STATE OF UTAH

GARY R. HERBERT
GOVERNOR

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

SPENCER J. COX
LIEUTENANT GOVERNOR

June 24, 2016

The Honorable Sylvia Mathews Burwell
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Burwell:

In compliance with the special terms and conditions (STCs) set forth by the Centers for Medicaid and Medicaid Services (CMS), and in accordance with Section 1115(f) of the Social Security Act, the State of Utah is requesting a five-year renewal of the 1115 Primary Care Network (PCN) Demonstration Waiver. The current waiver is set to expire on December 31, 2016. Renewal of this waiver is critical in continuing assistance for approximately 18,000 Utahns who would otherwise go without basic health care, and for more than 1,000 Utahns who are receiving assistance in paying their employer-sponsored health plan premiums. The extension, if approved, will permit Utah to continue operating its 1115 Demonstration Waiver from January 1, 2017, through December 31, 2021.

In addition to the renewal of our current waiver, we are also requesting several amendments to the waiver. Two of the amendments are a result of House Bill 437, "Health Care Revisions," which passed during the 2016 General Session of the Utah State Legislature. Utah views these amendments as being critical to providing much needed assistance to some of Utah's most needy citizens. The first amendment is a request to allow implementation of new Medicaid eligibility covering targeted groups of adults, ages 19-64, without dependent children. This is a Utah-specific approach to reducing the number of uninsured adults in Utah. The second amendment is a request to waive the Medicaid Institutions for Mental Diseases (IMD) exclusion under section 1905(a)(29)(B) of the Social Security Act to allow for medically necessary Residential Treatment Services for individuals with substance use disorders. This will allow for a full continuum of care for the treatment of substance use disorders.

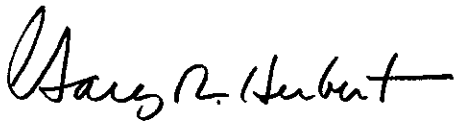
Additional amendments are included in this waiver request to allow modifications to the existing program in response to federal guidance, as well as other program changes.

Should you have any questions or require additional information please contact:

Nate Checketts,
Deputy Director of the Utah Department of Health
nchecketts@utah.gov
(O) 801-538-6689

Thank you for considering our waiver extension request and amendments. We look forward to your continued support and cooperation.

Respectfully,



Gary R. Herbert
Governor

Utah 1115 Demonstration Waiver

1115 Demonstration Waiver
Renewal Application pursuant to 1115 (f) of the Social Security Act

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

Renewal Period
January 1, 2017 through December 31, 2021

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Section 1: Extension Request

Utah is seeking a five-year extension of the Primary Care Network Demonstration Waiver pursuant to Section 1115(f) of the Social Security Act. The State is requesting several amendments to its existing 1115 waiver. They are as follows:

- Removal of High-Risk Pregnant Woman Demonstration Group (Demonstration Population II).
- Providing the same benefit available to current eligible parents to newly eligible parents up to 55 percent of the federal poverty level (FPL).
- Implementation of Mental Health Parity for the Non-Traditional Medicaid group.
- Termination of the EPSDT Waiver of Section 1902(a)(43).
- Removal of the sub group enrollment limits for the Primary Care Network Program (Demonstration Population I). The total enrollment limit for the program will remain at 25,000.
- Removal of the exclusion of Norplant as a covered family planning benefit.
- Waiver of the Medicaid Institutions for Mental Diseases (IMD) exclusion under Section 1905(a)(29)(B) of the Social Security Act to allow for medically necessary Residential Treatment Services for individuals with substance use disorders.
- Implementation of new Medicaid eligibility covering specific groups of adults without dependent children, ages 19-64.

All amendments above are discussed further in the amendment section below and/or in applicable attachments.

Section 2: History of Utah's 1115 Waiver

In the first few months of Governor Michael Leavitt's first term, Governor Leavitt introduced HealthPrint, a step by step incremental plan for reducing the uninsured rates in Utah. Under HealthPrint, Utah implemented initiatives targeted at very specific populations to increase coverage for children, seniors and the disabled. These initiatives were very successful in reducing the number of uninsured individuals in Utah. However, there was still a need to address the health care access needs of thousands of low income adults who had no health care coverage. In some cases, these were individuals with health issues not severe enough to qualify them as disabled for purposes of Medicaid, but clearly significant enough to interfere with their ability to find and maintain employment at a level that would also provide them with access to health care coverage.

Utah's Primary Care Network (PCN) was designed to serve adults in this low-income category, by offering limited benefits to cover their day-to-day needs, and to encourage them to use the health care system appropriately. The PCN program provides eligible individuals with ongoing access to primary care, pharmacy (up to four prescriptions per month) and emergency room coverage, as well as other limited services.

In order to fund the cost of providing services to a portion of uninsured adults, parent and care taker relatives with incomes below 40 percent FPL receive a slightly reduced benefit package. While reduced, the benefit package is still comprehensive and meets essential benefit requirements. According to the 2014 Health Insurance Analysis from the Behavioral Risk Surveillance System, 18.7 percent of all Utahns, age 19-64, declared that they were uninsured in 2011. During that same year (CY 2011), 41.3 percent of Utahns with a household income below 150 percent FPL were uninsured. Overall, uninsurance rates have improved in CY 2014,

the percent of uninsured among all Utahns, age 19-64, dropped 4.0 points to 14.7 percent; the uninsured rate dropped 13.5 points for Utahns age 19-64 with a household income below 150 percent FPL to 27.8 percent.

During the past ten years (SFY 2006 to SFY 2015), Utah's PCN has served 93,319 distinct individuals, with an average of 25,785 lives being covered each year. Although the Affordable Care Act removed the need for PCN to cover adults above 95 percent FPL, interest in the program has remained strong.

