% were still in a pregnant category, 1.43% were no longer Medicaid eligible (due to moving out of state, requesting closure, death, etc.), and the remaining members were eligible on child Medicaid or Blind/Disabled Medicaid.
3. For the 6,018 members who delivered between 4/1/2021 through 3/31/2022, the State calculated the total months before the delivery that each client was eligible for a pregnant aid category.
   a. This is the prenatal period. Utah includes this period in the calculation so that the State may apply the proxy methodology to the entire prenatal and postnatal period. This allows Utah to avoid a constant process of prior period adjustments as the State often learns of the end of pregnancy a few months after the fact.
   b. The prenatal months were calculated on average to be 6.27.
4. Of the 6,018 deliveries, Utah calculated the average duration of eligibility in the year after delivery.
   a. Utah acknowledges again that this analysis occurs during the months of the PHE. This calculation recognizes that certain exceptional circumstances, such as relocating out of state, voluntary account closure, or death, could lead to the termination of a member's eligibility prior to completing the 12-month period.
   b. The purpose of this calculation is to recognize that even with a coverage policy that would grant members 12 months of eligibility after the end of the pregnancy, some members do not experience the full 12 months.
   c. This number was calculated on average to be 11.64 months.
5. Utah calculated the "new postpartum months" as a percentage of the whole prenatal and postpartum period.
   a. This is calculated as 4.c (11.64 months) minus 2 months (to account for the postpartum period already covered as a state) divided by 4.c (11.64) + 3.b (6.27).
      i. (11.64-2)/(11.64+6.28) = 53.79%
6. Multiply 5.a by 2.c – the percentage of members who transitioned to expansion categories four months after delivery.
   a. 53.79% * 17.53% = 9.43%

Application

If approved, Utah would report 9.43% of all Medicaid expenditures with the criteria below as Group VIII Newly Eligible expenditures:

- Medicaid recipient aged 19-64; and
- service date occurs when the recipient is pregnant or within 12 months after the end of a pregnancy.

Claiming Methodology

When Utah Medicaid reports expenditures on CMS-64 forms, they will be reported as follows:

Coverage Group & Period	Type of Expenditure	64.9 Form Pre-Allocation	64.9 Form Post-Allocation
Prenatal through 60 days postpartum	FFS claims	90.57% of total computable (TC) reported on 64.9 Base	9.43% of TC reported on 64.9VIII Base
	Capitations under 1915(b) authority	90.57% of TC reported on 64.9 Waiver 1915(b)	9.43% of TC reported on 64.9VIII Waiver 1915(b)
Beyond 60 days postpartum through 12 months postpartum	FFS claims	90.57% of TC reported on 64.9 Waiver 1115	9.43% of TC reported on 64.9VIII Waiver 1115
	Capitations under 1915(b) authority	90.57% of TC reported on 64.9 Waiver 1115	9.43% of TC reported on 64.9VIII Waiver 1115

Department Assurances

The State assures that all individuals enrolled in the 12-month postpartum eligibility group will receive a package of services comparable to the state's Section 1937 Alternative Benefit Plan benefit package in accordance with Section 1903(i)(26) of the Social Security Act, including but not limited to:

a. Services that could be categorized under the 10 essential health benefit categories, plus federally qualified health centers/rural health clinic services, family planning services and supplies, non-emergency medical transportation and early and periodic screening diagnostic and treatment requirements;
b. Habilitative services;
c. No application of cost sharing on preventive services;
d. Adherence to mental health services parity requirements for fee-for-service (parity is required under managed care).

Attachment M: Evaluation Design

Utah Medicaid Reform 1115 Demonstration: Evaluation Design Document

Report prepared by the Public Consulting Group

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PUBLIC CONSULTING GROUP

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A. General Background Information

1. Demonstration Name and Timing

On June 30, 2022, the Centers for Medicare & Medicaid Services (CMS) approved a five-year extension of Utah's section 1115 waiver, formerly known as the "Primary Care Network (PCN) Demonstration" (hereafter, "the Demonstration" or "the 1115 Demonstration"). The current extension is entitled "Medicaid Reform 1115 Demonstration" and is approved for the five-year period from July 1, 2022, through June 30, 2027. Through the Demonstration, CMS has granted the state expenditure authorities to expand service offerings for vulnerable populations, move some members into integrated managed care plans, and to provide coverage to populations not otherwise eligible for Medicaid. The Utah Department of Health and Human Services (DHHS), Division of Integrated Healthcare (DIH) administers the Utah Medicaid program and is responsible for the implementation of the Demonstration.

2. Demonstration Goals

The Medicaid Reform 1115 Demonstration expands coverage for populations not traditionally eligible for Medicaid through direct coverage or premium subsidies. By providing access to preventive care and enhanced services to vulnerable populations, the Demonstration aims to improve health outcomes and to reduce cost of care.

The Demonstration goals, as outlined in the Special Terms and Conditions[7], are:

1. Provide health care coverage for low-income Utahns eligible under the Demonstration who would not otherwise have access to, or be able to afford, health care coverage;
2. Improve beneficiary health outcomes and quality of life;
3. Lower the uninsured rate of low income Utahns;
4. Provide continuity of coverage for individuals eligible under the Demonstration;
5. Increase access to primary care;
6. Reduce uncompensated care provided by Utah hospitals;
7. Reduce barriers to health care and housing, an important social determinant of health;
8. Increase the utilization of preventive dental services, while reducing emergency dental procedure costs;
9. Improve access to services across the continuum of care;
10. Provide for better care coordination for individuals transitioning to community-based care;
11. Reduce the utilization of emergency departments and inpatient hospital settings for treatment where utilization is preventable or medically inappropriate;
12. Reduce the overdose death rate; and
13. Improve access to fertility preservation services for Medicaid eligible individuals diagnosed with cancer, as well as access to in vitro fertilization (IVF) services for individuals diagnosed with certain genetic disorders

With the addition of the Substance Use Disorder (SUD) and Serious Mental Illness (SMI) Institution for Mental Diseases (IMD) amendment approvals, the state expanded its objectives to include the following for individuals with SUD and/or SMI:

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

[7] Source: medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-primary-care-network-protocol-apprvl-ltr-01082025.pdf

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

With the addition of the Pre-Release Services under Reentry Demonstration Initiative amendment approval, the state has further expanded its objectives to include the following for eligible individuals:

- Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;
- Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;
- Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable) and community-based providers
- Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;
- Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs;
- Reduce all-cause deaths in the near-term post-release;
- Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care; and
- Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release

3. Description

Utah's 1115 Demonstration was first approved in 2002 and has transformed over the last twenty years through extensions and amendments that have added new authorities and Demonstration populations.

The original PCN Demonstration provided a limited package of preventive and primary care benefits (the PCN benefit) to adults ages 19-64 with household incomes up to 150 percent of the Federal Poverty Level (FPL) and a slightly reduced benefit package to Parent/Caretaker Relatives (PCR) who comprised the Current Eligibles population. With Medicaid expansion in April 2019, PCN program participants became eligible for full state plan benefits, and the PCN benefit was phased out. The Current Eligible population was phased out by December 31, 2023, eliminating disparities in benefit packages by parental status. An assessment of the phase-out process is included in the evaluation design.

The 1115 Demonstration has historically served as a vehicle to provide premium assistance to adults with household incomes above Medicaid eligibility requirements. In 2006, the Utah Department of Health and Human Services (DHHS) amended the 1115 Demonstration to establish the Health Insurance Flexibility and Accountability Employer Sponsored Insurance (ESI) program, which provides premium assistance to adults with household incomes up to and including 150 percent of the FPL and CHIP-eligible children with family incomes up to 200 percent of the FPL. This was later amended to include adults with incomes up to 200 percent of the FPL and programmatically eligible adults and children obtaining coverage through COBRA[8]. Under the current 1115 Demonstration, premium assistance helps pay the individual's or family's share of monthly premium costs of ESI or COBRA and is aggregated under Utah's Premium

[8] Consolidated Omnibus Reconciliation Act of 1986

Partnership for Health Insurance Program (UPP). Individuals in the Adult Expansion population with access to employer-sponsored insurance are required to enroll, with few exceptions. The state also increased the maximum assistance reimbursement amount in July 2021 making this program more substantial and potentially increasing the number of individuals covered by UPP. In February 2024, CMS approved an increase in the premium subsidy for children that would otherwise receive CHIP services under the state plan from $120 to $180. If a plan offers dental coverage, the premium subsidy amount will increase from $140 to $200.

For nearly a decade, Utah's Demonstration has emphasized improving the behavioral health (BH) continuum of care. In November 2017 the state received approval to establish the Targeted Adult Medicaid (TAM) eligibility group. The TAM population consists of vulnerable adults ages 19-64, whose incomes are at or 0 percent of the FPL (effectively 5 percent of the FPL with the 5 percent disregard), and who meet detailed eligibility criteria in one of three targeted categories: chronically homeless, involved in the justice system and in need of substance use or mental health treatment, or are in need of substance use or mental health treatment. As of June 2022, enrollment in TAM was 9,384 individuals.

In December 2019, Utah received authority to enroll demonstration populations in managed care plans and to create an integrated managed care model, known as the Utah Medicaid Integrated Care (UMIC) plan. The four UMIC plans manage both physical and behavioral health benefits for the Adult Expansion population in Utah's five most populous counties: Davis, Salt Lake, Utah, Washington, and Weber. The Adult Expansion population in the rest of the state are enrolled in Accountable Care Organizations (ACOs) for their physical health service delivery system and in Prepaid Mental Health Plans (PMHPs) for their behavioral health service delivery system. The integrated care model is intended to provide more holistic and coordinated care than previously.

In March 2022, CMS approved the Housing Related Services and Supports (HRSS) amendment, allowing Utah to provide housing support services, such as tenancy supports, community transition services, and supportive living services to TAM individuals who meet additional eligibility criteria and exhibit one of seven risk factors. In an amendment approved in February 2024, an additional four risk factors were added to the HRSS program eligibility criteria to align eligibility with the sub-groups of the Targeted Adult group. The HRSS are paid on a fee-for-service basis. Providers are required to enroll and are evaluated to ensure they meet HRSS qualifications which includes being a certified case management provider. Once care plans have been approved, providers can submit claims for HRSS and receive reimbursement. As the program ramps up in the current waiver period, the state anticipates that HRSS will serve approximately 5,000 TAM individuals each year. By addressing crucial health related social needs in a high-needs population, the state anticipates that the HRSS program will improve participant health outcomes or quality of life and reduce non-housing related Medicaid costs.

In January 2025, CMS approved coverage of Health-Related Social Needs (HRSN) services. The amendment:

- expands the HRSS benefit to the Adult Expansion population and to recently incarcerated individuals;
- adds short-term rental assistance and short-term recuperative care for Adult Expansion and TAM populations;
- authorizes HRSN infrastructure investments; and
- authorizes the state to provide non-medical transportation (NMT) to and from HRSN services for eligible individuals.

Eligibility for HRSN services includes social and clinical risk factors and medical necessity criteria.

The 1115 Demonstration also includes components that focus on individuals with SUD and/or SMI, and youth with significant emotional disorder (SED) and/or behavioral challenges. Utah received approval of the SUD Implementation plan in November 2017. The Opioid Use Disorder (OUD) and SUD Program provides state plan behavioral health benefits to Demonstration participants. The state also received

authority to provide residential and inpatient OUD/SUD treatment services to all Medicaid beneficiaries while they are short term residents in treatment settings that qualify as IMDs.

The SMI/SED Implementation plan was approved in December 2020 and is similar in expenditure authority to the OUD/SUD program. The state is taking action to meet key milestones of the SMI/SED program including, ensuring quality of care in psychiatric hospitals and residential settings, improving care coordination and transitions to community-based care, increasing access to the continuum of care including crisis stabilization services, and earlier identification and engagement in treatment and increased integration. Together, the SUD and SMI components expand access to mental health services, opioid use disorder (OUD) and other substance use disorder (SUD) services. The 1115 Demonstration supports state efforts to enhance provider capacity, improve the availability of Medication Assisted Treatment (MAT) and improve access to a continuum of SMI evidence-based services at varied levels of intensity, including crisis stabilization services.

In February 2019, Utah received CMS approval to provide state plan Medicaid coverage to Former Foster Care Youth from another state (FFCYAS) who were ever enrolled in Medicaid in another state and are not otherwise Medicaid eligible in Utah. State plan coverage is provided to this population until 26 years of age.

In November 2019, Utah received CMS approval for the provision of intensive stabilization services (ISS) to Medicaid eligible children and youth under age 21 in state custody or at risk of being placed in state custody who are experiencing significant emotional and/or behavioral challenges. The ISS program provides both state plan BH services and home and community-based services (HCBS) that are not currently authorized through the state plan.

The Demonstration also authorized the Clinically Managed Residential Withdrawal Pilot from May 1, 2019, to April 1, 2021; this benefit became available statewide as of April 1, 2021 to all eligible Medicaid members. As a result, the State received approval on July 23, 2021, to remove this pilot project from the 1115 Demonstration and CMS is not requiring the State to evaluate this population.

The current 1115 Demonstration includes dental coverage for vulnerable populations. The PCN Demonstration first provided an adult dental benefit to the Current Eligibles population in November 2006. CMS approved dental benefits for adults with disabilities or blindness in 2017. In 2019, the state chose to provide comprehensive dental benefits to TAM adults receiving SUD treatment because research showed that dental coverage could increase initiation and engagement in treatment for individuals living with SUD. In 2020 dental benefits were extended to Medicaid eligible individuals aged 65 and older and to TAM adults in need of porcelain or porcelain-to-metal crowns. In January 2025, CMS approved an expansion of dental benefits to all Medicaid-eligible adults.

In February 2024, CMS approved an amendment to the current 1115 Demonstration enabling the state to receive expenditure authority for fertility preservation services provided to certain individuals diagnosed with cancer, as well as for in vitro fertilization (IVF) and genetic testing services for certain individuals. Under the IVF and genetic testing amendment, the state may provide genetic testing services to eligible individuals, preimplantation genetic testing of embryos, and IVF services to eligible individuals, ages 18 through 35, diagnosed by a physician with a genetic trait associated with cystic fibrosis, morquio syndrome, sickle cell anemia, spinal muscular atrophy, or myotonic dystrophy. Under the fertility treatment for individuals diagnosed with cancer amendment, the state is now enabled to provide fertility preservation for eligible individuals diagnosed with cancer and requiring treatment that may cause a substantial risk of sterility or iatrogenic infertility (i.e., infertility caused by treatment for cancer). Services covered under this once per lifetime benefit include the collection and storage of eggs or sperm and coverage for cryopreservation storage. Coverage for cryopreservation storage is covered as a single payment in five-year increments. In January 2025, CMS authorized an increase in the upper age limit for fertility preservation services for individuals diagnosed with cancer from 40 to 50 years of age.

In July 2024, CMS approved an additional amendment to the 1115 Demonstration called the “Pre-Release Services under Reentry Demonstration Initiative” that allows the state to provide limited coverage for a targeted set of services to certain eligible incarcerated individuals for 90 days prior to the individuals’

expected release. This amendment closely aligns with CMS's "Reentry Demonstration Opportunity," described in the State Medicaid Director Letter released in April 2023.

Individuals residing in a county jail, state prison, or youth correctional facility who have been determined eligible for Medicaid based on an application filed before or during incarceration are eligible to receive a limited set of pre-release benefits for up to 90-days before their expected release date. These benefits include, but are not limited to, case management, medication-assisted treatment for SUD, and physical and behavioral health clinical consultation services. A full description of the pre-release services can be found in Table 2: Additional Demonstration Benefits, Programs and Services

4. Populations

Table 1 provides a summary of the demonstration populations during the Demonstration period. Adult Expansion (AE) is the largest population, consisting of approximately 116,000 adults ages 19-64 with incomes up to 133 percent of the FPL. Additional demonstration benefits, programs, and services are summarized in Table 2. The evaluation design includes hypotheses and research questions for all key policies and programs of the demonstration.

Table 1: Demonstration Eligible Populations

Demonstration Eligible Populations	Eligibility[9]	Benefits[2]	Estimated Number of Annual Enrollees[10]
Current Eligibles (CE)	Adults aged 19-64 who are medically needy and not aged, blind, or disabled. Individuals who are pregnant are excluded, through the 60th day postpartum.	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. 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)	The CE population will be phased out entirely no later than December 31, 2023
Adult Expansion (AE)	Adults, age 19 through 64, who are not Current Eligibles, who are U.S. citizens/qualified non-citizens, are residents of Utah, and have household income at or below 133 percent of the FPL.	Expansion adults will receive state plan benefits and benefits that are the equivalent of (b)(3) services under the state's 1915(b) PMHP waiver, which include; psychoeducational services, personal services, respite care and supportive living services.	115,584
Utah Medicaid Integrated Care (UMIC) – a subgroup of the AE population	Adult Expansion members enrolled in the Utah Medicaid Integrated Care program, which operates in Utah's most populous counties: Davis, Salt Lake, Utah, Washington, and Weber.	Expansion adults will receive state plan benefits and benefits that are the equivalent of (b)(3) services under the state's 1915(b) PMHP waiver, which include; psychoeducational services, personal services, respite care and supportive	49,963

[9] ut-cms-amndmnt-aprvl.pdf (medicaid.gov)

[10] The annual estimates reflect the enrollment numbers reported in the Annual Monitoring Report for the period July 2021 – June 2022 for populations that are continuing from the prior waiver period. Estimates for TAM HRSS, a new population, are taken from the approved Waiver renewal. Estimates for IVF and genetic testing and fertility preservation treatments, and estimates for HRSN Services, are taken from the state's amendment applications to CMS. Estimates for the Justice-Involved populations are taken from state-generated updates to the state's amendment application to CMS.

Demonstration Eligible Populations	Eligibility[9]	Benefits[2]	Estimated Number of Annual Enrollees[10]
		living services.	
Demonstration Populations III, V, VI, and Current Eligible CHIP Children	Demonstration Population III - working adults, aged 19-64, their spouses, and their children ages 19-26, with gross family incomes above 133 percent of the FPL and up to and including 200 percent of the FPL, are not otherwise eligible for Medicaid and participate in an approved ESI plan. Demonstration Population V - same as Demonstration population III, except that the eligible individual or custodial parent/caretaker is able to enroll in COBRA continuation coverage. Current Eligible CHIP Children - 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 - children up to age 19 with family income up to 200 percent of the FPL who would meet the definition of a low-income child. Population is divided into 2 groups: COBRA-Eligible Children and COBRA-Continuation Children.	Individuals in these eligibility categories are eligible to receive premium assistance (through ESI or COBRA) in paying the employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans. Together, the ESI and COBRA benefits are the "Utah Premium Partnership Program" (UPP). Premium assistance is the sole Medicaid benefit provided to these members.	1,288
Targeted Adult Medicaid (TAM)	Includes adults, ages 19 through 64, with incomes below five percent of the FPL and no dependent children, who meet detailed criteria in one of three major categories: ● Chronic homelessness	Individuals enrolled in this eligibility category receive full Medicaid state plan benefits.	9,384

Demonstration Eligible Populations	Eligibility[9]	Benefits[2]	Estimated Number of Annual Enrollees[10]
	• Involved in the criminal justice system and in need of substance use or mental health treatment. • In need of substance use or mental health treatment		
Intensive Stabilizations Services (ISS)	Medicaid eligible children and youth under age 21, who are in state custody, or at risk of state custody, and experiencing significant emotional and/or behavioral challenges.	Individuals eligible for this category will receive state plan and home community-based crisis stabilization services during the first eight-weeks of the intensive program on a FFS basis using a daily bundled rate.	Anticipate 20
Former Foster Care Youth from Another State (FFCYAS)	Individuals under age 26, who were in foster care under the responsibility of a state other than Utah, or a tribe in such other state when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were ever enrolled in Medicaid, are now applying for Medicaid in Utah, and are not otherwise eligible for Medicaid.	Individuals enrolled in this eligibility category receive full Medicaid state plan benefits.	17

In addition to the benefits associated with each eligibility pathway outlined above, the Demonstration includes several benefits, programs, and services that have expanded over time to broaden access to care and to meet the needs of vulnerable populations (see Table 2).

Table 2: Additional Demonstration Benefits, Programs, and Services

Additional Demonstration Benefits, Programs, and Services	Eligibility[11]	Benefits[2]	Estimated Number of Annual Enrollees[12]
Dental Benefit	As of the amendment approved in January 2025: all individuals enrolled in Medicaid and are the age of 21 or older. Previously, dental benefits were available only to the aged, blind, or disabled groups, and to TAM members receiving SUD treatment.	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 porcelain or porcelain-to-metal crowns, if needed.	Entire Adult Expansion population 115,584
Health Related Social Needs (HRSN) Services	As of the amendment approved in January 2025: the following covered populations will be eligible to receive HRSN services if they also satisfy the applicable clinical and social risk criteria and the HRSN services is determined to be medically appropriate: Recently Incarcerated Individuals are eligible for HRSS. Adult Expansion and TAM demonstration populations are eligible for HRSS, Short-Term Rental Assistance, Short-Term Recuperative Care, and Short-Term Post Transition Housing	Housing-Related Services and Supports (HRSS): includes pre-tenancy navigation services, tenancy sustaining services, one-time transition and moving costs other than rent, home accessibility modifications and remediations that are medical necessary. Short-Term Rental Assistance: payment for rent and/or short-term temporary stays for up to six months in a 5-year period. Short-Term Recuperative Care (a/k/a Medical Respite): clinically oriented recuperative or rehabilitative services and supports for individuals	5,000

[11] ut-cms-amndmnt-aprvl.pdf (medicaid.gov)

[12] The annual estimates reflect the enrollment numbers reported in the Annual Monitoring Report for the period July 2021 – June 2022 for populations that are continuing from the prior waiver period. Estimates for TAM HRSS, a new population, are taken from the approved Waiver renewal. Estimates for IVF and genetic testing and fertility preservation treatments, and estimates for HRSN Services are taken from the state's amendment applications to CMS. Estimates for the Justice-Involved populations are taken from state-generated updates to the state's amendment application to CMS.

Additional Demonstration Benefits, Programs, and Services	Eligibility[11]	Benefits[2]	Estimated Number of Annual Enrollees[12]
		who require ongoing monitoring and continuous access to medical care. Short-Term Post Transition Housing: clinically oriented rehabilitative services and supports for individuals who do not require ongoing monitoring and continuous access to medical care.	
Serious Mental Illness (SMI) IMD Benefit	Medicaid recipients, age 21 through 64 receiving SMI services in IMD treatment settings.	The Demonstration grants Utah expenditure authority for services provided to beneficiaries during short term stays in an IMD to receive acute care for a primary diagnosis of SMI or SED for stays of up to 60 days, as long as the state shows at its midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving covered services in an IMD.	8
Opioid Use Disorder/ Substance Use Disorder Program	SUD benefits are available to all Medicaid members through state plan authority.	The Demonstration grants Utah expenditure authority to provide the following services in IMDs: residential treatment, withdrawal management, medication-assisted treatment (MAT), peer support, residential crisis stabilization.	767
In Vitro Fertilization and Genetic Testing Services	In Vitro Fertilization (IVF): Medicaid recipients ages 18-35 diagnosed by a physician or qualified health professional as having a genetic trait associated with cystic fibrosis, morquio syndrome, sickle cell anemia, or spinal muscular atrophy, and has a reproductive partner who has been diagnosed with the same condition. Has been diagnosed by a physician or	In vitro fertilization services, genetic testing services, and preimplantation genetic testing to test embryos for genetic disorders prior to transfer to the uterus. These services require prior authorization, and qualifying beneficiaries may receive up to three cycles of IVF per lifetime.	50

Additional Demonstration Benefits, Programs, and Services	Eligibility[11]	Benefits[2]	Estimated Number of Annual Enrollees[12]
	qualified health professional as having a genetic trait associated with myotonic dystrophy. Genetic testing: Medicaid recipients who have a familial medical history or are in an ethnic group that has a high risk of one or more of the following medical conditions: cystic fibrosis, morquio syndrome, myotonic dystrophy, sickle cell anemia, or spinal muscular atrophy.		
Fertility Preservation Benefit for Individuals Diagnosed with Cancer	Medicaid recipients diagnosed by a physician or qualified health professional as having an active cancer diagnosis requiring treatment that may cause a substantial risk of sterility or iatrogenic infertility. Post pubertal and up to age 50.	Individuals can receive egg and sperm collection and storage, preimplantation genetic testing prior to cryopreservation storage, cryopreservation storage. These benefits require prior authorization and are available once per lifetime.	226
Justice-Involved Reentry Benefit	Individuals who are inmates residing in county jails, state prisons, or youth correctional facilities and have been determined eligible for Medicaid pursuant to an application filed before or during incarceration.	Eligible individuals can receive the following pre-release services starting 90 days before their release from incarceration: ● Case management to assess and address physical and behavioral health needs; ● Medication-assisted treatment services for all types of SUD as clinically appropriate, with accompanying counseling; ● A 30-day supply of all prescription medications that have been prescribed for the individuals at the time of release;	Adults: 3,600 Youth:15

Additional Demonstration Benefits, Programs, and Services	Eligibility[11]	Benefits[2]	Estimated Number of Annual Enrollees[12]
		provided to the individual immediately upon release from the correctional facility; ● Physical and behavioral health clinical consultation services, as clinically appropriate, to diagnose health conditions, provide treatment, and support pre-release case managers' development of a post-release treatment plan and discharge planning; ● Diagnostic services, including laboratory and radiology services, and treatment services in addition to coverage for MAT described above; ● Prescribed drugs, in addition to MAT and the 30-day supply of prescription medication, and medication administration; ● Family planning services and supplies; ● Services provided by community health workers; ● Peer support services; ● Treatment for Hepatitis C; and ● Medical equipment and supplies and/or medical equipment provided upon release Youth eligible for CHIP will receive pre-release screening, diagnostic, and case management services	

Additional Demonstration Benefits, Programs, and Services	Eligibility[11]	Benefits[2]	Estimated Number of Annual Enrollees[12]
		starting 30 days before their release.[13]	

[13] Authority for pre-release services for CHIP eligible youth is covered under the SPA, and not held under the Utah Medicaid Reform 1115 Demonstration waiver; this evaluation will not include this population.

5. Context

The Utah Medicaid 1115 Demonstration also coincided with the unwinding of the Medicaid Continuous Enrollment requirement associated with the Covid-19 pandemic beginning in 2020. Enrollment in Medicaid remained high during the continuous enrollment period as states were required to keep current Medicaid beneficiaries enrolled. The unwinding of continuous eligibility for Medicaid began on March 1, 2023.[14] Under Utah's unwinding plan[15], every member's case was slated for a full review, with cases spread over a 12-month period. Cases most likely to change programs or coverage were prioritized for review, and those most likely to remain Medicaid eligible were deferred to later in the year. DHHS communicated with providers and beneficiaries about the redetermination process. Members are urged to update their contact information and check the unwinding website[16] to learn their anticipated review date. Redetermination will likely affect enrollment numbers in the Demonstration, as some individuals moved from one eligibility category to another, and individuals above income limits transitioned off Medicaid coverage. This evaluation design includes qualitative interviews and process metrics on implementation as it will be a moderating factor that may affect Demonstration outcomes.

[14] 10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision | KFF

[15] https://medicaid.utah.gov/unwinding/

[16] https://jobs.utah.gov/mycase/

B. Evaluation Questions and Hypotheses

1. Logic Model

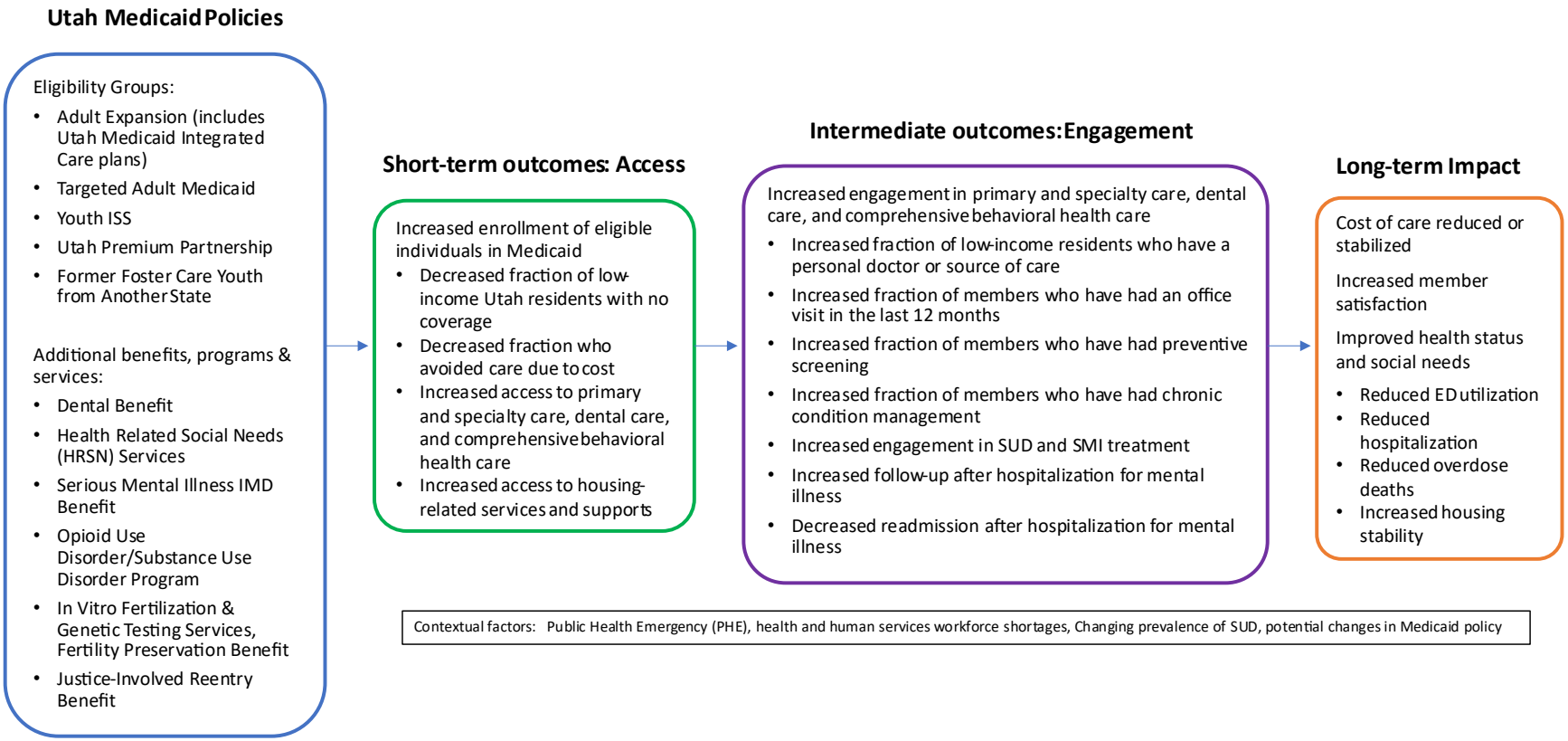


Figure 1: Medicaid Reform Demonstration Overall Logic Model

2. Hypotheses and Research Questions

The logic model above illustrates how the Demonstration objectives are expected to be achieved by program activities, following a natural progression from proximate to distal outcomes as the Demonstration goes on. Each outcome is represented by a testable hypothesis, listed below, about the impact of the Demonstration activities, and a corresponding research question. Tables 15-25 specify the measures that will be used to assess each hypothesis.

The hypotheses are organized by population or program/benefit, and are focused on the broad themes of increasing health care coverage, increasing access to primary care and appropriate utilization, reducing high-cost acute care utilization, including potentially preventable utilization, and reducing the cost of uncompensated care.

The first objective of the 1115 Demonstration, providing health care coverage for low-income Utahns eligible who would not otherwise have access to or be able to afford healthcare coverage, is achieved through enrollment in a number of the Demonstration populations, including the Adult Expansion, TAM, UPP, and ISS. Individuals in these populations would not otherwise be eligible for Medicaid without the presence of the Demonstration in Utah.[17] The first hypothesis is thus focused on the impact of the 1115 Demonstration overall on the population of low-income UT residents. A larger fraction of low-income UT residents is expected to report having access to coverage and engaging in healthcare relative to reported access and engagement in other states. Engagement in care is expected to improve member satisfaction and lead to reductions in inappropriate care utilizations, also known as "Low Value Care".

The second hypothesis is similar to the first hypothesis, and focuses specifically on the Adult Expansion population. The second hypothesis is that the Demonstration will improve healthcare access and engagement for the Adult Expansion population. The state hypothesizes that by providing coverage through Medicaid expansion, members will engage in primary and preventive care, which will lead to reductions in acute care utilization. The Utah Medicaid Integrated Care (UMIC) population, a subpopulation of the Adult Expansion population, consists of members in Utah's five-most populous counties who are enrolled in plans that integrate care for physical and behavioral health needs. Thus, the UMIC research questions are specific to the outcomes produced when members gain access to behavioral health care that is managed by the same managed care organization that manages their physical health care. It is anticipated that UMIC will improve engagement in BH services and reduce ED utilization.

The third hypothesis again focuses on access and engagement in healthcare, this time focusing on the TAM population. The state hypothesizes that the Demonstration will continue to improve healthcare access and engagement for this population.

The fourth hypothesis addresses the HRSN demonstration, which essentially expands the housing-related services and supports (HRSS) benefit previously available only to TAM members, to the entire Adult Expansion population who meet the needs-based eligibility criteria. The state is authorized to provide HRSS, short-term rental assistance, short-term recuperative care, short-term post-transition housing, and non-medical transportation (NMT). The evaluation design focuses on HRSS and NMT, with a planned implementation date of July 1, 2025. The other authorized services may, or may not, be implemented during the current demonstration period. If they are implemented, they should contribute to the same outcomes theorized for HRSS. It is anticipated that the HRSN demonstration will reduce the prevalence and severity of housing and transportation needs, increase continuity of BH treatment, and improve health outcomes for eligible members. Research questions include whether HRSN services were provided and utilized as planned, care manager perspectives on incorporating this new benefit, whether there is unmet need, and whether HRSS improves perceived health status. Other research questions about the HRSN demonstration focus on how HRSN affects high-cost acute care utilization.

The fifth and sixth hypotheses speak to BH services provided to Demonstration participants and Medicaid beneficiaries with SMI and SUD treated in Institutions of Mental Disease (IMD). The state anticipates that

[17] Individuals in the Current Eligibles population received expanded benefits through the waiver, although they would have received coverage regardless of the presence of the waiver.

BH coverage for residential and inpatient services provided to members in IMDs will lead to a reduction in inpatient stays, ED utilization, and rate of unplanned readmission among recipients, resulting in cost decrease or stabilization. The state also anticipates this will lessen unmet need and increase engagement in treatment to reduce overdose deaths in the long-term. The IE will monitor the impact of the state's efforts to increase access to crisis stabilization services. Greater utilization of non-hospital, non-residential services should lead to greater reductions in inpatient stays, ED utilization, and overdose deaths in the long-term.