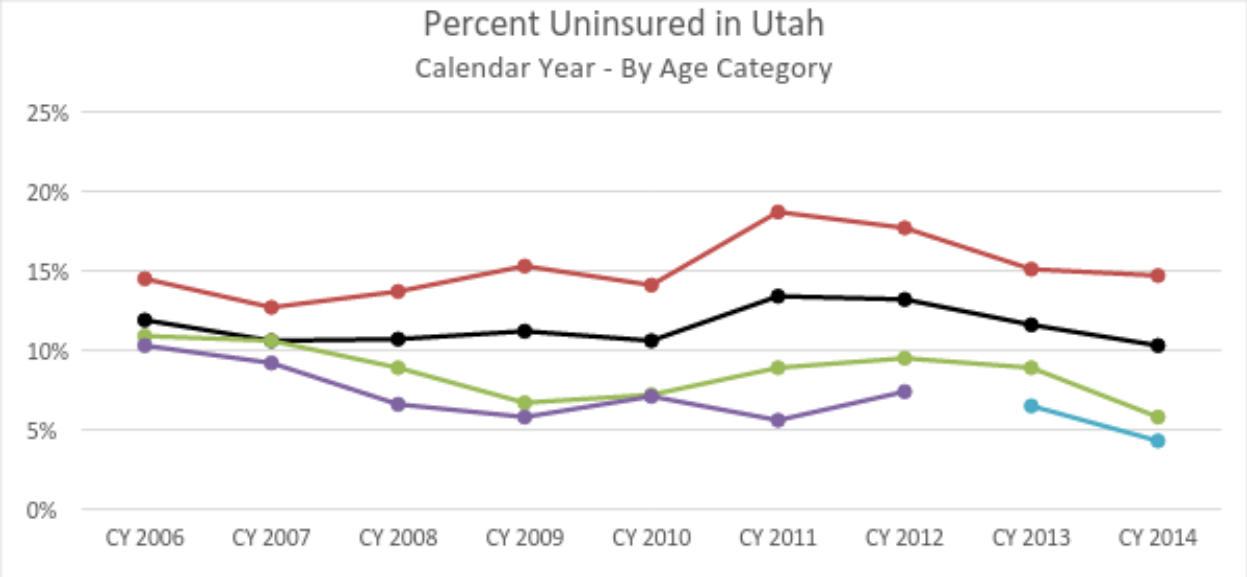

Figure 1. Summary of 2014 Health Insurance Analysis from the Behavioral Risk Factor Surveillance System (BRFSS): **https://ibis.health.utah.gov/pdf/opha/publication/ins/InsHighlights_2014.pdf**.

Amendments

- The Utah PCN 1115 Demonstration Waiver was submitted on December 11, 2001, approved on February 8, 2002, implemented on July 1, 2002, and was originally scheduled to expire on June 30, 2007.

- **Amendment #1 -** This amendment made a technical correction needed to ensure that certain current Medicaid eligibles (i.e., those age 19 and above who are eligible through Sections 1925 and 1931) in the Demonstration who become pregnant get the full Medicaid State Plan benefit package. It eliminated or reduced the benefit package for Current Eligibles to conform to changes to the benefits available under the State Plan. Finally, it increased the co-payment for hospital admissions from $100 to $220, again to conform with changes to the State Plan. (Approved on August 20, 2002, effective on July 1, 2002.)

- **Amendment #2 -** This amendment provided a premium assistance option called Covered at Work (CAW) for up to 6,000 of the 25,000 potential expansion enrollees. Specifically, the State subsidizes the employee's portion of the premium for up to five years. The employer-sponsored insurance must provide coverage equal to or greater than the limited Medicaid package. The subsidy is phased down over five years, to provide a span of time over which employees' wages can increase to the point of unsubsidized participation in the employer-sponsored plan. With this amendment, the State was also granted authority to reduce the enrollment fee for approximately 1,500 General Assistance beneficiaries, who are either

transitioning back to work or are awaiting a disability determination. These individuals were required to enroll in PCN, but the $50 fee was prohibitive as they earn less than $260 per month. For this population, the State reduced the enrollment fee to $15. (Approved on May 30, 2003, effective on May 30, 2003.)

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

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

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

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

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

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

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

  This amendment provides the option of ESI premium assistance to adults with countable household income up to and including 150 percent of the FPL, if the employee's cost to participate in the plan is at least 5 percent of the household's countable income. The State subsidizes premium assistance through a monthly subsidy of up to $150 per adult. The employer must pay at least half (50 percent) of the employee's health insurance premium, but no employer share of the premium is required for the spouse or children. Likewise, an ESI component for children provides CHIP-eligible children with family incomes up to and including 200 percent of the FPL with the option of ESI premium assistance through their parent's employer or direct CHIP coverage. The per-child monthly premium subsidy depends on whether dental benefits are provided in the ESI plan. If provided, the premium subsidy is $140 per month; otherwise, it drops to $120 per month. If dental benefits are not provided by a child's ESI plan, the State offers dental coverage through direct CHIP

coverage. Families and children are subject to the cost sharing of the employee's health plan, and the amounts are not limited to the title XXI out-of-pocket cost sharing limit of 5 percent. Benefits vary by the commercial health care plan product provided by each employer. However, Utah ensures that all participating plans cover, at a minimum, well-baby/well-child visits, age appropriate immunizations, dental services, physician visits, hospital inpatient and pharmacy. Families are provided with written information explaining the differences in benefits and cost sharing between direct coverage and the ESI plan so they can make an informed choice. All children have the choice to opt back into direct CHIP coverage at any time.