The seventh hypothesis addresses smaller Demonstration populations, which include UPP/ESI, ISS, , TAM Dental, and FFCYAS. The state anticipates that utilization for the services provided to these populations will increase and total cost of care will decrease, as these members engage in acute and preventive care. Although the number of Adult Expansion members enrolled in Employer Sponsored Insurance will grow due to the new provision present in this waiver requiring enrollment in ESI for all Adult Expansion members who have access to insurance through their employers, the number of members enrolled in ESI is not projected to exceed 1,385 members during this Demonstration period. As a result, the ESI population by itself is unlikely to lead to reductions in uncompensated care and inappropriate care utilization. In addition, the number of individuals in the FFCYAS population, and the number receiving ISS, were both very small in the prior Demonstration period. Therefore, the evaluation will include counts and a qualitative summary of program implementation.

Finally, hypotheses eight through eleven focus on the justice-involved (JI) population and the pre-release and reentry services newly covered. The state anticipates that the demonstration will enhance cross-system collaboration between the correctional and community-based services systems, that enrollment and redetermination support will improve continuity of coverage, and that coverage of pre-release and reentry services will improve engagement in high quality care, reduce unnecessary acute care utilization, and ultimately improve health outcomes for the JI population. In addition, the State will conduct a demonstration cost assessment including administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. The results of the cost assessment will be included in the Interim and Summative Evaluation Reports.

1. Hypothesis 1: The Demonstration overall will improve access to coverage and engagement in health care for low-income UT residents.
    - Primary research question 1.1: Did the fraction of low-income residents with no coverage decrease, relative to comparison states?
    - Primary research question 1.2: Did the fraction of low-income residents who avoided care due to cost decrease, relative to comparison states?
    - Primary research question 1.3: Did the fraction of low-income residents who have a personal doctor or usual source of care increase, relative to comparison states?
    - Primary research question 1.4: Did the fraction of low-income residents who had a primary or specialty care appointment in the last year increase, relative to comparison states?
    - Primary research question 1.5: Did the fraction of low-income residents who had a preventive screening in the last year increase, relative to comparison states?
    - Primary research question 1.6: What is the member experience of care in terms of access, timeliness, and patient-centeredness?
    - Primary research question 1.7: Did Low Value Care decrease among Demonstration participants, relative to baseline?

2. Hypothesis 2: The Demonstration will improve healthcare access and engagement for the Adult Expansion population.
    - Primary research question 2.1: Did inpatient hospital utilization decrease, relative to baseline, for the Adult Expansion population?

- Primary research question 2.2: Did ED visits decrease, relative to baseline, for the Adult Expansion population?
  - Subsidiary research question 2.2a: Did ED visits for BH conditions decrease, relative to baseline, for the Adult Expansion population?
  - Subsidiary research question 2.2.b: Did UMIC plans reduce ED visits for BH conditions for Adult Expansion population, relative to FFS or physical health-only ACO plans?
- Primary research question 2.3: Did engagement in primary and ambulatory care increase, relative to baseline, for the Adult Expansion population?
- Primary research question 2.4: Did engagement in behavioral health care increase, relative to baseline, for the Adult Expansion population?
  - Subsidiary research question 2.4.a: Did UMIC plans improve engagement in behavioral health care for the Adult Expansion population, relative to FFS or physical health-only ACO plans?
- Primary research question 2.5: Did engagement in treatment for chronic conditions increase, relative to baseline, for the Adult Expansion population?
- Primary research question 2.6: Did preventive cancer screening increase, relative to baseline, for the Adult Expansion population?
- Primary research question 2.7: Did dental service provision increase relative to baseline for the Adult Expansion population?
- Primary research question 2.8: Did ED visits for non-traumatic dental conditions decrease relative to baseline for the Adult Expansion population?
- Primary research question 2.9: Did follow-up after ED visits for non-traumatic dental conditions increase relative to baseline for the Adult Expansion population?
- Primary research question 2.10: To what extent are beneficiaries aware of the dental care benefit?

3. Hypothesis 3: The Demonstration will improve healthcare access and engagement for the TAM population.

- Primary research question 3.1: Did inpatient hospital utilization decrease, relative to baseline, for the TAM population?
- Primary research question 3.2: Did ED visits decrease, relative to baseline, for the TAM population?
  - Subsidiary research question 3.2.a: Did ED visits for BH conditions decrease, relative to baseline, for the TAM population?
- Primary research question 3.3: Did engagement in primary and ambulatory care increase, relative to baseline, for the TAM population?
- Primary research question 3.4: Did engagement in behavioral health care increase, relative to baseline, for the TAM population?
- Primary research question 3.5: Did dental service provision increase relative to baseline for the TAM population?
- Primary research question 3.6: Did ED visits for non-traumatic dental conditions decrease relative to baseline for the TAM population?

- Primary research question 3.7: Did follow-up after ED visits for non-traumatic dental conditions increase relative to baseline for the TAM population?

4. Hypothesis 4: The HRSN Services demonstration will effectively mitigate members' housing and transportation needs, lead to more appropriate service utilization and improved physical and mental health outcomes.
   - Primary research question 4.1: What is the prevalence and severity of beneficiaries' social needs?
   - Primary research question 4.2: Were HRSN services provided and utilized as planned?
   - Primary research question 4.3: Did the HRSN demonstration effectively mitigate beneficiaries' housing and transportation needs?
   - Primary research question 4.4: Did high-cost acute utilization decrease, relative to baseline, for HRSN recipients?
   - Primary research question 4.5: Did engagement in primary and ambulatory care increase, relative to baseline, for HRSN recipients?
   - Primary research question 4.6: Did engagement in behavioral health care increase, relative to baseline, for HRSN recipients?
   - Primary research question 4.7: From the beneficiaries perspective, did the HRSN services meet their housing-related needs, support their engagement in behavioral health care, and overall positively impact their physical and mental health?
   - Primary research question 4.8: Did state and local investments in housing supports change over time during the HRSN demonstration?
   - Primary research question 4.9: Were there any improvements in the quality and effectiveness of downstream housing-related services and supports?

5. Hypothesis 5: The SMI and SUD Demonstrations increased access to appropriate treatment.
   - Primary research question 5.1: Did the number of individuals receiving services for SMI and/or SUD increase, relative to baseline?
   - Primary research question 5.2: Did ED visits for BH conditions decrease among individuals with SMI and/or SUD diagnoses, relative to baseline?
   - Primary research question 5.3: Did inpatient days (outside of IMDs) decrease, relative to baseline, for individuals with SMI and/or SUD?
   - Primary research question 5.4: Did engagement in SUD treatment increase among individuals with SUD diagnoses relative to baseline?
   - Primary research question 5.5: Did unplanned readmission following hospitalization for psychiatric treatment decrease among individuals with SMI relative to baseline?
   - Primary research question 5.6: Did utilization of any mental health service increase among low-income residents, relative to comparison states?
   - Primary research question 5.7: Did the number of individuals needing but not receiving SUD treatment decrease among low-income residents, relative to comparison states?
   - Primary research question 5.8: Did the rate of overdose deaths decrease, relative to baseline?

- Primary research question 5.9: Did the number of individuals receiving crisis stabilization services increase (with an emphasis on non-hospital, non-residential services[18]?

6. Hypothesis 6: The SMI and SUD Demonstrations stabilized or reduced cost of care for these populations.
   - Primary research question 6.1: Did the total cost of care for individuals with SMI diagnoses change, relative to baseline?
     - Subsidiary research question 6.1.a: Did costs related to the diagnosis and treatment of SMI change, relative to baseline? (SMI-IMD costs + other SMI costs + non-SMI costs)?
     - Subsidiary research question 6.1.b: What types of care (inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care) are the primary drivers of the cost of care for the SMI population?
   - Primary research question 6.2: Did the total cost of care for individuals with SUD diagnoses change, relative to baseline?
     - Subsidiary research question 6.2.a: Did costs related to the diagnosis and treatment of SUD change, relative to baseline? (SUD-IMD costs + other SUD costs + non-SUD costs)?
     - Subsidiary research question 6.2.b: What types of care (inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care) are the primary drivers of the cost of care for the SUD population?

7. Hypothesis 7: The Demonstration delivered coverage/ services appropriately to individuals in the smaller Demonstration populations and programs.

   UPP/ESI
   - Primary research question 7.1: Did the number of individuals receiving coverage increase relative to baseline?
   - Primary research question 7.2: What was the average total Medicaid cost of care for enrollees?
   - Primary research question 7.3: Did the pmpm cost for enrollees change over time?

   ISS
   - Primary research question 7.4: Did the number of individuals receiving ISS increase relative to baseline?

   Former Foster Care Youth from Another State (FFCYAS)
   - Primary research question 7.5: How many FFCYAS received coverage?

   Fertility and Genetic Testing Services
   - Primary research question 7.6: Did the number of individuals receiving fertility preservation services increase relative to baseline?
   - Primary research question 7.7 Did the number of individuals receiving genetic testing services increase relative to baseline?

[18] This includes services made available through crisis call centers, mobile crisis units, and coordinated community response services as defined in STC 12.4 SMI/SED Financing Plan.

8. Hypothesis 8: The Justice-Involved Reentry Benefit will enhance cross-system communication and coordination between correctional and community services.
    - Primary research question 8.1: Did the Demonstration's services facilitate beneficiaries' post-release transitions to care?
    - Primary research question 8.2: Was communication and coordination between the correctional system and community-based health services enhanced?

9. Hypothesis 9: The Justice-Involved Reentry Benefit will improve pre-release service provision during the covered period and continuity of coverage for the justice-involved population.

- Primary research question 9.1: What Demonstration services did justice-involved individuals receive in the pre-release period?
- Primary research question 9.2: What was beneficiaries' experience of pre-release service provision?
- Primary research question 9.3: Were beneficiaries potentially in need of behavioral health services identified in the pre-release period?
- Primary research question 9.4: What fraction of justice-involved individuals received navigation support for accessing Medicaid coverage pre-release?
- Primary research question: 9.5: Did reentry continuity of coverage improve for incarcerated individuals compared to the pre-demonstration comparison population?

10. Hypothesis 10: The Justice-Involved Reentry Benefit's 90-day pre-release coverage period ("the coverage timeline") will support effective program implementation.

- Primary research question 10.1: Did the coverage timeline facilitate providing more coordinated, efficient, and effective reentry planning?
    - Subsidiary research question 10.1.a: Were assessments and care plans completed in a timely manner?
    - Subsidiary research question 10.1.b: Did beneficiaries receive a 30-day supply of all prescribed medications immediately upon release from the carceral setting?
- Primary research question 10.2: Did the coverage timeline enable pre-release management and stabilization of clinical, physical, and behavioral health conditions?
- Primary research question 10.3: Did the coverage timeline help mitigate potential operational challenges the state might have encountered in a more compressed timeline?

11. Hypothesis 11: The Justice-Involved Reentry Benefit will improve engagement in health care services and social, reduce acute care utilization, and improve health outcomes for the justice-involved population post-release.

- Primary research question 11.1: Did engagement in appropriate health care services post-release increase relative to a pre-demonstration comparison population?
- Primary research question 11.2: Did inpatient hospital utilization post-release decrease relative to the pre-demonstration comparison population?
- Primary research question 11.3: Did ED visits post-release decrease, relative to the pre-demonstration comparison population?

- Primary research question 11.4: Did the rate of deaths post-release decrease relative to the pre-demonstration population?
- Primary research question 11.5: Was the timing or provision of specific pre-release services associated with better post-release outcomes?

3. Independent Assessments

In addition to evaluating the hypotheses and research questions outlined in the previous section, several independent assessments will be conducted. The purpose and methods for each of these assessments are described here.

Wind-down of Current Eligibles

An assessment of the wind-down of the Current Eligibles (CE) demonstration population will be conducted. The original PCN Demonstration provided a limited package of preventive and primary care benefits (the PCN benefit) to adults ages 19-64 with household incomes up to 150 percent of the Federal Poverty Level (FPL) and a slightly reduced benefit package to Parent/Caretaker Relatives (PCR) who comprised the Current Eligibles population. With Medicaid expansion in April 2019, PCN program participants became eligible for full state plan benefits, and the PCN benefit was phased out. The Current Eligible population was phased out entirely on December 31, 2023, eliminating disparities in benefit packages by parental status.

The research question is: Was the wind-down process implemented efficiently and effectively? The assessment data sources are:

- Key Informant Interviews (KIIs) with 2-3 State agency staff
- MRT Demonstration Quarterly Monitoring Reports

High-level topics for the KIIs include operational challenges and successes, strategies implemented to overcome barriers, and overall lessons learned throughout the wind-down process.

Cost Assessments

A Demonstration cost assessment will be conducted. The IE will use the cost analyses in concert with findings from hypothesis tests to assess the demonstration's effects on the fiscal sustainability of the State's Medicaid program.

The IE will conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

For the HRSN Demonstration, the IE will conduct a cost analysis to support developing comprehensive and accurate cost estimates of providing such services.

Table 3: Description of Cost Assessments

Cost Assessment	Description
Medicaid Reform Demonstration	• Administrative costs, health service expenditures, uncompensated care • Exclude JIR costs, exclude HRSN costs
Justice-Involved Reentry	• Administrative costs, health service expenditures • Estimates of cost saved through reduced ED visits & hospital admissions

Health Related Social Needs	• Costs associated with potentially preventable high-acuity health care • Administrative costs, health service expenditures • Infrastructure investments

The cost assessments will rely on administrative data, the specific measures and data sources are provided in Table 4.

Table 4: Cost Assessment Measures & Data Sources

Measure	Data Source
Administrative Costs of the Demonstration • Report for JIR, HRSN, all other • Total and per beneficiary per month • PMPM growth rate	Form CMS-64
Medicaid Health Service Expenditures • Report for JIR, HRSN, all other • Total and per beneficiary per month • PMPM growth rate • Report by type of service, identify cost drivers, where possible	Form CMS-64, Medicaid claims data
Demonstration Costs: sum of administrative & services • Report for JIR, HRSN, all other • Total and per beneficiary per month • PMPM growth rate	Form CMS-64, Medicaid claims data
HRSN Infrastructure Costs	Form CMS-64, Annual Monitoring Reports
Provider Uncompensated Care Costs	CMS-HCRIS, NASHP HCT

C. Methodology

1. Evaluation Approach

The Independent Evaluator (IE) will use a mixed-methods evaluation approach that will combine administrative and survey data as well as qualitative data to address the goals and hypotheses presented in the Demonstration application and answer all research questions listed above.

The evaluation will employ multiple comparison strategies, both in-state and out-of-state. Interrupted Time Series (ITS) is the preferred approach to analyze the impact of the Demonstration by comparing trends during the pre-demonstration period to the Demonstration period. ITS will be the approach in all instances for which there is sufficient pre-demonstration data available. When pre-demonstration data is not available the evaluation will rely on descriptive statistics and trends over time To assess the impact of UMIC plans, regression analysis will compare members in three plan types – fee for service, physical health-only ACO, and UMIC.

Results will be stratified by demographic characteristics SMI/SUD status, and plan type, when sufficient numbers are available to permit comparisons. A summary of the characteristics of the Demonstration populations as of the end of the previous waiver period (June 30, 2022) is provided in Table 13 in the Subgroup Analyses section.

Comparisons to Medicaid beneficiaries in other states also provide valuable context. A difference-in-difference (DiD) comparison, and a synthetic control method (SCM), will be used to compare the impact of the Demonstration as a whole on the aggregate Medicaid population to Medicaid beneficiaries in other states. Out-of-state comparisons will address the research question "Did the Demonstration as a whole improve health care access and quality for the Medicaid beneficiary population?"

Member perspectives will be collected through a customized member survey, and through interviews of members receiving HRSS and pre-release and reentry services. Where a survey provides a broader and more representative sample, individual interviews allow for in-depth understanding of member experiences. Additional qualitative data will be collected through key informant interviews with stakeholders. Together, these complementary methods will enable a comprehensive evaluation of the Demonstration.

2. Target and Comparison Populations

As summarized in Table 1, the Demonstration provides coverage and services for multiple populations. Out-of-state comparison using national survey data and other publicly available data sources will be used for investigating the impact of the Demonstration as a whole on the full Medicaid eligible population. For specific populations, the comparison will be to pre-Demonstration trends. For UMIC plans, the comparison will be to other plan types without integrated BH services. The Demonstration populations (the target groups) and the approach to comparisons are shown below in Table 5.

Table 5: Demonstration Populations, Benefits, and Comparisons

Demonstration (target) Population	Program Implementation Start	Baseline Years	Comparison[1]	Analytic Approach
Substance Use Disorder (SUD) IMD	November 9, 2017	November 1, 2017 - June 30, 2022	Pre-SUD demonstration baseline	Trend over time, Interrupted Time Series
Targeted Adult Medicaid (TAM)	November 1, 2017	November 1, 2017 - June 30, 2022	Pre-demonstration baseline	Trend over time, Interrupted Time Series
Adult Expansion Population	April 1, 2019 (partial expansion, up to 100% of the FPL) January 1, 2020 full expansion	July 1, 2018-June 30, 2022	Pre-demonstration baseline	Trend over time, Interrupted Time Series
Utah Medicaid Integrated Care (UMIC- subset of the Adult Expansion Population)	January 1, 2020	N/A	Three plan types: FFS, ACO, UMIC	Multiple Linear Regression
Serious Mental Illness (SMI) IMD	December 1, 2020	December 1, 2020 - June 30, 2022	Pre-demonstration baseline	Trend over time, Interrupted Time Series
Expanded Dental Benefit	January 13, 2025	January 1 2020 – December 31, 2024	Pre-Dental demonstration baseline	Interrupted Time Series
Health-related Social Needs Services	July 1, 2025	July 1, 2020—June 30, 2025	Pre-HRSN demonstration baseline	Longitudinal cohort design with pre-HRSN demonstration baseline, if available
Justice-Involved Adults	February 1, 2026	February 1, 2022-January 31, 2026	Pre-demonstration comparison baseline	Trend over time, Interrupted Time Series

[1] The term "pre-demonstration baseline" refers to the time period before the start of the current Demonstration period; before July 1, 2022. The term "pre-demonstration comparison baseline" refers to individuals who were incarcerated in Utah county jails or state prisons whose Medicaid status was paused due to incarceration.