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

During its initial period of operation, Utah's COBRA Premium Assistance Program (CPAP) worked in tandem with the subsidy provided under the American Recovery and Reinvestment Act of 2009 (ARRA) for the purchase of COBRA coverage. Specifically, ARRA provided a federal subsidy of 65 percent of the cost of COBRA coverage, to individuals and families affected by involuntary job loss occurring September 1, 2008 through May 31, 2010. As long as the individual received the ARRA subsidy, the State provided the family with premium assistance based on the number of eligible individuals, but limited to the lower of 35 percent of the cost of COBRA that remains the individual's responsibility or the maximum amounts allowable by the State under the STCs.

The ARRA COBRA subsidy was of limited duration and eligibility and ended May 31, 2010. Once the ARRA subsidy ended, or for those not eligible for the ARRA COBRA subsidy, the Utah CPAP continues to provide a monthly payment for up to 18 months to offset the cost of COBRA coverage. Under the Utah program, the amount of premium assistance available to a family will be based on the number of eligible individuals in the household. However, as with the existing ESI program, the State will use various administrative databases to ensure that it does not exceed the individual/family's share of the cost of the COBRA premium.

The Utah CPAP program will provide premium assistance to eligible individuals and families with existing COBRA coverage. Individuals and families, who are COBRA-eligible but uninsured, may also apply for enrollment in the Utah CPAP. The State may provide premium assistance for up to three months of retroactive eligibility. CPAP assistance will be limited to the maximums set in the ESI program, will last for the period of COBRA coverage, and will not exceed the family's share of the cost of the premium or the maximum amounts allowable as set by the State under these STCs. CMS originally approved this amendment on December 18, 2009.

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

- **Amendment #12-** This amendment reduced the income eligibility for Demonstration population I from 100 percent FPL to 95 percent FPL. This amendment was approved by CMS on December 10, 2014.

New Amendments

- **Amendment #13**- Remove High Risk Pregnant Women Group

  This demonstration allowed pregnant women with assets over the asset limit to pay an asset co-pay to be eligible for Medicaid. Due to the Affordable Care Act, and removal of the asset test, this demonstration group is no longer needed. Pregnant women previously in this group are now eligible for Medicaid without a co-pay.

- **Amendment #14-** Mental Health Parity and Exclusion of Norplant as a Covered Benefit

  This amendment will allow changes to be made to Non-Traditional Medicaid benefits to comply with mental health parity. This applies to recipients referred to as Current Eligibles. The changes being made to comply with mental health parity are:

  - Removing the 30 day limit for inpatient treatment and the 30 visit outpatient limit
  - Adding coverage of targeted case management for substance abuse treatment
  - Removing the 30 visit limit for targeted case management for the Chronically Mentally Ill.

  This amendment also includes removing the exclusion of Norplant as a covered benefit. Norplant will now be a covered family planning benefit.

- **Amendment #15-** Termination of EPSDT Waiver

  This amendment will terminate the EPSDT waiver of Section 1902(a)(43) for individuals aged 19 and 20, for all Title XIX populations affected by this waiver. The State will cover certain services required to treat a condition identified during an EPSDT screening for this age group.

- **Amendment #16**- New Medicaid Program- Adults Without Dependent Children

  This amendment will allow the State to implement Medicaid eligibility for adults without dependent children, ages 19-64, who meet targeted eligibility criteria. Approval of this amendment will allow the State to implement provisions of a Utah law enacted in March 2016. The details of this request are outlined in **Attachment 9**.

- **Amendment #17-** Residential Treatment for Substance Use Disorder

  This amendment will waive the IMD exclusion found in Section 1905(a)(29)(B) that prohibits the use of federal Medicaid funds for care provided to most patients in substance use disorder residential treatment facilities larger than 16 beds. The details of this request are outlined in **Attachment 10**.

- **Amendment #18**- Removal of Primary Care Network Sub Group Enrollment Limits

  This amendment will remove the sub group enrollment limits for Primary Care Network (Demonstration Population I). Currently the enrollment limits are an annual average of 16,000 for the parent caretaker relative group, and 9,000 for the adults without dependent children group. There will continue to be a total annual average enrollment limit of 25,000 for PCN, but each group will not have an individual limit.

- **Amendment #19**- Benefits for Newly Eligible Parents up to 55 percent FPL
  The state will be submitting through a state plan amendment, a request to increase the income limit to 55 percent FPL, for newly eligible parents in the current eligibles group. This amendment will allow the state to provide the same benefit available to current eligible parents to newly eligible parents in this group.

Extensions

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

Section 1115(f) Extension- On February 3, 2010, the state of Utah formally requested an extension of their PCN 1115 Demonstration Waiver under the authority of Section 1115(f) of the Social Security Act. The demonstration, which would have expired on June 30, 2010, was approved for a three year extension from July 1, 2010, through June 30, 2013.

Section 1115 Extension- On December 19, 2012 the state of Utah formally requested an extension of their PCN 1115 Demonstration Waiver under the authority of Section 1115(f) of the Social Security Act. The demonstration was set to expire on June 30, 2013. The request was to renew the waiver for the period of July 1, 2013 through June 30, 2016. CMS never acted on the request for extension. The extension was informally on hold pending Utah's decision to expand Medicaid to the optional adult population between 0-138 percent FPL.

Section 1115 Extension- On December 24, 2013, CMS approved a temporary extension of Utah's 1115 PCN Demonstration Waiver until December 31, 2014.

Section 1115 Extension- On December 19, 2014, CMS approved a temporary extension of Utah's 1115 PCN Demonstration Waiver to allow the State to consider its approach to Medicaid expansion. This extension also authorized a decrease in the PCN income limit to 95 percent FPL, as well as allowing authority to make individuals age 19-26, whose parents are enrolled in ESI, eligible for premium assistance under the demonstration. This was set to expire December 31, 2015.

Section 1115(f) Extension- On June 26, 2015 the state of Utah formally requested an extension of their PCN 1115 Demonstration Waiver under the authority of Section 1115(f) of the Social Security Act. The demonstration which would have expired on December 31, 2015, was approved for a one year extension from January 1, 2016 through December 31, 2016.

Section 3: Program Description and Objectives

Utah's Primary Care Network (PCN) is a statewide Section 1115 Demonstration to expand Medicaid coverage to certain able-bodied adults who were not previously eligible for State Plan services, and to offer these adults and children eligible for CHIP an alternative to traditional direct coverage public programs. For State Plan eligibles who are categorically or medically needy parents or other caretaker relatives, the Demonstration provides a reduced benefit package. Savings from this State Plan population fund a Medicaid expansion for uninsured adults age 19 to 64, with family incomes up to 95 percent FPL. This expansion population of parents, caretaker relatives, and childless adults is covered for a limited package of preventive and primary care services.

The PCN Demonstration was amended in October 2006 to also use Demonstration savings to offer assistance with payment of ESI premiums through Utah's Premium Partnership for Health

Insurance (UPP). The UPP program uses Title XIX funds to provide up to $150 per month in ESI premium assistance to each uninsured adult in families with income up to 200 percent FPL (a September 2012 amendment increased the FPL from the original level of 150 percent FPL). UPP also uses Title XXI funds to provide premium assistance up to $120 per month, per child for CHIP eligible children with a family income up 200 percent FPL. UPP children receive dental coverage through direct CHIP coverage or they receive an additional $20 per month if they receive dental coverage through the ESI.

Effective December 18, 2009, the PCN Demonstration was further amended to enable the State to provide premium assistance to children and adults for coverage obtained under the provisions of COBRA.

Effective January 1, 2014, the PCN Demonstration was amended to reduce the eligibility income level for Demonstration Population I to 100 percent FPL, consistent with the changes in eligibility with the implementation of ACA. In addition, this extension required Utah to use MAGI based methodologies for determining income. Further, the extension approved a transition plan to move Demonstration I individuals with income at 100 percent FPL or greater, off the PCN program and to the federal marketplace. Finally, this extension also amended the waiver to require cost sharing for all demonstration populations, where applicable, consistent with the Utah Medicaid State Plan.

Effective December 19, 2014, the PCN Demonstration was further amended to reduce the eligibility income level for Demonstration Population I from 100 percent FPL to 95 percent FPL. This amendment was made because the combination of the implementation of the Federal Facilitated Marketplace (FFM), the MAGI income methodology and the provisions of the Primary Care Network Program created a unique “donut hole” for some of Utah’s most needy citizens.

Section 4: Compliance with Special Terms and Conditions

Utah has successfully completed all deliverables required by the Primary Care Network Special Terms and Conditions and continues to work diligently to assure compliance with all waiver requirements. The State maintains comprehensive administrative rules, eligibility policies, and provider manuals that are regularly updated to reflect the most current operational policies and procedures of the Primary Care Network Demonstration Waiver.

Utah has complied with all applicable federal statutes relating to nondiscrimination.

Utah has complied with all applicable requirements of the Medicaid and CHIP expressed in laws, regulations, and policy statements, not expressly waived or identified as non-applicable in the Special Terms and Conditions (STCs), apply to Utah's 1115 Demonstration Waiver, Primary Care Network.

Utah has complied with and has come into compliance with all changes in Federal law affecting the Medicaid or CHIP program that have occurred after the approval of the demonstration award date.

Utah's 1115 Demonstration Waiver adheres to all requirements of the approved 1115 waiver.

Utah has remained within the budget neutrality expenditure cap for all populations.

Section 5: Compliance with Budget Neutrality Requirements

See Attachment 1

Section 6: Program Evaluation

See Attachment 2

Section 7: Public Notice and Tribal Consultation

Public Notice of the State's request for renewal and amendment, and notice of Public Hearing was published in the Utah State Bulletin on May 1, 2016 (**Attachment 3**). A press release was also issued on May 9, 2016. The public had until June 8, 2016 to provide comment.

On May 13, 2016, a presentation regarding the request for renewal of Utah's 1115 Waiver and amendments was provided to the Utah Indian Health Advisory Board (**Attachment 4**). This is the first step in our approved consultation process.

On May 19, 2016, the State held a meeting of the Medical Care Advisory Committee from 1:30 PM to 3:30 PM to take public comment on the PCN Demonstration Waiver extension request. (**Attachment 5**)

On May 25, 2016 the State held a public hearing from 1:00 PM to 3:00 PM to take public comment on the extension request. An overview of the waiver request was presented. A copy of the overview document is attached. **(Attachment 6)**

On May 31, 2016 the State held a public hearing from 11:30PM to 1:00PM to take public comment on the extension request. An overview of the waiver request was presented. A copy of the overview document is attached. **(Attachment 6)**

A second public comment period was opened July 16, 2016 through August 15, 2016, specifically to request comments related to the budget neutrality documents. Public comment notification can be found at http://www.utahlegals.com/notice.php?id=283846.

Public comments received during both public comment periods and public hearings, as well as the state's responses are contained in Attachment 12.

Section 8: Quality Initiatives

Current Eligibles in thirteen counties receive physical health services through full risk capitated Medicaid Accountable Care Organization (ACO) managed care plans. Mental health and substance use disorder services for populations covered under this waiver are also provided through pre-paid mental health plans.

A link to the State's latest External Quality Review report is included with this request for renewal. (**Attachment 7**)

A link to Utah's 2014 (Children) and 2015 (Adults) Consumer Assessment of Health Plans Survey (CAHPS) is included with this request for renewal. (**Attachment 8**)

Section 9: Future Possible Amendments

After approval of the demonstration application, the State of Utah intends to pursue an amendment seeking flexibility to direct a portion of the demonstration savings into a pool to fund delivery system reforms. These reforms will be aligned and designed to:

- Facilitate the construction of a system of integrated care;
- Help expedite the transformation of Utah Medicaid fee-for-service and managed care reimbursement methodologies to alternative and value based payment arrangements; and

- Improve care quality and the efficiency of care provided to Medicaid and other patients.