Justice-Involved Reentry Comparison Group

To analyze outcomes for the Justice-Involved Adults, the IE plans to construct a historical, pre-demonstration comparison group comprised of individuals who were incarcerated in Utah county jails or state prisons before the implementation of the Justice-Involved Reentry benefit. Utah DHHS will provide Medicaid claims data for the pre-demonstration comparison group through the standardized claims-data transfer process. Utah DHHS can identify individuals for this population who have a suspension status due to incarceration for their Medicaid eligibility, and were assigned the "incarcerated benefit" during their incarceration, but are unable to identify specific carceral facilities. The accurate identification of this group relies on the historical assignment of the "incarcerated benefit". All adults released from incarceration in Utah during the pre-demonstration baseline period, identified by a lift of Medicaid suspension status due to

incarceration, will be included in the comparison group. There are no other criteria for inclusion in the comparison group. The IE has established a data use agreement between the IE, Utah DHHS, and the Utah Office of Vital Records and Statistics (OVRS) to provide vital statistics data. Appropriate identifiers will be used, including name, date of birth, social security number, and a unique client identifier to link vital statistics data with Medicaid data for the pre-demonstration comparison group.

Several demonstration populations are too small to feasibly conduct a comparison to a baseline period. The analytic approaches for these demonstration populations are primarily trend over time and descriptive statistics.

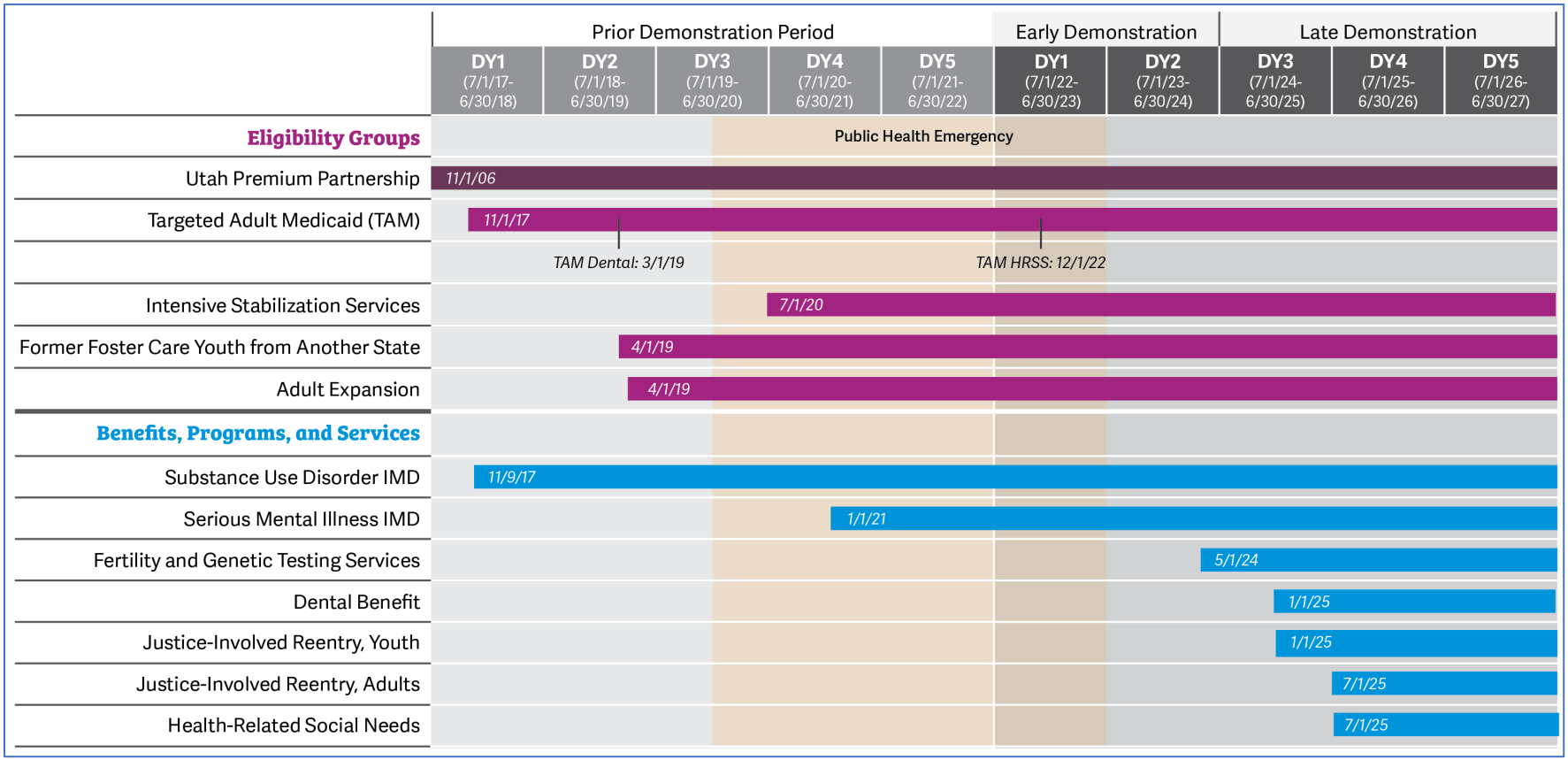
Table 6: Small Demonstration Populations

Demonstration (target) Population	Program Implementation Start	Analytic Approach
Utah Premium Partnership Program (UPP)	November 1, 2006	Trend over time, descriptive statistics
TAM Dental	March 1, 2019	Trend over time, descriptive statistics
Former Foster Care Youth from Another State (FFCYAS)	March 1, 2019	Counts (small population size)
Intensive Stabilizations Services (ISS)	July 1, 2020	Counts (small population size)
TAM members receiving Housing Related Services and Supports (HRSS)	December 1, 2022	Trend over time, descriptive statistics, qualitative interviews and analysis
Fertility and Genetic Testing Services	May 1, 2024	Counts (small population size)
Justice-Involved Youth	January 1, 2025	Counts (small population size)

3. Evaluation Period

This evaluation will cover the five-year Demonstration period from July 1, 2022, through June 30, 2027. The pre-Demonstration baseline will be the previous waiver period from July 1, 2017- June 30, 2022. The IE acknowledges that many policies authorized under this waiver are continuations of policies implemented in previous waiver periods. The goal of this evaluation is to quantify any gains realized in the current waiver period. As a result, the baseline period for each analysis will be specific to program start dates listed in Table 5. Please see Figure 2 below for more information. Sensitivity analysis will be conducted to determine whether excluding part of 2020 due to the Covid-19 PHE is appropriate.

Figure 2: Eligibility Groups and Services Timeline



*The planned implementation start date for the Justice-Involved Reentry benefit for adults has been extended from July 1, 2025 to February 1, 2026. This image will be updated when the JIR benefit for adults has launched.

4. Evaluation Measures

Evaluation hypotheses and corresponding measures are listed in Section F.4., Evaluation Tables.

5. Data Sources

The evaluation will use the following quantitative and qualitative data sources:

- National Surveys and Other Publicly Available Data Sources:
  - Behavioral Risk Factor Surveillance System (BRFSS)
  - National Survey of Drug Use and Health (NSDUH)
  - National Academy for State Health Policy's (NASHP) Hospital Cost Tool (HCT)
- Utah Specific Data Sources:
  - Medicaid Administrative Data
    - Eligibility & enrollment
    - Claims
    - Cost (Form CMS-64)
  - Carceral Facility Administrative Data
  - Justice-Involved Correctional Facility Readiness Assessment
  - Vital Statistics
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey
  - Custom member survey
  - Participant interviews with TAM members receiving HRSS, JIR beneficiaries, and HRSN service recipients
  - Key Informant Interviews (KIIs)

National Surveys and Other Publicly Available Data Sources

Measures employing national survey data and other publicly available data sources for an out-of-state comparison will use a three-year pre-Demonstration baseline.

<u>BRFSS</u>

The BRFSS is a large, high-quality federal survey that may be used to measure outcomes of interest for out-of-state comparison groups. Importantly, the BRFSS contains respondents' state identifiers and demographic variables needed for comparison purposes. The IE will use the BRFSS data to address research questions related to coverage and access to care among low-income residents (Table 8).

The BRFSS insurance coverage question outcome does not allow determination of the source of coverage (e.g., Medicaid, Medicare, or private insurance) for years prior to 2022. In order to approximate which respondents are Medicaid eligible and who fall below 138 percent of the FPL, a continuous value for household income will be imputed using the midpoint of BRFSS income category. Using imputed income with household size allows the ability to link to annual thresholds for 138 percent FPL in each state. This method will be employed for the years prior to 2022 only.

The IE has also conducted power analysis for using the BRFSS. Our analyses will have high statistical power due to the large sample sizes involved. We estimated the minimum detectable effect sizes for each of our outcomes using Hu & Hoover's (2018) power equation for non-randomized longitudinal difference-in-difference studies:

$$MDES = \frac{T(1-\rho)\sigma}{bkn} \times \left(z_{1-\frac{\alpha}{2}} + z_{1-\beta}\right)^2$$

Where:

MDES = the minimum detectable effect size, defined as a percentage point change in outcome
T = the total number of time periods
b = the number of pre-intervention periods
k = the number of post-intervention periods
n = sample size
σ = standard deviation
ρ = serial correlation
$z_{1-\frac{\alpha}{2}}$ = The critical z-value for statistical significance
$z_{1-\beta}$ = desired statistical power

The final analysis will include 5 pre-intervention years and three post-intervention years. We used BRFSS data to identify serial correlations, standard deviations, and sample sizes for each study outcome. Serial correlation is the relationship between state-level means in consecutive years. We then calculated minimum detectable effect sizes (MDES) at 80% power and α=0.05. The MDES ranges from 0.41% to 0.58% for our access outcomes. For preventive service outcomes, the MDES ranges from 0.54% (receipt of annual checkup) to 2.29% (receipt of HPV test in the past 12 months). The sexual and reproductive health questions are only asked of female respondents in even years, which limits our ability to detect smaller effects.

Table 7: Minimum Detectable Effect Sizes

Outcome	Serial correlation	Standard deviation	Sample size	MDES
Insurance Coverage	0.891	0.478	116,482	0.41
Having a personal doctor	0.840	0.488	116,893	0.48
Avoided care due to cost	0.796	0.460	117,000	0.58
Receipt of annual checkup	0.809	0.482	115,376	0.54
Receipt of mammogram in past 12 months	0.758	0.430	26,814	1.41

Notes: SD = Standard deviation. MDES = Minimum detectable effect size (percentage point change) at 80% for a difference-in-differences analysis with α=0.05.

NSDUH

To investigate the SUD and SMI waiver impact, the IE will use the NSDUH public use dataset. NSDUH collects data annually on incidence and treatment of mental health and substance use conditions. Key NSDUH questions address whether individuals have experienced BH conditions, and whether they have received treatment. The NSDUH public use dataset does not contain enough information to conduct a power analysis.

NASHP HCT

To investigate the Demonstration's impact on uncompensated care costs, the IIE will use the NASHP HCT. The HCT provides a range of measures for hospital revenue, costs, profitability, and break-even points across over 4,600 hospitals nationwide. The underlying dataset includes variables extracted and calculated from the national Healthcare Cost Report Information System (HCRIS).

Table 8: National Surveys and Other Publicly Available Data

Survey	Topic	Survey Questions
BRFSS	Health Risk Factors	• Insurance Coverage • Having a personal doctor • Avoided care due to cost • Receipt of annual checkup • Receipt of mammogram in past 12 months
NSDUH	BH Needs and Services	• Received treatment for SUD in the last 12 months • Received treatment for mental health condition in the last 12 months • Needed, but did not receive, treatment for BH condition
NASHP Hospital Cost Tool	Uncompensated Care Cost	• Uncompensated care/bad debt as a percentage of net patient revenue, and as a percentage of operating expenditures

Medicaid Administrative Data

The IE anticipates receiving claims and other Medicaid administrative data, such as eligibility files, from the state on an annual basis. Administrative data is expected to be of high quality, in terms of completeness and accuracy.

The IE anticipates having access to aggregate CAHPS data collected by the health plans and reported to DHHS. Health plans are able to distinguish between ACO and UMIC plan enrollment in CAHPS data and report this information to the state. This data will allow for comparisons of plan types.

CAHPS data will also be used to analyze differences in access to care coordination and patient satisfaction between subgroups. Because CAHPS data will be available only in aggregate, subgroup analysis will be limited to the available demographic stratifications: age, race (White and Other), ethnicity (Hispanic/ Not Hispanic), and gender.

Correctional Facility Readiness Assessment and Carceral Facility Administrative Data

The state developed a Correctional Facility Readiness Assessment tool that is administered to each participating carceral facility prior to their implementation of the JIR benefit. The Readiness Assessment is a 37 item REDCap survey completed by an appropriate representative of each carceral facility. It captures information about facilities' existing operations and procedures (including screening for Medicaid enrollment, use of data sharing agreements, use of case management services, and provision of specific health services covered under the JIR benefit) and their plans for standing up the needed systems to support the JIR benefit.

The IE anticipates utilizing the results of the Correctional Facility Readiness Assessment to assess the pre-release services and operational capabilities of participating facilities prior to implementation of the Demonstration. This is important context for understanding the successes and challenges of Demonstration implementation.

Carceral facility administrative data refers to data elements that are pertinent to the evaluation of the Demonstration that are not captured in Medicaid administrative data. These data elements will be collected by the carceral facilities, and will be included in a Data Use Agreement developed between the carceral facilities, DHHS, and the IE. These data elements include information on date of incarceration, Medicaid eligibility screening and application support, care planning, 30 day supply of Rx Medication upon release, and provision of health or social service referrals pre-release.

The JIR evaluation design is being prepared in parallel with the JIR implementation planning process, which includes establishing an electronic interface between carceral facilities and Medicaid systems to enable more "real-time" eligibility and enrollment data to be exchanged. In addition, Medicaid is working closely with the participating carceral facilities to establish data collection tools, processes, and workflows. The data needs for the evaluation were shared with the implementation team.

Custom member survey

The member survey will be administered once during the Demonstration period to a sample of approximately 6,000 adult Medicaid members who received a mental health diagnosis or service in the past 6 months. The mental health selection criteria is needed because a section of the survey is about access to mental health care. Examples of survey topics are summarized below in Table 9.

Table 9: Member Survey Topics

Focus Area	Example topics
Access to Care	• Able to obtain care in a timely manner • Ease of obtaining BH services • Barriers to accessing care
Patient-centered care	• Satisfaction with amount of time doctor spent • Doctor explains in a way you can understand
Coordination of care	• Primary care doctor has information needed about specialty care received

Survey Design

The IE will design the survey to assess the impact of the Demonstration on members' access to and engagement in health care. The survey will cover key topic areas related to members' recent history of health care coverage, access to health care (whether they have a primary care provider, if they have seen a specialist when needed, the regularity with which they obtain preventive care, etc.), and experience with care coordination. Being mindful of respondent burden, the IE aims for the survey length to not exceed 12 minutes when administered by phone.

Sample Frame Development and Sampling

The IE will work with DHHS to obtain the necessary member data, from which the IE will select a sample of members to survey. The sample will be comprised of 4,000 members. Assuming an approximately 35% response rate, we expect n=1,400 completed surveys (expected confidence interval of +/-2.54 at the 95% confidence level). To ensure that the sample accurately reflects the member population, the IE will conduct implicit random sampling using the appropriate variables available in the Pathways member database, such as gender, age, race/ethnicity, income, and length of enrollment in the program.

Assuming equal propensity for non-response between subgroups, we expect that this sample size will allow for reliable estimates for some subgroups of interest within a margin of error of +/- 5 percentage points, including by age group (individuals aged 19-26 years, aged 27-44 years, and aged 45-64 years), sex, and some racial and ethnic groups (Asian, White, Hispanic, Black, American Indian/Alaska Native and individuals of multiple races).

The ability to detect a significant difference between two groups is in part dependent on the measured prevalence of an outcome, and it will vary for each variable captured in the survey. Generally, if the prevalence of an outcome is around 50% in one group, this study is powered to detect a difference of 6.7 to 15.7 percentage points between respondents of different age groups, genders and racial and ethnic groups, with probability (power) of 80% at the 95% confidence level. If the prevalence of an outcome is

very rare or very common (e.g., prevalence of 5% or 95%), this study is powered to detect smaller differences of 2.5 to 9.4 percentage points.

Survey Preparation

To maximize response rates, the IE will prepare the survey for three modes of data collection – mail, online (via smartphone/tablet device/PC), and phone. Each version will be thoroughly tested for quality control. The survey will also be translated into Spanish for interviewing respondents whose preferred language may be Spanish. Additional languages may be added if a need is identified.

Survey Administration

The IE will send the survey by mail to all members in the selected sample together with a cover letter (which will include an online link to the survey), and postage paid business reply envelope. For beneficiaries for whom email addresses are available, we will also send an email invitation with a link to the survey, followed by weekly reminder emails. After 21 days from the mailing, the IE will begin phone follow-up to non-respondents to administer the survey over the phone. To maximize response rates, the IE will make up to five phone attempts to each non-respondent at different times of day and during different days of the week including weekdays and weekends.