Before submitting such an amendment, the State will seek guidance from CMS on the design of the program and conduct a robust public education and input process. At this time, the State envisions that a significant portion of this initiative will be funded through IGTs from the University of Utah Health Care (UUHC) system, the State's academic medical center, and other governmental entities.

ATTACHMENT 1

Compliance with Budget Neutrality Requirements

1115 PCN Waiver Demonstration

I. CALCULATION OF BUDGET NEUTRALITY LIMIT (Without Waiver Ceiling)

A	C	D	E	F	G	H	I	J	K	L
				Member Months				Budget Neutrality		Budget Neutrality
		SFY15-DY13	----------				----------	Limit DY 13	Effective FMAP	Limit DY 13
	CMS Inflation Factor	PM/PM	QE 9/14	QE 12/14	QE 3/15	QE 6/15	Total	(TF)	(Blended for SFY)	(FF)
								Total Funds		**Federal Funds**
Current Eligibles	1.05	$853.46	95,284	91,358	93,841	97,315	377,798	$322,434,073	70.50%	$227,316,021
1902(r)(2) - PCN	1.05	$118.46	20,080	26,504	24,108	17,915	88,607	$10,496,261	70.50%	$7,399,864
1902(r)(2) - HIFA	1.05	$241.86	670	851	1,176	1,252	3,949	$955,116	70.50%	$673,357
						Total BN Limit		$333,885,450	70.50%	$235,389,242

				Member Months				Budget Neutrality		Budget Neutrality
		SFY16-DY14	----------				----------	Limit DY 14	Effective FMAP	Limit DY 14
		PM/PM	QE 9/15	QE 12/15	QE 3/16	QE 6/16	Total	(TF)	(Blended for SFY)	(FF)
								Total Funds		**Federal Funds**
Current Eligibles	1.05	$896.13	98,561	97,701	94,450	94,450	385,161	$345,153,975	70.32%	$242,712,275
1902(r)(2) - PCN	1.05	$124.38	17,145	21,301	22,152	22,152	82,750	$10,292,509	70.32%	$7,237,692
1902(r)(2) - HIFA	1.05	$253.96	1,358	1,469	987	987	4,802	$1,219,369	70.32%	$857,461
						Total BN Limit		$356,665,853	70.32%	$250,807,428

				Member Months				Budget Neutrality		Budget Neutrality
		SFY17-DY15	----------				----------	Limit DY 15	Effective FMAP	Limit DY 15
		PM/PM	QE 9/16	QE 12/16	QE 3/17	QE 6/17	Total	(TF)	(Blended for SFY)	(FF)
								Total Funds		**Federal Funds**
Current Eligibles	1.05	$940.94	94,450	94,450	94,450	94,450	377,798	$355,483,565	69.98%	$248,767,399
1902(r)(2) - PCN	1.05	$130.60	22,152	22,152	22,152	22,152	88,607	$11,572,127	69.98%	$8,098,175
PCN II *	1.05	$120.83	New Waiver Extension Begins-->		21,386	21,386	42,771	$5,168,054	69.98%	$3,616,604
1902(r)(2) - HIFA	1.05	$266.65	987	987	987	987	3,949	$1,053,016	69.98%	$736,900
Current Eligibles II **	1.05	$373.16	New Waiver Extension Begins-->		10,500	10,500	21,000	$7,836,360	69.98%	$5,483,885
Adult Expansion ***	1.05	$932.89	New Waiver Extension Begins-->		19,500	19,500	39,000	$36,382,710	69.98%	$25,460,620
						Total BN Limit		$417,495,832	69.98%	$292,163,583

				Member Months				Budget Neutrality		Budget Neutrality
		SFY18-DY16	----------				----------	Limit DY 16	Effective FMAP	Limit DY 16
		PM/PM	QE 9/17	QE 12/17	QE 3/18	QE 6/18	Total	(TF)	(Blended for SFY)	(FF)
								Total Funds		**Federal Funds**
Current Eligibles	1.05	$987.98	94,450	94,450	94,450	94,450	377,798	$373,257,743	69.79%	$260,496,579
1902(r)(2) - PCN	1.05	$137.13	22,152	22,152	22,152	22,152	88,607	$12,150,734	69.79%	$8,479,997
PCN II *	1.05	$126.87	21,386	21,386	21,386	21,386	85,542	$10,852,913	69.79%	$7,574,248
1902(r)(2) - HIFA	1.05	$279.99	987	987	987	987	3,949	$1,105,666	69.79%	$771,645
Current Eligibles II **	1.05	$391.82	10,500	10,500	10,500	10,500	42,000	$16,456,356	69.79%	$11,484,891
Adult Expansion ***	1.05	$979.53	19,500	19,500	19,500	19,500	78,000	$76,403,691	69.79%	$53,322,136
						Total BN Limit		$490,227,104	69.79%	$342,129,496

				Member Months				Budget Neutrality		Budget Neutrality
		SFY19-DY17	----------				----------	Limit DY 17	Effective FMAP	Limit DY 17
		PM/PM	QE 9/18	QE 12/18	QE 3/19	QE 6/19	Total	(TF)	(Blended for SFY)	(FF)
								Total Funds		**Federal Funds**
Current Eligibles	1.05	$1,037.38	94,450	94,450	94,450	94,450	377,798	$391,920,631	69.79%	$273,521,408
1902(r)(2) - PCN	1.05	$143.99	22,152	22,152	22,152	22,152	88,607	$12,758,271	69.79%	$8,903,997
PCN II *	1.05	$133.22	21,386	21,386	21,386	21,386	85,542	$11,395,559	69.79%	$7,952,961
1902(r)(2) - HIFA	1.05	$293.99	987	987	987	987	3,949	$1,160,950	69.79%	$810,227
Current Eligibles II **	1.05	$411.41	10,500	10,500	10,500	10,500	42,000	$17,279,174	69.79%	$12,059,135
Adult Expansion ***	1.05	$1,028.51	19,500	19,500	19,500	19,500	78,000	$80,223,876	69.79%	$55,988,243
						Total BN Limit		$514,738,459	69.79%	$359,235,971