Data Analysis and Reporting

The IE will apply weights to the survey data to ensure that the weighted distribution of survey respondents accurately reflects the distribution of the member population on key population metrics, including gender, age, race/ethnicity, income, and length of enrollment in the program. Analysis of the survey data will focus on understanding members' access to health care, availability of employer-sponsored health insurance, and plans to transition to commercial health insurance. The IE will include analysis by key subgroups of interest, such as gender, age, and race/ethnicity.

Participant interviews with members receiving HRSS and/or pre-release and reentry services

Participant interviews will provide a necessary understanding of the experience of members receiving HRSS as well as pre-release and reentry services, including facilitators and barriers impacting the key outcome measures. The IE anticipates that the HRSS and JI populations will overlap, and interviews will be tailored to the experience and services received by members. The IE will conduct phone interviews to directly capture the input of participants, with privacy protections in accordance with CMS guidelines. Two waves of interviews will be conducted, with approximately 75-80 individuals in each wave (based on projected enrollment of approximately 56000 individuals) or until thematic saturation is reached for each subgroup. For this component of the evaluation, the IE is partnering with Dr. Palmira Santos, a doctoral-level social worker and researcher with expertise in interviewing individuals experiencing housing insecurity, BH conditions, and justice-involvement. Dr. Santos will lead the development of the interview guides, conduct interviews, and analyze results.

Potential interviewees will be invited to participate by their case managers, who will explain that the purpose of the evaluation is to improve the program and ask for permission to release their phone number. If an individual chooses to participate, the interviewer will receive only a first name (or chosen alias) and phone number for each participant. When a participant is reached by phone the interviewer will explain the evaluation and seek informed consent before beginning the interview.

Interviewees will be given a gift card as a thank-you, in a small amount for a store that does not sell alcohol or cigarettes.

Table 10: Participant Interview Topics

Interview Question	Example topics
How do participants' interaction with care managers happen? In what ways is it helpful, or not helpful?	Outreach approach, engagement, and follow through. Understanding of participant needs and perspective – whether care manager took steps to assist or explained limitations of service
What role did the HRSS case manager have in participants' housing situation?	Addressing specific patient needs, timeliness, role of other housing liaisons
What factors enhance or inhibit participants' engagement in behavioral health care?	Factors (barriers/facilitators) to access, coordination, continuity, and outcome
Are participants experiencing unmet needs for health care, including SUD and SMI treatment?	Participation in behavioral and physical health services and support. Use of the ED and hospitalizations (avoidable and/or BH related) – perspective on alternatives. Participation in preventive, acute and chronic condition services
Do participants perceive their life circumstances have changed since receiving HRSS services?	Previous and current life (SDOH, family, work etc.) situation
Did participants receive services in the pre-release period that met their needs? Was there enough time to get the screening and services you needed prior to release? And did such services result in stable physical and behavioral health upon release?	Access to and quality of pre-release services (case management, behavioral health care, diagnostic services, family planning services). Perceptions of stigma associated with care.
Were participants' post-release transitions to care needs adequately met by the pre-release services?	Access to care and medications, continuity of coverage, care, medication, and providers.

NOTE: Participants interviewed include TAM members receiving HRSS, JIR beneficiaries, and HRSN service recipients

Key Informant Interviews

Qualitative data on program implementation will be gathered through key informant interviews (KIIs) with providers and state administrators. A total of 30-35 -30 KIIs are planned; three at each of the four health plans, five state employees participating in implementation, at least three community-based providers, case managers supporting HRSS and JIR, and carceral-setting administrators.

In addition to the administrative contacts from the ACOs and MCOs, the IE will interview at least three community-based providers, such as primary care providers and behavioral health clinicians, who directly serve Medicaid patients at sites such as community health centers, in order to capture the perspective of front-line clinicians working through the UMIC Demonstration. These providers will be asked about topics including integration of behavioral health care, barriers to access, and their perceptions of patients' engagement in care.

Because HRSS and JIR are new components of the Demonstration, interviews with case managers will provide essential insights into the challenges and successes during implementation. Case managers will be asked about topics including their observations regarding communication with members and providers, ways in which HRSS and JIR services are effective or not, and promising practices in care coordination for a population with housing instability and/or justice-involvement.

Semi-structured key informant interviews lasting 30-45 minutes per contact will be conducted by phone or

videoconference, with privacy protections in accordance with CMS guidelines. Interviews will be recorded and transcribed. The IE will develop Interview guides in collaboration with DHHS for providers, health plans, and for state administrators involved in implementation of the Demonstration. The interview guide and questions will be tailored to the interviewee role. For example, state administrators will be invited to discuss the program rollout and feedback received from plans, health plan representatives will be asked about the plan's approach to integrating BH services, and questions regarding telehealth experiences will be directed towards clinicians.

As appropriate, interviews will explore successes and challenges with regard to program implementation, and other topics drawn from the logic model; examples are shown in Table7..[19] Interview guides will include questions that address disparities and health equity as appropriate for the interviewee's role. This may include population health analysis strategies, language services, and targeted outreach programs.

Table 11: Topics for Key Informant Interviews

Interview Question	Example topics
Was the Demonstration implemented effectively? Could the pre-release services provided under the JIR benefit have been effectively implemented in a shorter time period? Why or why not?	● Perceived successes and challenges in implementation ○ Care integration with behavioral health ● Perceived steps towards integrating behavioral health with physical health services, e.g., screening and referrals ● Perceptions about the role of telehealth in achieving Demonstration goals
Was cross-system coordination effective?	● Experiences with communication and data sharing between the carceral settings, Medicaid, and community-based services/healthcare
To what extent are BH services integrated with physical health services?	● Screening and referrals ● Care coordination for members with BH conditions ● Sharing of patient data across practices ● Access to MAT pre-release and post-release
Did enrollment or outcomes differ by demographic factors?	● Perceptions of barriers to access and participation in care ● Steps health plans/providers are taking to identify, understand, and address disparities in access and engagement
Was continuity of coverage and care improved by the Demonstration?	● Medicaid enrollment or redetermination navigation support for justice-involved population ● Access to care pre-release in the carceral setting

6. Analytic Methods

Quantitative Analyses

The evaluation design includes multiple analytic strategies to answer the research questions and provide robust conclusions. The proposed approach is to use quasi-experimental analyses, employing descriptive statistics, trends over time, interrupted time-series analysis (ITS), regression, difference-in-differences

[19] KIIs will cover topics relevant to the evaluation of the Adult Expansion and ESI components of the Demonstration as well; these are covered in separate evaluation designs.

(DiD), and synthetic control methods (SCM) Quasi-experimental analyses will be conducted where data is available. Multivariate regression will be used to model outcomes over time, following individuals longitudinally. This approach allows for the trend over time to be adjusted for changes in the Demonstration populations as members enter and leave the Populations. For example, for Hypotheses 4, 5, and 6, interrupted time series will be used where data is available over the time period of interest.

For smaller Demonstration populations and small subgroups where regression analysis is not feasible, the evaluation will focus on trends over time. For example, Hypothesis 6 focuses on the smaller demonstration populations; most research questions for this hypothesis will be addressed with descriptive statistics, such as service counts and cost over time.

The specific analytic method for each research question is provided in section F.4 Evaluation Tables.

Table 12: Summary of Analytic Tactics to be Used for Evaluation

Method	Comparison	Data sources
Subgroup comparison	Demonstration participants stratified by demographic and health factors	Encounter data, Administrative data
Event study/ time series	Trend during Demonstration vs baseline	Encounter data, Administrative data
Difference in difference; Synthetic Control Methods	Pre/Post change in Utah vs Pre/Post change in other states; predicted outcomes for 'synthetic UT'	National surveys and other public data sources

Descriptive statistics

The evaluation will provide summary tables of population size and characteristics, and outcomes for the three groups of Demonstration participants. Data will be analyzed using standard tests as rates, proportions, frequencies, and measures of central tendency (e.g., mean, median, mode). These tables will be used to develop a quantitative picture of the population, to describe raw trends, and to identify characteristics that will be included as covariates in regression modeling.

Prior to performing regression analysis of the plan types within AE, the composition of the beneficiary population in the three groups (FFS, ACO, and UMIC) will be compared to identify differences in demographic or clinical characteristics. ANOVA/MANOVA tests will be used as a first pass comparison of mean outcomes for the three groups. For metrics derived from BRFSS survey data, results for Utah will be compared to national averages for each year.

Trend over time and linear regression modeling

Outcomes of interest will be plotted over time for the duration of the Demonstration. The trend for each evaluation group will be modeled using multivariate linear regression and compared. The null hypothesis will be that the groups have identical trends. In order to account for demographic characteristics such as age and gender that may differ among groups, the IE will use inverse probability of treatment weighting. Individuals in intervention groups will be assigned weights based on the composition of the reference group, producing groups that are equivalent for measurable characteristics and allowing any difference in outcomes to be attributed to the intervention.[20]

For the measures with binary outcomes the models will be logistic; Poisson models will be used for count-based outcomes. The mixed effects logistic regression model accommodates for both fixed and random effects. In this case, it allows for the fact that members can appear multiple times in the datasets and that they can appear different numbers of times resulting in unbalanced data. The models will include the 'client id' variable as a random effect. The outcome variable will be the binary or count outcome. To assess changes over time for each population, a fixed effect for measurement year and population will be included in addition to an interaction term between them. Measurement year will be included as a continuous variable

[20] Austin PC, Stuart EA. Moving towards best practice when using inverse probability of treatment weighting (IPTW) using the propensity score to estimate causal treatment effects in observational studies. Stat Med. 2015; 34(28):3661–79. Epub 2015/08/05. https://doi.org/10.1002/sim.6607 PMID: 26238958; PubMed Central PMCID: PMC4626409.

after plotting raw trends to assess linearity. Adjusted models will include the covariates gender, race/ethnicity, age as a continuous variable, region, and SMI/SUD diagnosis group, as appropriate. Additional covariates will be considered for analyses specific to the JIR benefit, such as facility type. The post-release address of the JIR beneficiary may impact access to care outcomes and will be considered as a covariate. When adjustment variables besides age, gender and race are not statistically significantly associated ($p < 0.05$) the IE will proceed with a stepwise selection to reduce the number of covariates in the model. The IE will also run stratified mixed models by gender, age group and race/ethnicity with the same adjustment procedures, if subgroup size is adequate. Models are described in the following formulas.

Mixed logistic regression model

$$logit(Y = 1_{ij}) = \beta_0 + \beta_1 Pop_i + \beta_2 MY_{ij} + \beta_3 MY_{ij} * Pop_i + \beta_x X_i + \gamma_{0i}$$

Mixed Poisson regression model

$$log\ log\ (Y)_{ij} = \beta_0 + \beta_1 Pop_i + \beta_2 MY_{ij} + \beta_3 MY_{ij} * Pop_i + \beta_x X_i + \gamma_{0i} + ln\ (offset)$$

Where Y corresponds to outcome of interest with a different expression depending on its distribution, β_0 to the overall intercept of the model, $\beta_1 Pop_i$ to the effect of belonging to a certain population group compared to a reference group, $\beta_2 MY_{ij}$ to the effect of measurement year as a continuous variable, $\beta_3 MY_{ij} * Pop_i$ is the interaction effect between population and measurement year which allows us to estimate change over time between populations, $\beta_x X_i$ corresponds to individual level adjustment covariates, and γ_{0i} corresponds to the random intercept of each client to account for the clustering effect of appearing in more than one measurement year. In the case of Poisson models, the model includes an offset, for EDU corresponding the total number of clients and for IPU to the total member-months.

Difference-in-difference

To examine the impact of the demonstration on its overarching aim of improved access, PCG will conduct a difference-in-difference (DiD) analysis to model the effect of the demonstration in Utah relative to comparison states. The comparison states are those states not exposed to the treatment of interest – in this case, all other states that either (1) have not expanded Medicaid, or (2) expanded Medicaid before the pre-intervention period (July 1st 2017 – June 30th 2022) The parallel trends assumption will be tested over the five years before the demonstration period. Sensitivity analysis will be conducted to determine whether the PHE influences the baseline or the parallel trends assumption.

The DiD model equation is:

$$Y_{its} = \alpha_s + \beta_t + \beta_2 Expansion_s + \beta_3 Post_t + \beta_4 Intervention_s \times Post_t + \delta X_{it} + \varepsilon_{ist}$$

Where:

Y_{its} = Our outcome(s) of interest

α_s = A vector of state fixed effects

β_t = A vector month and year fixed effects

$Intervention_s$ = A binary indicator for residence in our treated state (Utah)

$Post_t$ = A binary indicator for whether the outcome occurred during the demonstration period

δX_{it} = A vector of observed individual-level characteristics

Covariates will include respondent age, education, employment status, household size, veteran status, sex, household income, homeownership status, presence of children in the household, survey month, and whether the survey was conducted via landline or cell phone. The regression coefficient β_4 thus represents our regression-adjusted estimates of changes in outcomes associated with Utah's Medicaid expansion, after controlling for state, month, year, and observed covariates.

Synthetic control method

In addition to the DiD approach, the IE will use synthetic control methods (SCM) to estimate the association between implementation of the Demonstration and study outcomes. SCM have been employed to evaluate state-level policy impacts because they are particularly useful when estimating the impact of a policy change that affects a small number of treatment groups (i.e., a state).[21, 22, 23, 24] These methods are a quasi-experimental approach similar to traditional difference-in-difference (DID) estimation but require fewer assumptions to obtain estimates of association. DID assumes that any differential changes in outcomes between treated and control groups are attributable to the policy change. Yet treated and control groups are often nonequivalent in terms of pre-treatment outcome levels, trends in outcomes, and other important covariates. To mitigate this limitation, researchers typically attempt to control for observed variables that may be associated with both treatment likelihood and the outcome of interest. However, treatment and control groups may still differ in terms of outcome pre-trends and levels due to unobserved factors. This introduces potential selection issues, which may bias any estimates of association.

In contrast, SCM constructs a synthetic control. The synthetic control is constructed using a weighted average of the states included, with weights determined through a fully empirical process; weights for individual control units may range from 0 to 1 and are assigned so the synthetic control is as similar as possible to the treated group in terms of outcome pre-trends. Unlike traditional regression, inclusion of covariates is not required to achieve equivalence between treated and control groups.

Public Health Emergency; Sensitivity Analysis

The pre-Demonstration baseline period to be used for all quasi-experimental methods includes the period where the Covid-19 pandemic had a profound impact on health care utilization. First, trends for UT and controls will be modeled with and without the most affected months in 2020 and 2021. This sensitivity analysis will help to identify whether the groups have been impacted differentially. If the pattern changes observed in the first quarter of the Public Health Emergency are similar for all evaluation groups, then confounding of the results by pandemic impacts is less likely. The most affected quarters may be omitted from the baseline depending on the results.

Subgroup Analyses

The evaluation will seek to understand how different subgroups of participants are impacted by the Demonstration. Analyses will partition participants by gender, race/ethnicity, age, and SMI/ SUD diagnosis status. Where possible, race will include White, Black, Asian, Latinx, and Native American populations and Ethnicity will be characterized as Hispanic/Not Hispanic. Due to the low prevalence of some subgroups, it may be necessary to combine racial and ethnic groups for purposes of stratification. As seen in Table 13below, 45% of race/ethnicity data gathered during the previous waiver period was missing. It is unlikely the evaluation will be able to identify racial/ethnic disparities in outcomes due to the high amount of missing data unless there is substantial improvement in the availability of this data. While data on region is available (urban, rural, frontier), the state does not plan to conduct subgroup analyses by geographic location because

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[21] Abadie, A., 2012. *Synthetic control methods for comparative case studies: estimating the effect of California's tobacco control program. J Am Stat Assoc* 105(490):493-505. https://www.tandfonline.com/doi/abs/10.1198/jasa.2009.ap08746

[22] Rudolph, K.E., *et al.*, 2015. *Association between Connecticut's Permit-ti-Purchase handgun law and homicides. Am J Public Health* 105(8):e49-e54. https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2015.302703

[23] Santella-Tenorio, J. *et al*., 2020. *Association of recreational cannabis laws in Colorado and Washington state with changes in traffic fatalities. JAMA* 180 (8):1061-1068. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2767647

[24] Bhatt, A. *et al.* 2020. *Association of changes in Missouri firearm laws with adolescent and young adult suicides by firearms. JAMA Netw Open* 3(11). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772526

the geography variable is confounded with Plan Type. Specifically, Adult Expansion members in 5 counties *must* enroll in the UMIC plans with integrated physical and behavioral health benefits. In 8 other counties, Adult Expansion *must* enroll in an ACO and a Prepaid Mental Health Plan. In the remaining counties of the state, members may enroll in an ACO or stay with FFS.

Analyses of the JIR benefit will be stratified by adult versus juvenile facility and by facility type (prison vs jail), as feasible. In Utah, there are 26 jails, two prisons, and nine juvenile detention centers. The IE's ability to stratify analyses by facility type will depend on facility-level participation in implementing the JIR benefit during the course of the demonstration period. Analyses will also be stratified by beneficiary demographic characteristics such as gender, age, SMI/SUD diagnosis, and length of incarceration as feasible.

Table 13: Previous Waiver Demonstration Period; Population Characteristics

Demographic / Health Characteristic		Adult Expansion (N= 92,026)	Targeted Adult Medicaid (N=9,582)
Gender	Male	44,703 (48.6%)	7,223 (75.4%)
	Female	47,323 (51.4%)	2,359 (24.6%)
Age	19-44	62,781 (68.2%)	6,948 (72.5%)
	45-54	15,821 (17.2%)	1,791 (18.7%)
	55-64	13,424 (14.6%)	843 (8.8%)
Race/ethnicity	Other/Missing	41,772 (45.4%)	3,840 (40.1%)
	White (non-Hispanic)	14,963 (16.3%)	1,634 (17.1%)
	Hispanic, Black, AIAN, Pacific Islander	35,291 (38.3%)	4,108 (42.9%)
SMI/SUD Diagnosis	None	66,539 (72.3%)	1,781 (18.6%)
	SMI Only	3,155 (3.4%)	171 (1.8%)
	SUD Only	16,658 (18.1%)	5,652 (59.0%)
	Both SMI/SUD	5,674 (6.2%)	1,978 (20.6%)

NOTE: The characteristics shown above represent every person ever enrolled during the previous waiver demonstration period (7/1/2017--6/30/2022), as of their last appearance in the claims data.

Cost Analyses for SUD and SMI Demonstrations

The analytic methods for the SUD Demonstration cost analysis are detailed below. *The same approach will be taken for the SMI Demonstration.* The only difference is the target group and the dates of the pre-demonstration baseline periods (outlined in Table 5).

SUD demonstration target group beneficiaries will be identified based on claims and encounters with an SUD diagnosis and/or procedure code. Pharmacy claims and encounters with a dispensed drug for Medication Assisted Treatment (MAT) will also be used to identify the population of interest. Once a beneficiary has been identified, they will remain in the population of interest until 11 months pass without another qualifying SUD claim or encounter.

There will be three levels of cost analyses:

I. Total Cost of Care = Total Medicaid Costs (claims and managed care capitation payments) + federal costs (Total Medicaid Costs * the Utah specific Federal Financial Participation rate)

II. Costs related to the diagnosis and treatment of SUD = SUD-IMD costs + other SUD costs + non-SUD costs

III. Source of care cost drivers = inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care

The Total Cost of Care will not include administrative costs, as the State does not currently track administrative costs specific to these demonstrations. Given the large number of waivers and amendments in Utah, it is not possible to estimate administrative costs separately.

Within each of the three levels, the results will be stratified by: SUD diagnosis only; SMI/SUD dual diagnosis. Given the lack of a comparison group, an interrupted time series model will be used to estimate the linear effects of the SUD demonstration. The IE will conduct both a logit model for estimating zero-cost months and a generalized linear model [GLM] for estimating non-zero cost months. The GLM model will use log costs to account for costs that are not normally distributed.

Qualitative analysis

Qualitative analysis will be used for participant and key informant interview transcripts. The research questions to be addressed, with corresponding example topics, are listed in Tables 18, 22, 23, 24, and 25 (Attachment 4). Interviews will address these questions by probing for perspectives from providers and from administrators involved in implementing the Demonstration. Thematic analysis using a coding tree derived from the Demonstration logic model will be used to excerpt transcripts. Additional themes that arise during coding will be added to the analysis. Results of provider interviews will be used to add context to the quantitative findings regarding experience of care, beneficiary engagement, and barriers to engagement. Results of provider and administrator interviews will address implementation and will inform the Evaluation Report chapter on Lessons Learned and Recommendations.

D. Methodological Limitations

1. **Lack of a true comparison group.** The Demonstration is implemented statewide, making a perfect comparison group impossible. To mitigate this limitation, the IE plans to use both in-state comparison among benefit groups, and out-of-state comparisons using national survey data sources. The JIR amendment to the Demonstration specifically also lacks a true comparison group as the state is unable to collect data from carceral settings who have not yet implemented the pre-release and reentry services. While the IE considered the use of leveraging the phased implementation of the JIR benefit by facility to create a comparison group and allow for a more rigorous analysis, data collection from non-participating facilities is not feasible due to limitations in data collection and data sharing infrastructure and processes at this time. To address this limitation, the IE plans to use a historical pre-demonstration comparison group, comprised of individuals who were incarcerated and released from state carceral facilities during the two years prior to the demonstration.

2. **Lack of pre-demonstration data on health care service provision in carceral settings.** Interrupted time-series is the preferred statistical method for analyzing the impact of the JIR demonstration by comparing pre-demonstration trends to post-intervention trends. The lack of pre-demonstration data on health care service provision in carceral settings prohibits using ITS to determine the impact of JIR on access to healthcare services pre-release.

3. **Sample size.** Population sample sizes may not support quasi-experimental analyses or stratification. Full UMIC participation is projected to be around 60,000 individuals. The data set for specific outcomes may not have sufficient size statistical analysis on all subgroups of interest. The IE will explore disparities in outcomes by race/ethnicity within the groups where numbers are sufficient. To further investigate health equity, KII interview guides will include questions about health plan efforts to identify and remediate disparities in access, such as population health analyses and targeted outreach. TAM and other populations are smaller. For the smallest populations, regression analysis is unlikely to be feasible, so descriptive and trend over time analyses will be used and stratification will be limited. For the ISS FFCYAS, and youth JI populations, the number of individuals may be too small to support significance testing, in which case descriptive results will be provided.

4. **Health Plan Reporting.** The independent evaluator will receive aggregate CAHPS data reported in aggregate by the health plans, stratified by gender, age, and race/ethnicity. Patient-level data is not available for privacy reasons. Data aggregation will limit the available subgroup analyses that can be performed. The current age and race/ethnicity reporting buckets for CAHPS data are limited and are not standardized across health plans. In order to aggregate data across the population, the IE will combine categories as needed, creating wider age bands, and characterizing race as White/Other.

5. **Lack of data on source of insurance coverage in national survey data.** The use of national survey data allows for out of state comparison groups but limits the ability to specifically identify individuals enrolled in the Demonstration. As noted in Section C.5, prior to 2022 the BRFSS insurance coverage outcome did not allow determination of the source of coverage (e.g., Medicaid, Medicare, or private insurance) As a result, it was not possible to identify individuals enrolled in Medicaid and thus not possible to determine if respondents fell into the Demonstration group or were enrolled in Medicaid in comparison states. While an approximation will be achieved by using income and household size to define a sample representing Demonstration participants as closely as possible, the inclusion of respondents who may not be part of the Demonstration group or be Medicaid enrolled in comparison

states is expected to attenuate the effect estimates during the pre-demonstration period. While differences in BRFSS responses between Utah and the comparison states are of interest, the evaluation's results should be interpreted as associations and may not necessarily be directly attributed to the Demonstration.

6. **Historic effects.** The impacts of the Covid-19 pandemic/PHE were profound in 2020 and 2021 and are likely to continue to influence health care delivery well into the current Demonstration period. Analytic techniques described above will be used to minimize confounding by PHE effects during the baseline period. The PHE unwinding will take place during the Demonstration period, with eligibility redeterminations beginning in April 2023, and may lead to unusual levels of disenrollment and enrollment category changes. Ongoing direct and indirect impacts of the PHE such as staffing shortages will be considered in interpreting findings.

7. **Data availability for national surveys, publicly available data sources, and carceral setting data.** The evaluation design includes national surveys and other publicly available data sources for some research questions that involve comparisons between states and over time. The design plan is contingent on the continued administration of these surveys, data release schedules, the elements included in public use files, the timing and process for accessing restricted data, and the comparability of the surveys to previous years. The NASHP HCT utilizes cost reports submitted by hospitals; as such, hospital reporting errors may be introduced. Should barriers be encountered, the IE will explore other options. Additionally, the JIR amendment introduces data from the carceral setting (prisons, jails, and youth correctional facilities). The IE anticipates that there may be early availability or quality challenges with this new data source, as carceral facilities become familiarized with Medicaid billing and claims systems.

8. **Implementation dates and data sources for amendments newly approved during the Demonstration period.** The evaluation design includes evaluation plans for amendments newly approved during the Demonstration period (JIR and HRSN) that have not been implemented at the time of writing this evaluation design document. The evaluation of these amendments relies on administrative data sources that are currently being designed or built. The IE works closely with the state to align on data sources and availability. In addition, the JIR and HRSN implementations may take place too late in the Demonstration to generate sufficient claims data for claims-based measures, or for year-over-year comparisons to be feasible.

F. Attachments

1. Independent Evaluator

As required by the Centers for Medicare & Medicaid Services (CMS) and the Section 1115 Demonstration's Special Terms and Conditions (STCs), DHHS conducted an open solicitation process to secure a third-party evaluator to conduct an evaluation of the State of Utah's Section 1115 Demonstration.
The State issued one contract for all evaluation activities and the production of required CMS reports.[25] As the successful bidder, Public Consulting Group (PCG) demonstrated the following qualifications:

- Experience conducting program evaluations for programs administered by the federal department of Health and Human Services.
- Ability to provide at least two examples of program evaluations conducted meeting the above criterion.
- Experience with Medicaid claims data.
- Experience complying with human subjects' protection and data confidentiality laws (state and federal)
- Experience with quantitative and qualitative evaluation design, implementation, analysis, and reporting, and impact evaluations in public health and social services settings.

Consistent with the requirements of the State of Utah Division of Purchasing, DHHS selected and retained PCG as an independent evaluator to complete the independent evaluation of the Demonstration. DHHS contracted with the evaluator, PCG, to promote an independent evaluation, following the general requirements for each state contractor as well as project-specific standards.
The third-party evaluator, PCG, will conduct an evaluation following guidelines set forth by DHHS and CMS. The Department retains responsibility for monitoring the Demonstration activities and providing oversight of the evaluation design and overall approach for the contractor. To ensure a fair and impartial evaluation and mitigate any potential conflict of interest, the independent evaluator, PCG, will:

- Conduct an evaluation of the 1115 Demonstration hypotheses for the Adult Expansion, Current Eligible, Targeted Adult Medicaid (TAM), Targeted Adult Dental (TAM-Dental), Blind and Disabled Dental (BDD), Aged Dental, Employer-Sponsored Insurance (ESI), Utah Premium Partnership (UPP), Intensive Stabilization Services (ISS), and Former Foster Care Youth from Another State (FFCYAS) populations of the 1115 waiver, as well as for the Serious Mental Illness (SMI) and Substance Use Disorder (SUD) components[26], IVF and Genetic Testing, Fertility Treatment for Individuals Diagnosed with Cancer, Housing Related Services and Supports and Justice-Involved Reentry Services to determine if the goals and objectives of the Demonstration have been achieved.
- Meet the evaluation requirements of the 1115 Demonstration STCs.
- Follow the CMS approved evaluation design.
- Provide DHHS with the required annual interim evaluation report and summative evaluation report at the end of the 1115 Demonstration approval period, by the due dates outlined in the contract.
- Provide future evaluations as required by the contract, at the option of DHHS, and develop the evaluation design and implement the design upon CMS approval.
- Complete any required IRB applications, data sharing agreements, or other documents needed to protect human subjects and data confidentiality.

[25] This procurement sought an Independent Evaluator for all the components of the current waiver period which runs from July 1, 2022, through June 30, 2027. PCG was awarded a five-year contract covering these components.
[26] The Utah Department of Health requested that PCG develop a single comprehensive Evaluation Design for the Utah Medicaid Reform 1115 Demonstration encompassing all evaluation populations and waiver components.

- Appropriately safeguard evaluation data in compliance with HIPAA requirements, protection of human subjects, data sharing agreements, state or federal laws, and other applicable regulations.

The 1115 Demonstration evaluation conducted by PCG will determine if the goals and objectives of the 1115 Demonstration have been achieved. The evaluation will meet the requirement of the 1115 Demonstration STCs, follow the CMS approved evaluation design, and provide required deliverables.
DHHS staff worked with the evaluator to identify and address concerns that might arise during the administration of the contract. By requiring initial satisfaction of these standards by the contracting party in order to be awarded the contract, as well as ongoing maintenance of the requirements during the term of service, DHHS is in a position to receive an objective evaluation report that is the product of a fair, impartial, and conflict-free evaluation.

2. Evaluation Budget

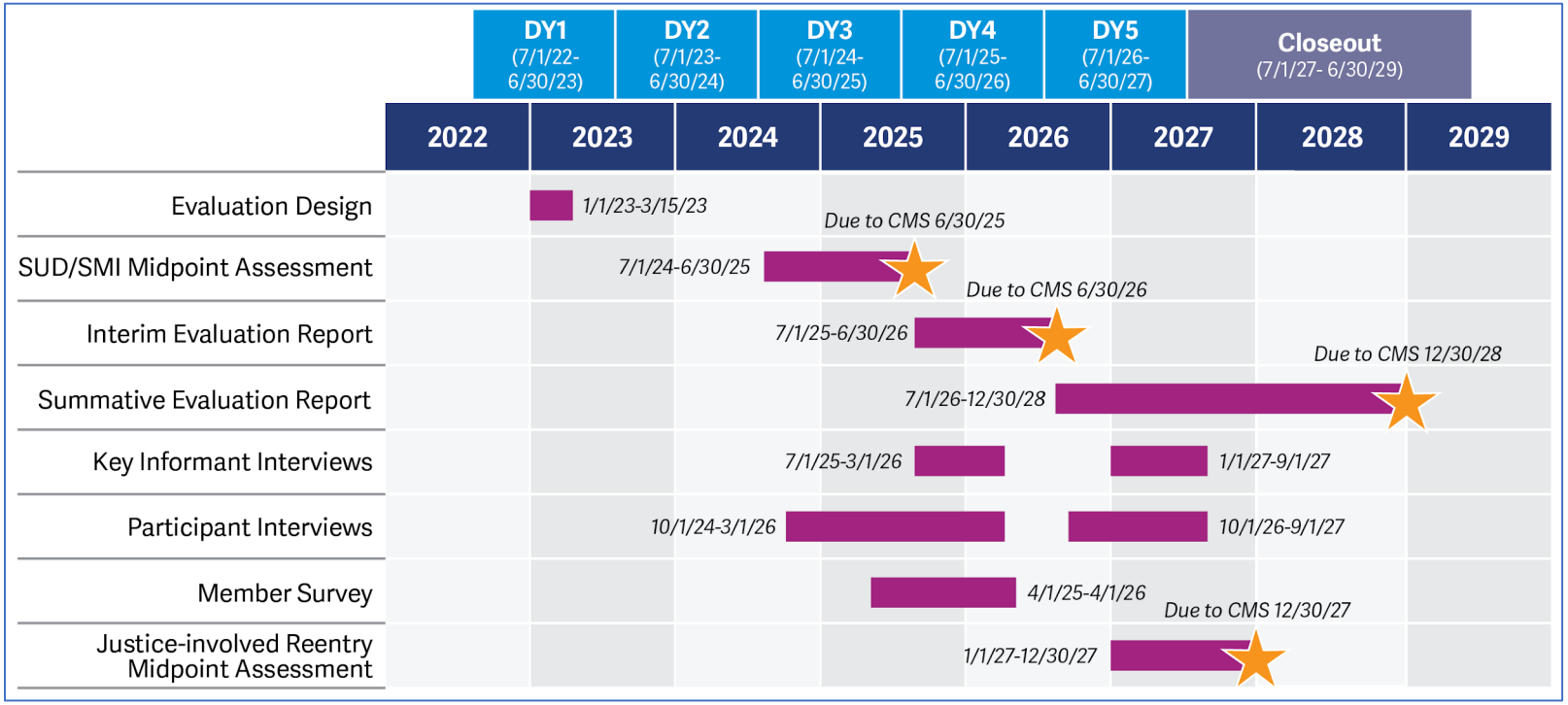
Table 14: Estimated Evaluation Budget

Evaluation Activity	Current Demonstration Period							
	DY1	DY2	DY3	DY4	DY5	Post Yr1	Post Yr2	TOTAL
	7/1/2022 – 6/30/2023	7/1/2023 – 6/30/2024	7/1/2024 – 6/30/2025	7/1/2025 – 6/30/2026	7/1/2026 – 6/30/2027	7/1/2027 – 6/30/2028	7/1/2028 – 6/30/2029	
Project Management	$49,500	$49,500	$153,082	$204,110	$102,055	$82,920	$76,541	**$717,708**
Evaluation Design		$16,875	$255,137	$68,037				**$340,049**
Quantitative Data	$289,980	$48,973	$102,055	$204,110	$204,110	$160,311	$163,288	**$1,172,827**
Summative Report Prior Demo Period	$143,820	$157,790						**$301,610**
Key Informant Interviews			$81,644	$136,073	$68,037	$27,640	$25,514	**$338,908**
Participant Interviews Wave 1		$50,000	$91,849	$149,680				**$291,529**
Custom Member Survey		$180,000	$10,205	$244,932	$68,037			**$503,174**
Participant Interviews Wave 2					$163,288	$22,112	$15,308	**$200,708**
Midpoint Assessment: SUD/SMI		$71,100	$204,110					**$275,210**
Interim Report			$122,466	$353,790	$40,822			**$517,078**
Midpoint Assessment: JIR						$116,087		**$116,087**
Summative Report					$34,018	$143,727	$229,623	**$407,368**
TOTAL	**$483,300**	**$574,238**	**$1,020,548**	**$1,360,731**	**$680,366**	**$552,797**	**$510,274**	**$5,182,256**

Note: Line items for new primary data collection activities (interviews and surveys) include costs for developing the tools, gathering the data, and performing data analytics.