				Member Months				Budget Neutrality		Budget Neutrality
		SFY20-DY18	----------				----------	Limit DY 18	Effective FMAP	Limit DY 18
		PM/PM	QE 9/19	QE 12/19	QE 3/20	QE 6/20	Total	(TF)	(Blended for SFY)	(FF)
								Total Funds		**Federal Funds**
Current Eligibles	1.05	$1,089.25	94,450	94,450	94,450	94,450	377,798	$411,516,662	69.79%	$287,197,479
1902(r)(2) - PCN	1.05	$151.19	22,152	22,152	22,152	22,152	88,607	$13,396,184	69.79%	$9,349,197
PCN II *	1.05	$139.88	21,386	21,386	21,386	21,386	85,542	$11,965,337	69.79%	$8,350,609
1902(r)(2) - HIFA	1.05	$308.69	987	987	987	987	3,949	$1,218,997	69.79%	$850,738
Current Eligibles II **	1.05	$431.98	10,500	10,500	10,500	10,500	42,000	$18,143,132	69.79%	$12,662,092
Adult Expansion ***	1.05	$1,079.94	19,500	19,500	19,500	19,500	78,000	$84,235,069	69.79%	$58,787,655
						Total BN Limit		$540,475,382	69.79%	$377,197,769

				Member Months				Budget Neutrality		Budget Neutrality
		SFY21-DY19	----------				----------	Limit DY 18	Effective FMAP	Limit DY 18
		PM/PM	QE 9/20	QE 12/20	QE 3/21	QE 6/21	Total	(TF)	(Blended for SFY)	(FF)
								Total Funds		**Federal Funds**
Current Eligibles	1.05	$1,143.71	94,450	94,450	94,450	94,450	377,798	$432,092,495	69.79%	$301,557,352
1902(r)(2) - PCN	1.05	$158.75	22,152	22,152	22,152	22,152	88,607	$14,065,993	69.79%	$9,816,657
PCN II *	1.05	$146.87	21,386	21,386	21,386	21,386	85,542	$12,563,604	69.79%	$8,768,139
1902(r)(2) - HIFA	1.05	$324.12	987	987	987	987	3,949	$1,279,947	69.79%	$893,275
Current Eligibles II **	1.05	$453.58	10,500	10,500	10,500	10,500	42,000	$19,050,289	69.79%	$13,295,197
Adult Expansion ***	1.05	$1,133.93	19,500	19,500	19,500	19,500	78,000	$88,446,823	69.79%	$61,727,038
						Total BN Limit		$567,499,151	69.79%	$396,057,658

				Member Months				Budget Neutrality		Budget Neutrality
		SFY22-DY20	----------				----------	Limit DY 18	Effective FMAP	Limit DY 18
		PM/PM	QE 9/21	QE 12/21	<------End of Waiver Extension		Total	(TF)	(Blended for SFY)	(FF)
								Total Funds		**Federal Funds**
Current Eligibles	1.05	$1,200.90	94,450	94,450			188,899	$226,848,560	69.79%	$158,317,610
1902(r)(2) - PCN	1.05	$166.68	22,152	22,152			44,304	$7,384,646	69.79%	$5,153,745
PCN II *	1.05	$154.21	21,386	21,386			42,771	$6,595,892	69.79%	$4,603,273
1902(r)(2) - HIFA	1.05	$340.33	987	987			1,975	$671,972	69.79%	$468,969
Current Eligibles II **	1.05	$476.26	10,500	10,500			21,000	$10,001,402	69.79%	$6,979,978
Adult Expansion ***	1.05	$1,190.63	19,500	19,500			39,000	$46,434,582	69.79%	$32,406,695
						Total BN Limit		$297,937,054	69.79%	$207,930,270

* SFY2015 Costs/Member Months used as a proxy for PCN II PMPM
** Milliman's PMPM estimate for Current Eligibles - 5/5/16
*** Milliman's PMPM estimate for Adult Expansion - 5/5/16
= Neutrality Limit without waiver ceiling
= Actual Member Months
= Estimated Member Months

II. WAIVER COSTS AND VARIANCE FROM BUDGET NEUTRALITY LIMIT BY QUARTER (Federal Funds)

A	B	C	D	E	F	G	H	I	J	K	L
					EXPENDITURES (Federal Funds)						
		Current Eligibles	**Demo Population I - PCN**		**Demo Population II**	**Demo Population III - HIFA**					
			Adults w/ Children	**Childless Adults**		**Adults w/ Children**	**Childless Adults**	**Current Eligibles II**	**Adult Expansion**		
	BUDGET NEUTRALITY LIMIT (FF)	(Sections 1925 and 1931 Adults and Medically Needy Adults)	(Section 1902(r)(2) Adults; also Known as Hypothetical State Plan Eligibles	(PCN Adults in Demo Population I = 1115)	(High-Risk Pregnant Women = 1115)	(Section 1902(r)(2) Adults; also Known as Hypothetical State Plan Eligibles	(HIFA Adults in Demo Population III = 1115 Expansion Group)	(Adults w/ Children 41-55% FPL)	(Childless Adults 0% FPL)		
State Fiscal Year (SFY)- Demonstration Year (DY)										**TOTAL**	**VARIANCE**
SFY15-DY13	$235,389,242	$121,818,957	$3,680,770	$9,038,162	$17,994	$340,914	$10,048			$134,906,845	$100,482,397
	QE 9/14	$28,420,265	$757,709	$2,117,542	$13,523	$58,794	$2,315			$31,370,148	
	QE 12/14	$32,199,953	$1,035,542	$2,615,201	$4,226	$73,983	$2,295			$35,931,200	
	QE 3/15	$28,594,171	$1,153,257	$2,481,997	$185	$100,649	$2,499			$32,332,758	
	QE 6/15	$32,089,293	$750,034	$1,866,826	$60	$110,888	$2,939			$34,820,040	
SFY16-DY14	$250,807,428	$120,144,539	$2,711,921	$5,891,357	$6,026	$435,525	$9,707			$129,199,074	$121,608,354
	QE 9/15	$30,564,749	$637,704	$1,630,248	$21	$115,928	$2,811			$32,951,461	
	QE 12/15	$29,217,735	$472,101	$517,878	$0	$124,637	$1,957			$30,334,308	
	QE 3/16	$30,181,028	$801,058	$1,871,615	$3,003	$97,480	$2,469			$32,956,653	
	QE 6/16	$30,181,028	$801,058	$1,871,615	$3,003	$97,480	$2,469			$32,956,653	
SFY17-DY15	$292,163,583	$126,151,766	$2,847,517	$6,185,925	$6,327	$457,301	$10,192	$5,485,452	$25,467,897	$166,612,377	$125,551,207
	QE 9/16	$31,537,942	$711,879	$1,546,481	$1,582	$114,325	$2,548			$33,914,757	
	QE 12/16	$31,537,942	$711,879	$1,546,481	$1,582	$114,325	$2,548			$33,914,757	
	QE 3/17	$31,537,942	$711,879	$1,546,481	$1,582	$114,325	$2,548	$2,742,726	$12,733,949	$49,391,431	
	QE 6/17	$31,537,942	$711,879	$1,546,481	$1,582	$114,325	$2,548	$2,742,726	$12,733,949	$49,391,431	
SFY18-DY16	$342,129,496	$132,459,355	$2,989,893	$6,495,221	$6,644	$480,166	$10,702	$11,519,449	$53,482,584	$207,444,012	$134,685,484
	QE 9/17	$33,114,839	$747,473	$1,623,805	$1,661	$120,041	$2,675	$2,879,862	$13,370,646	$51,861,003	
	QE 12/17	$33,114,839	$747,473	$1,623,805	$1,661	$120,041	$2,675	$2,879,862	$13,370,646	$51,861,003	
	QE 3/18	$33,114,839	$747,473	$1,623,805	$1,661	$120,041	$2,675	$2,879,862	$13,370,646	$51,861,003	
	QE 6/18	$33,114,839	$747,473	$1,623,805	$1,661	$120,041	$2,675	$2,879,862	$13,370,646	$51,861,003	
SFY19-DY17	$359,235,971	$139,082,322	$3,139,387	$6,819,982	$6,976	$504,174	$11,237	$12,095,422	$56,156,713	$217,816,213	$141,419,758
	QE 9/18	$34,770,581	$784,847	$1,704,995	$1,744	$126,044	$2,809	$3,023,855	$14,039,178	$54,454,053	
	QE 12/18	$34,770,581	$784,847	$1,704,995	$1,744	$126,044	$2,809	$3,023,855	$14,039,178	$54,454,053	
	QE 3/19	$34,770,581	$784,847	$1,704,995	$1,744	$126,044	$2,809	$3,023,855	$14,039,178	$54,454,053	
	QE 6/19	$34,770,581	$784,847	$1,704,995	$1,744	$126,044	$2,809	$3,023,855	$14,039,178	$54,454,053	
SFY20-DY18	$377,197,769	$146,036,438	$3,296,357	$7,160,981	$7,325	$529,383	$11,799	$12,700,193	$58,964,549	$228,707,023	$148,490,746
	QE 9/19	$36,509,110	$824,089	$1,790,245	$1,831	$132,346	$2,950	$3,175,048	$14,741,137	$57,176,756	
	QE 12/19	$36,509,110	$824,089	$1,790,245	$1,831	$132,346	$2,950	$3,175,048	$14,741,137	$57,176,756	
	QE 3/20	$36,509,110	$824,089	$1,790,245	$1,831	$132,346	$2,950	$3,175,048	$14,741,137	$57,176,756	
	QE 6/20	$36,509,110	$824,089	$1,790,245	$1,831	$132,346	$2,950	$3,175,048	$14,741,137	$57,176,756	
SFY21-DY19	$396,057,658	$153,338,260	$3,461,174	$7,519,030	$7,691	$555,852	$12,388	$13,335,202	$61,912,776	$240,142,374	$155,915,283
	QE 9/20	$38,334,565	$865,294	$1,879,757	$1,923	$138,963	$3,097	$3,333,801	$15,478,194	$60,035,594	
	QE 12/20	$38,334,565	$865,294	$1,879,757	$1,923	$138,963	$3,097	$3,333,801	$15,478,194	$60,035,594	
	QE 3/21	$38,334,565	$865,294	$1,879,757	$1,923	$138,963	$3,097	$3,333,801	$15,478,194	$60,035,594	
	QE 6/21	$38,334,565	$865,294	$1,879,757	$1,923	$138,963	$3,097	$3,333,801	$15,478,194	$60,035,594	
SFY22-DY20	$207,930,270	$80,502,587	$1,817,117	$3,947,491	$4,038	$291,822	$6,504	$7,000,981	$32,504,207	$126,074,747	$81,855,524
	QE 9/21	$40,251,293	$908,558	$1,973,745	$2,019	$145,911	$3,252	$3,500,491	$16,252,104	$63,037,373	
	QE 12/21	$40,251,293	$908,558	$1,973,745	$2,019	$145,911	$3,252	$3,500,491	$16,252,104	$63,037,373	
	End of Waiver Extension										
											Cummulative savings in federal funds at the end of waiver extension 12/31/2021
TOTAL BUDGET NEUTRALITY LIMIT SFY 2003-2022	$4,036,008,502									$2,625,707,591	$1,410,300,911