3. Timeline and Major Milestones

Figure 3: Evaluation Timeline



4. Evaluation Tables

Table 15: Evaluation Summary, Hypothesis 1, Low-income UT residents

Hypothesis 1: The 1115 Demonstration overall will improve access to coverage and engagement in health care for low-income UT residents.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 1.1: Did the fraction of low-income residents with no coverage decrease, relative to comparison states?				
Comparison states	Any coverage	Fraction with any health insurance coverage	BRFSS	Difference-in-difference Synthetic control model
Primary research question 1.2: Did the fraction of low-income residents who avoided care due to cost decrease, relative to comparison states?				
Comparison states	Avoided care due to cost	Fraction who delayed or avoided needed care because of cost	BRFSS	Difference-in-difference Synthetic control model
Primary research question 1.3: Did the fraction of low-income residents who have a personal doctor or usual source of care increase, relative to comparison states?				
Comparison states	Has a personal doctor	Fraction who says they have one person they think of as their person doctor or provider	BRFSS	Difference-in-difference Synthetic control model
Primary research question 1.4: Did the fraction of low-income residents who had a primary or specialty care appointment in the last year increase, relative to comparison states?				
Comparison states	Had a primary or specialty appointment	Had a checkup or visit with a specialist in the last 12 months	BRFSS	Difference-in-difference Synthetic control model
Primary research question 1.5: Did the fraction of low-income residents who had a preventive screening in the last year increase, relative to comparison states?				
Comparison states	Had a preventative screening	Fraction who reported having a mammogram in the last 12 months	BRFSS	Difference-in-difference Synthetic control model
Primary research question 1.6: What is the member experience of care in terms of access, timeliness, and patient-centeredness?				
Pre-Demonstration baseline	Member satisfaction	Getting needed care Getting needed care quickly How well doctors communicate	CAHPS	Descriptive statistics; Trend over time
n/a Single point in time survey	Member satisfaction	Access to care Access to BH care Barriers to accessing physical care Barriers to accessing behavioral health care Patient centered care Coordination of care	Custom Member/ Beneficiary Survey	Descriptive statistics

Hypothesis 1: The 1115 Demonstration overall will improve access to coverage and engagement in health care for low-income UT residents.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 1.7: Did Low Value Care decrease among Demonstration participants, relative to baseline?				
Pre-Demonstration baseline	Low Value Care	List of low value care scenarios appropriate for the Demonstration will be developed	Claims	Trend over time Interrupted Time Series

Table 16: Evaluation Summary, Hypothesis 2, Adult Expansion / UMIC

Hypothesis 2: The Demonstration will improve healthcare access and engagement for the Adult Expansion population.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 2.1: Did inpatient hospital utilization decrease, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	Inpatient Utilization (IPU)	Inpatient admissions per member per year	Claims	Trend over time Interrupted Time Series
Primary research question 2.2: Did ED visits decrease, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	ED visits (EDU)	ED visits per member per year	Claims	Trend over time Interrupted Time Series
Subsidiary research question 2.2.a: Did ED visits for BH conditions decrease, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	ED-BH visits (EDU-BH)	ED visits for BH condition per member per year	Claims	Trend over time Interrupted Time Series
Subsidiary research question 2.2.b: Did UMIC plans reduce ED visits for BH conditions for Adult Expansion population, relative to FFS or physical health-only ACO plans?				
Plan Type Comparison: UMIC, FFS/PMHP, ACO/PMHP	ED-BH visits (EDU-BH)	ED visits for BH condition per member per year	Claims	Multiple linear regression; ANOVA

Primary research question 2.3: Did engagement in primary and ambulatory care increase, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	Adults' Access to Preventative/Ambulatory Health Services (AAP)	Fraction of beneficiaries who had an ambulatory or preventive care visit during the measurement year	Claims	Interrupted Time Series
Primary research question 2.4: Did engagement in behavioral health care increase, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	Antidepressant Medication Management (AMM)	Adults with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications.	Claims	Interrupted Time Series
Pre-Demonstration baseline	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Fraction with a new episode of alcohol or other drug dependence who: 1) initiated treatment within 14 days of diagnosis. 2) engaged in continued treatment within 34 days of the initiation visit.	Claims	Interrupted Time Series
Pre-Demonstration baseline	Follow-Up After Hospitalization for Mental Illness (FUH)	Following discharge for mental illness or intentional self-harm, fraction with outpatient follow-up in 7 days, and within 30 days.	Claims	Interrupted Time Series
Pre-Demonstration baseline	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (REA)	The rate of unplanned, 30-day, readmission for Demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Claims	Interrupted Time Series
Subsidiary research question 2.4.a: Did UMIC plans improve engagement in behavioral health care for Adult Expansion population, relative to FFS or physical health-only ACO plans?				
Plan Type Comparison: UMIC, FFS/PMHP, ACO/PMHP	Antidepressant Medication Management (AMM)	Adults with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant	Claims	Multiple linear regression; ANOVA

		medications.		
Plan Type Comparison: UMIC, FFS/PMHP, ACO/PMHP	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Fraction with a new episode of alcohol or other drug dependence who: 1) initiated treatment within 14 days of diagnosis. 2) engaged in continued treatment within 34 days of the initiation visit.	Claims	Multiple linear regression; ANOVA
Plan Type Comparison: UMIC, FFS/PMHP, ACO/PMHP	Follow-Up After Hospitalization for Mental Illness (FUH)	Following discharge for mental illness or intentional self-harm, fraction with outpatient follow-up in 7 days, and within 30 days.	Claims	Multiple linear regression; ANOVA
Plan Type Comparison: UMIC, FFS/PMHP, ACO/PMHP	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (REA)	The rate of unplanned, 30-day, readmission for Demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Claims	Multiple linear regression; ANOVA
Primary research question 2.5: Did engagement in treatment for chronic conditions increase, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	Monitoring for persistent medications (MPM)	Assesses adults who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (for hypertension or heart disease) during the measurement year and received at least one therapeutic monitoring event for the therapeutic agent during the measurement year:	Claims	Interrupted Time Series
Pre-Demonstration baseline	Engagement in Diabetes Care (EDC)	Adults with type 1 or type 2 diabetes who had at least two A1C tests in the year	Claims	Interrupted Time Series
Primary research question 2.6: Did preventive cancer screening increase, relative to baseline, for the Adult Expansion population?				

Pre-Demonstration baseline	Breast Cancer Screening (BCS)	Women 50 years and over who had at least one mammogram to screen for breast cancer in the past two years	Claims	Interrupted Time Series
Primary research question 2.7: Did dental service provision increase relative to baseline for the Adult Expansion population?				
N/A	Dental Service Recipients	Number of unique individuals who received dental services	Claims	Descriptive statistics
N/A	Dental Services	Number of dental services provided	Claims	Descriptive statistics
Primary research question 2.8: Did ED visits for non-traumatic dental conditions decrease relative to baseline for the Adult Expansion population?				
Pre-Dental Expansion baseline	Ambulatory Care Sensitive ED Visits for Non-Traumatic Dental Conditions in Adults (Dental Quality Alliance measure EDV-A-A)	Number of emergency department (ED) visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 member months for adults	Pre-Dental Expansion baseline	Interrupted Time Series
Primary research question 2.9: Did follow-up after ED visits for non-traumatic dental conditions increase relative to baseline for the Adult Expansion population?				
Pre-Dental Expansion baseline	Follow-Up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (Dental Quality Alliance EDF-A-A)	The percentage of ambulatory care sensitive non-traumatic dental condition emergency department visits among adults aged 18 years and older in the reporting period for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit	Claims	Interrupted Time Series
Primary research question 2.10: To what extent are beneficiaries aware of the dental care benefit?				
N/A	Dental Benefit Awareness	Percentage of survey respondents who answer “yes” to: Does your health insurance cover any dental services, such as routine cleanings?	Custom Member Survey	Descriptive statistics

Table 17: Evaluation Summary, Hypothesis 3, TAM

Hypothesis 3: The Demonstration will improve healthcare access and engagement for the TAM population.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 3.1: Did inpatient hospital utilization decrease, relative to baseline, for the TAM population?				
Pre-Demonstration baseline	Inpatient Utilization (IPU)	Inpatient admissions per member per year	Claims	Interrupted Time Series

Primary research question 3.2: Did ED visits decrease, relative to baseline, for the TAM population?				
Pre-Demonstration baseline	ED visits (EDU)	ED visits per member per year	Claims	Interrupted Time Series
Subsidiary research question 3.2.a: Did ED visits for BH conditions decrease, relative to baseline, for the TAM population?				
Pre-Demonstration baseline	ED-BH visits	ED visits for BH condition per member per year	Claims	Interrupted Time Series
Primary research question 3.3: Did engagement in primary and ambulatory care increase, relative to baseline, for the TAM population?				
Pre-Demonstration baseline	Adults' Access to Preventative/Ambulatory Health Services (AAP)	Fraction of beneficiaries who had an ambulatory or preventive care visit during the measurement year	Claims	Interrupted Time Series
Baseline	Monitoring for persistent medications (MPM)	Assesses adults who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (for hypertension or heart disease) during the measurement year and received at least one therapeutic monitoring event for the therapeutic agent during the measurement year:	Claims	Interrupted Time Series
Primary research question 3.4: Did engagement in behavioral health care increase, relative to baseline, for the TAM population?				
Pre-Demonstration baseline	Follow-Up After Hospitalization for Mental Illness (FUH)	Following discharge for mental illness or intentional self-harm, fraction with outpatient follow-up in 7 days, and within 30 days.	Claims	Interrupted Time Series

Pre-Demonstration baseline	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (REA)	The rate of unplanned, 30-day, readmission for Demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Claims	Interrupted Time Series
Pre-Demonstration baseline	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Fraction with a new episode of alcohol or other drug dependence who: 1) initiated treatment within 14 days of diagnosis. 2) engaged in continued treatment within 34 days of the initiation visit.	Claims	Interrupted Time Series
Primary research question 3.5: Did dental service provision increase relative to baseline for the TAM population?				
N/A	Dental Service Recipients	Number of unique individuals who received dental services	Claims	Descriptive statistics
N/A	Dental Services	Number of dental services provided	Claims	Descriptive statistics
Primary research question 3.6: Did ED visits for non-traumatic dental conditions decrease relative to baseline for the TAM population?				
Pre-TAM Dental Benefit baseline	Ambulatory Care Sensitive ED Visits for Non-Traumatic Dental Conditions in Adults (Dental Quality Alliance measure EDV-A-A)	Number of emergency department (ED) visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 member months for adults	Claims	Interrupted Time Series
Primary research question 3.7: Did follow-up after ED visits for non-traumatic dental conditions increase relative to baseline for the TAM population?				

Pre-TAM Dental Benefit baseline	Follow-Up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (Dental Quality Alliance EDF-A-A)	The percentage of ambulatory care sensitive non-traumatic dental condition emergency department visits among adults aged 18 years and older in the reporting period for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit	Claims	Interrupted Time Series

Table 18: Evaluation Summary, Hypothesis 4, HRSN Demonstration

Hypothesis 4: The HRSN Services demonstration will effectively mitigate members' housing and transportation needs, lead to more appropriate service utilization and improved physical and mental health outcomes.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 4.1: What is the prevalence and severity of beneficiaries' social needs?				
N/A	Prevalence of housing-related needs; individual level	Number and percent of beneficiaries eligible for HRSS	Administrative Data	Descriptive statistics
N/A	Extent of housing-related needs; Community level	Housing affordability (<=30% of income) at the county level	American Community Survey, Area Health Resources File	Trend over time
Primary research question 4.2: Were HRSN services provided and utilized as planned?				
N/A	HRSN Provider Availability	Number of HRSN providers and description of service offerings	Administrative	Descriptive statistics
N/A	HRSN Service Utilization	HRSN service counts by type of service	Claims	Descriptive statistics Trend over time

Hypothesis 4: The HRSN Services demonstration will effectively mitigate members' housing and transportation needs, lead to more appropriate service utilization and improved physical and mental health outcomes.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
N/A	NMT Utilization	NMT service counts	Administra tive	Descriptive statistics Trend over time
Primary research question 4.3: Did the HRSN demonstration effectively mitigate beneficiaries' housing and transportation needs?				
N/A	Found housing	Fraction of previously unhoused HRSS participants who moved into housing while receiving HRSS.	Administra tive	Descriptive statistics
N/A	Housing stability	Fraction of HRSS participants who maintained stable housing for a defined time period.	Case records	Descriptive statistics
Primary research question 4.4: Did high-cost acute utilization decrease, relative to baseline, for HRSN recipients?				
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	ED visits	ED visits condition per member per year	Claims	Trend over time or Interrupted time series
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	ED-BH visits	ED visits for BH condition per member per year	Claims	Trend over time or Interrupted time series
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	Potentially preventable ED visits	ED visits for ambulatory sensitive conditions, such as asthma, urinary tract infections, and complications from diabetes (AHRQ measure)	Claims	Trend over time or Interrupted time series
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	Inpatient utilization	Inpatient stays per member year	Claims	Trend over time or Interrupted time series
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	Potentially preventable inpatient utilization	Inpatient stays for ambulatory sensitive conditions, such as asthma, urinary tract infections, and complications from diabetes (AHRQ measure)	Claims	Trend over time or Interrupted time series
Primary research question 4.5 Did engagement in primary and ambulatory care increase, relative to baseline, for HRSN recipients?				
Longitudinal cohort design with pre-HRSN demonstration	Adults' Access to Preventative/Ambulato	Fraction of beneficiaries who had an ambulatory or preventive care	Claims	Trend over time or Interrupted time series

Hypothesis 4: The HRSN Services demonstration will effectively mitigate members' housing and transportation needs, lead to more appropriate service utilization and improved physical and mental health outcomes.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
baseline, if available	ry Health Services (AAP)	visit during the measurement year		
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	Monitoring for persistent medications	Assesses adults who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (for hypertension or heart disease) during the measurement year and received at least one therapeutic monitoring event for the therapeutic agent during the measurement year:	Claims	Trend over time or Interrupted time series
Primary research question 4.6: Did engagement in behavioral health care increase, relative to baseline, for HRSN recipients?				
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (REA)	The rate of unplanned, 30-day, readmission for Demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Claims	Trend over time or Interrupted time series
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	Follow-Up After Hospitalization for Mental Illness (FUH)	Following discharge for mental illness or intentional self-harm, fraction with outpatient follow-up in 7 days, and within 30 days.	Claims	Trend over time or Interrupted time series
Primary research question 4.7: From the beneficiaries' perspective, did the HRSN services meet their housing-related needs, support their engagement in behavioral health care, and overall positively impact their physical and mental health?				
N/A	Quality of HRSS, participant perspective	How satisfied are participants with the HRSS they received? What was helpful, not helpful? How easy or difficult is it to find appropriate housing without, and with, HRSS assistance? Are participants	Participant Interviews	Qualitative analysis

Hypothesis 4: The HRSN Services demonstration will effectively mitigate members' housing and transportation needs, lead to more appropriate service utilization and improved physical and mental health outcomes.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
		satisfied with their housing arrangements?		
N/A	Engagement in care, participant perspective	What factors enhance or inhibit participants' engagement in physical health care? in behavioral health care?	Participant Interviews	Qualitative analysis
N/A	Overall physical and mental health, participant perspective	How do participants think their physical and mental health has changed since receiving HRSS services?	Participant Interviews	Qualitative analysis
Primary research question 4.8: Did state and local investments in housing supports change over time during the HRSN demonstration?				
Baseline year	Local availability of HRSS	Percent change in number of HRSS type programs for the duration of the amendment	Administrative: Maintenance of Effort section of Annual Monitoring Reports	Percent change in each year compared to the baseline year
Primary research question 4.9: Were there any improvements in the quality and effectiveness of downstream housing-related services and supports?				
N/A	HRSN Provider Self-Assessment	Provider perceptions of the impact of infrastructure investments and related supports on the quality and effectiveness of their housing-related services and supports.	Key Informant Interviews	Qualitative

Table 19: Evaluation Summary, Hypothesis 5, SMI/SUD

Hypothesis 5: The SMI and SUD Demonstrations increased access to appropriate treatment.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 5.1: Did the number of individuals receiving services for SMI and/or SUD increase, relative to baseline?				
Baseline year (DY1)	Service Counts: SUD	Number of members receiving SUD treatment	Claims	Descriptive statistics; Trend over time
Baseline year (DY1)	Service Counts: SMI	Number of members receiving SUD treatment	Claims	Descriptive statistics; Trend over time
Primary research question 5.2: Did ED visits for BH conditions decrease among individuals with SMI and/or SUD diagnoses, relative to baseline?				
Pre-Demonstration baseline Stratify by: SMI only, SUD only, SMI/SUD dually diagnosed	ED-BH visits	ED visits for BH condition per member per year	Claims	Interrupted Time Series
Primary research question 5.3: Did inpatient days (outside of IMDs) decrease, relative to baseline, for individuals with SMI and/or SUD?				
Pre-Demonstration baseline Stratify by: SMI only, SUD only, SMI/SUD dually diagnosed	Inpatient days	Inpatient days PMPY, exclusive of IMD stays	Claims	Interrupted Time Series
Primary research question 5.4: Did engagement in SUD treatment increase among individuals with SUD diagnoses relative to baseline?				
Pre-Demonstration baseline	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Fraction with a new episode of alcohol or other drug dependence who: 1) initiated treatment within 14 days of diagnosis. 2) engaged in continued treatment within 34 days of the initiation visit.	Claims	Interrupted Time Series
Primary research question 5.5: Did unplanned readmission following hospitalization for psychiatric treatment decrease among individuals with SMI relative to baseline?				
Pre-Demonstration baseline	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric	The rate of unplanned, 30-day, readmission for Demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's	Claims	Interrupted Time Series

Hypothesis 5: The SMI and SUD Demonstrations increased access to appropriate treatment.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
	Facility (REA)	disease.		
Primary research question 5.6: Did utilization of any mental health service increase among low-income residents, relative to comparison states?				
Comparison states	Mental health treatment	Percentage who reported receiving mental health (non-SUD) treatment in the last 12 months	NSDUH	Difference-in-difference; Synthetic control model
Primary research question 5.7: Did the number of individuals needing but not receiving SUD service decrease among low-income residents, relative to comparison states?				
Comparison states	SUD treatment	Percentage who reported receiving SUD treatment in the last 12 months	NSDUH	Difference-in-difference; Synthetic control model
Primary research question 5.8: Did the rate of overdose deaths decrease, relative to baseline?				
Pre-Demonstration baseline	Overdose deaths	State rate of overdose deaths	Administrative	Interrupted Time Series
Primary research question 5.9: Did the number of individuals receiving crisis stabilization services increase (with an emphasis on non-hospital, non-residential services)?				
Pre-Demonstration baseline	Crisis stabilization services	Crisis Stabilization service count	Claims	Interrupted Time Series

Table 20: Evaluation Summary, Hypothesis 6, SMI/SUD Cost of Care

Hypothesis 6: The SMI and SUD Demonstrations stabilized or reduced cost of care for these populations.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 6.1: Did the total cost of care for individuals with SMI diagnoses change, relative to baseline?				
Pre-Demonstration baseline	Total Cost of Care	Total costs per beneficiary per month is the sum of the state's Medicaid costs (inpatient, outpatient, pharmacy, long-term care, IMD, and	Claims	Interrupted time series

Hypothesis 6: The SMI and SUD Demonstrations stabilized or reduced cost of care for these populations.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
		MCO capitated payments) and the federal cost (total Medicaid * FMAP for Utah).		
Subsidiary research question 6.1.a: Did costs related to the diagnosis and treatment of SMI change, relative to baseline? (SMI-IMD costs + other SMI costs + non-SMI costs)?				
Pre-Demonstration baseline	Costs related to the diagnosis and treatment of SMI	These costs include *SMI-IMD costs + other SMI costs + non-SMI costs*	Claims	Interrupted time series

Subsidiary research question 6.1.b: What types of care (inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care) are the primary drivers of the cost of care for the SMI population?				
Pre-Demonstration baseline	Source of treatment cost drivers	These costs include inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care	Claims	Interrupted time series
Primary research question 6.2: Did the total cost of care for individuals with SUD diagnoses change, relative to baseline?				
Pre-Demonstration baseline	Total Cost of Care	Total costs per beneficiary per month is the sum of the state's Medicaid costs (inpatient, outpatient, pharmacy, long-term care, IMD, and MCO capitated payments) and the federal cost (total Medicaid * FMAP for Utah).	Claims	Interrupted time series
Subsidiary research question 6.2.a: Did costs related to the diagnosis and treatment of SUD change, relative to baseline? (SUD-IMD costs + other SUD costs + non-SUD costs)?				
Pre-Demonstration baseline	Costs related to the diagnosis and treatment of SMI	These costs include *SMI-IMD costs + other SMI costs + non-SMI costs*	Claims	Interrupted time series
Subsidiary research question 6.2.b: What types of care (inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care) are the primary drivers of the cost of care for the SUD population?				
Pre-Demonstration baseline	Source of treatment cost drivers	These costs include *inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care*	Claims	Interrupted time series

Table 21: Evaluation Summary, Hypothesis 7, Small Demonstration Populations: UPP/ESI, ISS, FFCYAS, Fertility and Genetic Testing Services

Hypothesis 7: The Demonstration delivered coverage/ services appropriately to individuals in the smaller Demonstration populations.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
UPP/ESI				
Primary research question 7.1: Did the number of individuals receiving coverage increase relative to baseline?				
Baseline year (DY1)	Enrollment	Number of unique individuals enrolled in each plan (UPP/ESI)	Claims	Descriptive statistics Trend over time

Hypothesis 7: The Demonstration delivered coverage/ services appropriately to individuals in the smaller Demonstration populations.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 7.2: What was the average total Medicaid cost of care for enrollees?				
Baseline year (DY1)	Total cost of care	Total cost of care (paid claims plus premium payments) for each plan (UPP/ESI)	Claims	Descriptive statistics Trend over time
Primary research question 7.3: Did the pmpm cost for enrollees change over time?				
Baseline year (DY1)	Average pmpm expenditure	Total per member per month cost of care (paid claims plus premium payments) for each plan (UPP/ESI)	Claims	Descriptive statistics Trend over time
ISS				
Primary research question 7.4 Did the number of individuals receiving ISS increase relative to baseline?				
Baseline year (DY1)	ISS Service Recipients	Number of unique individuals who received ISS	Claims	Counts
FFCYAS				
Primary research question 7.5: How many FFCYAS received coverage?				
Baseline year (DY1)	Number of FFCYAS	Number of unique individuals in FFCYAS coverage group	Required Monitoring Reports	Counts
Fertility and Genetic Testing Services				
Primary research question 7.6: Did the number of individuals receiving fertility preservation services increase relative to baseline?				
Baseline year (DY1)	Fertility services	Number of unique individuals receiving fertility preservation services	Claims	Counts
Primary research question 7.7: Did the number of individuals receiving genetic testing services increase relative to baseline?				
Baseline year (DY1)	Genetic testing services	Number of unique individuals receiving genetic testing services	Claims	Counts

Table 22: Evaluation Summary, Hypothesis 8, Justice-Involved Populations

Hypothesis 8: The Justice-Involved Reentry Benefit will enhance cross-system communication and coordination between correctional and community services.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 8.1: Did the Demonstration's services facilitate beneficiaries' post-release transitions to care?				
N/A	Were beneficiaries able to access and engage in continuous care post-release that met their needs?	Beneficiaries' Perceptions	Beneficiary Interviews	Qualitative Analysis
N/A	Were beneficiaries able to access and engage in continuous care post-release that met their needs?	Case Managers' Perceptions	Case Manager Interviews	Qualitative Analysis
Primary research question 8.2: Was communication and coordination between the correctional system and community-based health services enhanced?				
N/A	What changes were made to communication systems between institutions?	Correctional system staff Perceptions	Correctional system staff interviews	Qualitative Analysis
N/A	What changes were made to communication systems between institutions?	Community-based providers' Perceptions	Community-based providers interviews	Qualitative Analysis

Table 23: Evaluation Summary, Hypothesis 9, Justice-Involved Populations

Hypothesis 9: The Justice-Involved Reentry Benefit will improve pre-release service provision during the covered period and continuity of coverage for the justice-involved population.						
Comparison Strategy	**Measure Name**	**Measure Description**	**Numerator**	**Denominator**	**Data source**	**Analytic Approach**
Primary research question 9.1: What Demonstration services did justice-involved individuals receive in the pre-release period?						
N/A	Pre-release service distribution	Distribution of services rendered by service type and date. Service types include: clinical consultation (non-BH), diagnostic (radiology and lab), treatment (non-MAT), family planning and supplies, CHW, hepatitis C, medical equipment and supplies, hepatitis C screening, hepatitis C treatment if indicated, SUD services, MAT, MAT counseling, peer support	N/A	N/A	Claims/administrative	Descriptive statistics
N/A	Pre-demonstration carceral setting service offerings	Description of services offered by participating carceral settings in their institution's pre-demonstration	N/A	N/A	Carceral Facility Readiness Assessment and Key Informant Interviews	Document Review Descriptive statistics Qualitative Analysis
N/A	What services (case management or care provision) did beneficiaries receive in the 90 days before release? What services that beneficiaries needed did they not receive in the	Beneficiaries' Perceptions	N/A	N/A	Beneficiary Interviews	Qualitative Analysis

	90 days before your release?					
Primary research question 9.2: What was beneficiaries' experience of pre-release service provision?						
N/A	Beneficiary experience of pre-release services	Beneficiary self-reported experience of quality of care	N/A	N/A	Beneficiary interviews	Qualitative Analysis
N/A	Provider availability	Ratio of facility Medicaid-enrolled providers to JIR beneficiaries	Medicaid-enrolled providers	JIR beneficiaries	TBD[27]	Descriptive statistics stratified by provider type
N/A	Pre-release service wait time	Time from JIR benefit start date to first Medicaid reimbursed service	N/A	N/A	Claims	Descriptive statistics stratified by service type (where feasible)

Primary research question 9.3: Were beneficiaries potentially in need of behavioral health services identified during the pre-release period?						
N/A	Diagnosed Mental Health Disorders (DMH)	The percentage of JIR beneficiaries who were diagnosed with a mental health disorder	Of the denominator, number diagnosed with a mental health disorder	JIR beneficiaries	Claims	Descriptive statistics
N/A	Diagnosed Substance Use Disorders (DSU)	The percentage of JIR beneficiaries who were diagnosed with a substance use disorder ● Alcohol disorder	Of the denominator, number diagnosed with a	JIR beneficiaries	Claims	Descriptive statistics

[27] The data source for facility Medicaid-enrolled providers has not yet been fully determined. It will likely be a combination of Medicaid provider enrollment data and carceral facility administrative data, such lists of providers that have entered into contracts or agreements with the facility.

		• Opioid disorder • Other or unspecified drugs • Any SUD	substance use disorder			
Primary research question 9.4: What fraction of justice-involved individuals received navigation support for accessing Medicaid coverage pre-release?						
N/A	Intake coverage screening	Percentage of individuals newly incarcerated in participating institutions who were screened for coverage status.[28]	Newly incarcerated individuals screened for Medicaid coverage	All newly incarcerated individuals in participating facilities	Carceral Facility Administrative Data	Descriptive statistics (stratified by time from intake to screening)
N/A	Medicaid renewal applications for justice-involved population	Percentage of incarcerated individuals who responded completely to Medicaid redetermination request	Incarcerated individuals who responded completely to Medicaid redeterminati on requests	Incarcerated individuals who received Medicaid redetermination requests	Medicaid Administrative Data: Eligibility and Enrollment	Descriptive statistics
N/A	New Medicaid applications for justice-involved population	Number of incarcerated individuals who submitted applications for Medicaid coverage	N/A/	N/A	Medicaid Administrative Data: Eligibility and Enrollment	Descriptive statistics
Primary research question 9.5: Did JIR beneficiaries experience gaps in coverage at the time of release?						
N/A.[29]	Reentry continuity of coverage	Average number of days from release to Medicaid coverage	N/A	N/A	Medicaid Administrative Data: Eligibility and Enrollment	Descriptive statistics

- [28] In addition to coverage screening of newly incarcerated individuals, the carceral facilities will also screen individuals who were incarcerated prior to the demonstration. The process and timeline for such screenings is not yet in place. The IE may add a measure for screening of previously incarcerated individuals to the design once the planning process is complete.
- [29] The preferred design it to compare JIR beneficiaries to a pre-demonstration group, or a non-participating comparison group, on continuity of coverage. The design will include the comparison approach if release dates are available for a potential comparison group.

		reinstatement for incarcerated individuals with suspended status				

Table 24: Evaluation Summary, Hypothesis 10, Justice-Involved Populations

Hypothesis 10: The Justice-Involved Reentry Benefit's 90-day pre- release coverage period ("the coverage timeline") will support effective program implementation.						
Comparison Strategy	**Measure Name**	**Measure Description**	**Numerator**	**Denominator**	**Data source**	**Analytic Approach**
Primary research question 10.1: Did the coverage timeline facilitate providing coordinated, efficient, and effective reentry planning?						
Subsidiary research question 10.1.a: Were assessments and care plans completed in a timely manner?						
N/A	Timely case management assessment	Time from JIR benefit start to first case management meeting/assessment	N/A	N/A	Carceral Facility Administrative Data	Descriptive statistics
N/A	Timely care planning	Time from JIR benefit start date to development of a care plan	N/A	N/A	Carceral Facility Administrative Data	Descriptive statistics
Subsidiary research question 10.1.b: Did beneficiaries receive a 30-day supply of all prescribed medications immediately upon release from the carceral setting?						
N/A	Prescription Medication Supply	Percentage of JIR beneficiaries who received a 30-day supply of all prescription medications that have been prescribed for the individual at the time of release immediately upon release from the correctional facility	JIR beneficiaries who received a 30-day supply of all prescription medications at release	JIR beneficiaries with prescription medication needs	Carceral Facility Administrative Data	Descriptive statistics
Primary research question 10.2: Did the coverage timeline enable pre-release management and stabilization of clinical, physical, and behavioral						

Hypothesis 10: The Justice-Involved Reentry Benefit's 90-day pre- release coverage period ("the coverage timeline") will support effective program implementation.						
Comparison Strategy	**Measure Name**	**Measure Description**	**Numerato r**	**Denominato r**	**Data source**	**Analytic Approach**
health conditions?						
N/A	Did the coverage timeline enable pre-release management and stabilization of clinical, physical, and behavioral health conditions?	Beneficiary Perceptions	N/A	N/A	Beneficiary Interviews	Qualitative Analysis
Primary research question 10.3: Did the coverage timeline help mitigate potential operational challenges the state might have encountered in a more compressed timeline?						
N/A	Did the coverage timeline help mitigate operational challenges?	State and Correctional System Perceptions	N/A	N/A	State and Correctional system staff interviews	Qualitative Analysis

Table 25: Evaluation Summary, Hypothesis 11, Justice-Involved Populations

Hypothesis 11: The Justice-Involved Reentry Benefit will improve engagement in health care and social services, reduce acute care utilization, and improve health outcomes for the justice-involved population post-release.						
Comparison Strategy	**Measure Name**	**Measure Description**	**Numerator**	**Denominator**	**Data source**	**Analytic Approach**
Primary research question 11.1: Did engagement in appropriate health care services post-release increase relative to a pre-demonstration comparison population?						
Pre-demonstration comparison population	Controlling High Blood Pressure (CBP)	The percentage of JIR beneficiaries who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled	JIR beneficiaries with a diagnosis of hypertension with blood pressure adequately	JIR beneficiaries with a diagnosis of hypertension	Claims	Trend over time Interrupted Time Series

Hypothesis 11: The Justice-Involved Reentry Benefit will improve engagement in health care and social services, reduce acute care utilization, and improve health outcomes for the justice-involved population post-release.						
Comparison Strategy	**Measure Name**	**Measure Description**	**Numerator**	**Denominator**	**Data source**	**Analytic Approach**
			controlled			
Pre-demonstration comparison population	Monitoring for Persistent Medications (MPM)	JIR beneficiaries who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (for hypertension or heart disease) during the measurement year and received at least one therapeutic monitoring event for the therapeutic agent during the measurement year	JIR beneficiaries who received at least 180 treatment days of ambulatory medication for a select therapeutic agent and received at least one therapeutic monitoring event for the therapeutic agent	JIR beneficiaries prescribed an ambulatory medication therapy	Claims	Trend over time Interrupted Time Series
Pre-demonstration comparison population	Adults' Access to Preventative/Ambulatory Health Services (AAP)	Fraction of JIR beneficiaries who had an ambulatory or preventive care visit during the measurement year	Number of JIR beneficiaries who had an ambulatory or preventive care visit	JIR beneficiaries	Claims	Trend over time Interrupted Time Series
Pre-demonstration comparison population	Pharmacotherapy for Opioid Use Disorder (POD)	The percentage of OUD pharmacotherapy events that lasted at least 180 days among JIR beneficiaries with a diagnosis of OUD and a new OUD pharmacotherapy	OUD pharmacotherapy events that lasted at least 180 days	JIR beneficiaries with a diagnosis of OUD and a new OUD pharmacotherapy event	Claims	Trend over time Interrupted Time Series

Hypothesis 11: The Justice-Involved Reentry Benefit will improve engagement in health care and social services, reduce acute care utilization, and improve health outcomes for the justice-involved population post-release.						
Comparison Strategy	**Measure Name**	**Measure Description**	**Numerator**	**Denominator**	**Data source**	**Analytic Approach**
		event				
N/A	Access to social services post-release	Beneficiary and case manager perceptions of beneficiary engagement in social services in the post-release period	N/A	N/A	Beneficiary and case manager interviews	Qualitative Analysis
Primary research question 11.2: Did inpatient hospital utilization post-release decrease relative to the pre-demonstration comparison population?						
Pre-demonstration comparison population	Inpatient Utilization (IPU)	Inpatient admissions per JIR beneficiary per year	Total inpatient admissions	Total JIR beneficiaries	Claims	Trend over time Interrupted Time Series
Primary research question 11.3: Did ED visits post-release decrease, relative to the pre-demonstration comparison population?						
Pre-demonstration comparison population	ED visits (EDU)	ED visits per JIR beneficiary per year	Total ED visits	Total JIR beneficiaries	Claims	Trend over time Interrupted Time Series
Pre-demonstration comparison population	ED-BH visits (EDU-BH)	ED visits for BH condition per JIR beneficiary per year	Total ED visits for BH conditions	Total JIR beneficiaries	Claims	Trend over time Interrupted Time Series
Pre-demonstration comparison population	Potentially Preventable ED visits	Non-Emergent ED visits per JIR beneficiary per year	Total non-emergent ED visits	Total JIR beneficiaries	Claims	Trend over time Interrupted Time Series
Primary research question 11.4: Did the rate of deaths post-release decrease relative to the pre-demonstration comparison population?						
Pre-demonstration comparison population	All-cause deaths	All-cause deaths among JIR beneficiaries	All cause deaths among JIR beneficiaries	JIR beneficiaries	Vital statistics	Trend over time Interrupted Time Series
Pre-demonstration comparison population	Suicide deaths	Suicide deaths among JIR beneficiaries	Suicide deaths among JIR beneficiaries	JIR beneficiaries	Vital statistics	Trend over time Interrupted Time Series

Hypothesis 11: The Justice-Involved Reentry Benefit will improve engagement in health care and social services, reduce acute care utilization, and improve health outcomes for the justice-involved population post-release.						
Comparison Strategy	**Measure Name**	**Measure Description**	**Numerator**	**Denominator**	**Data source**	**Analytic Approach**
Pre-demonstration comparison population	Overdose deaths	Overdose deaths among JIR beneficiaries	Overdose deaths among JIR beneficiaries	JIR beneficiaries	Vital statistics	Trend over time Interrupted Time Series
Primary research question 11.5: Was the timing or provision of specific pre-release services associated with better post-release outcomes?						
Associations between the pre-release service distribution data and post-release outcomes (utilization, engagement, deaths) will be explored. There are no new measures needed for this analysis.						Exploratory Regression