Legend
- = Estimated Figures
- = Neutrality Limit without waiver ceiling
- = Actual Expenditures from MBES/CBES reports including prior period adjustments
- = Actual Quarterly Expenditures from MBES/CBES reports with no prior period adjustments

III. SUMMARY BY DEMONSTRATION YEAR AND CUMULATIVELY (Federal Funds)

A	B	C	D	E	F	G	H	I
Demostration Year (DY)	Budget Neutrality Limit	Waiver Costs on CMS-64	Annual Variance	Variance As % of Annual BN Limit	Cumulative Budget Neutrality Limit	Cumulative Waiver Costs on CMS-64	Cumulative Variance	Variance As % of Cumulative BN Limit
DY #1 (SFY 2003)	$64,151,353	$68,519,660	-$4,368,307	-6.81%	$64,151,353	$68,519,660	-$4,368,307	-6.81%
DY #2 (SFY 2004)	$80,491,312	$77,006,658	$3,484,654	4.33%	$144,642,666	$145,526,318	-$883,652	-0.61%
DY #3 (SFY 2005)	$94,403,172	$90,341,017	$4,062,155	4.30%	$239,045,838	$235,867,335	$3,178,503	1.33%
DY #4 (SFY 2006)	$97,638,785	$87,381,267	$10,257,518	10.51%	$336,684,622	$323,248,602	$13,436,020	3.99%
DY #5 (SFY 2007)	$86,958,239	$85,043,219	$1,915,020	2.20%	$423,642,861	$408,291,821	$15,351,040	3.62%
DY #6 (SFY 2008)	$86,915,636	$83,042,595	$3,873,041	4.46%	$510,558,497	$491,334,416	$19,224,081	3.77%
DY #7 (SFY 2009)	$107,710,583	$98,019,023	$9,691,560	9.00%	$618,269,080	$589,353,439	$28,915,641	4.68%
DY #8 (SFY 2010)	$136,144,532	$118,491,450	$17,653,082	12.97%	$754,413,612	$707,844,889	$46,568,723	6.17%
DY #9 (SFY 2011)	$165,352,483	$113,971,006	$51,381,477	31.07%	$919,766,095	$821,815,895	$97,950,200	10.65%
DY #10 (SFY 2012)	$204,481,176	$103,683,923	$100,797,253	49.29%	$1,124,247,271	$925,499,818	$198,747,453	17.68%
DY #11 (SFY 2013)	$219,132,390	$122,343,993	$96,788,397	44.17%	$1,343,379,661	$1,047,843,811	$295,535,850	22.00%
DY #12 (SFY 2014)	$231,717,424	$126,961,116	$104,756,308	45.21%	$1,575,097,084	$1,174,804,927	$400,292,157	25.41%
DY #13 (SFY 2015)	$235,389,242	$134,906,845	$100,482,397	42.69%	$1,810,486,326	$1,309,711,772	$500,774,554	27.66%
DY #14 (SFY 2016)	$250,807,428	$129,199,074	$121,608,354	48.49%	$2,061,293,754	$1,438,910,846	$622,382,908	30.19%
DY #15 (SFY 2017)	$292,163,583	$166,612,377	$125,551,207	42.97%	$2,353,457,338	$1,605,523,223	$747,934,115	31.78%
DY #16 (SFY 2018)	$342,129,496	$207,444,012	$134,685,484	39.37%	$2,695,586,834	$1,812,967,235	$882,619,599	32.74%
DY #17 (SFY 2019)	$359,235,971	$217,816,213	$141,419,758	39.37%	$3,054,822,805	$2,030,783,447	$1,024,039,357	33.52%
DY #18 (SFY 2020)	$377,197,769	$228,707,023	$148,490,746	39.37%	$3,432,020,574	$2,259,490,470	$1,172,530,103	34.16%
DY #19 (SFY 2021)	$396,057,658	$240,142,374	$155,915,283	39.37%	$3,828,078,232	$2,499,632,845	$1,328,445,387	34.70%
DY #20 (SFY 2022) Only includes 2 qtrs since waiver extension ends 12/31/21	$207,930,270	$126,074,747	$81,855,524	39.37%	$4,036,008,502	$2,625,707,591	$1,410,300,911	34.94%

Legend

= Estimated Figures
= Neutrality Limit without waiver ceiling QTD Amount
= Actual Expenditures 1115 Waivers QTD Amount

ATTACHMENT 2

Program Evaluation

Evaluation of Utah's 1115 Demonstration Waiver

Primary Care Network, High-Risk Pregnancy, and Utah's Premium Partnership

Prepared: December 20, 2012

Updated: April 22, 2016

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Hypothesis 1: The demonstration will not negatively impact the overall well-being, in relation to health status, of Current Eligibles (Non-Traditional Medicaid) who experience reduced benefits and increased cost sharing. 10

Hypothesis 2a: The demonstration will improve well-being in Utah by reducing the number of Utahns without coverage for primary health care. 11

Hypothesis 2b: The demonstration will improve well-being in Utah by improving PCN enrollees' access to primary care. 13

Hypothesis 2c: The demonstration will improve well-being in Utah by improving the overall well-being in the health status of PCN enrollees. 14

Hypothesis 3: The demonstration will reduce the number of unnecessary visits to emergency departments by PCN enrollees. 16

Hypothesis 4: The demonstration will increase the number of prenatal visits for High-Risk pregnancies in comparison to the general population. 18

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Hypothesis 6: The demonstration will assist individuals currently eligible for or enrolled in COBRA with monthly premium reimbursement to help reduce the number of uninsured while reducing the rate of uninsurance. 21

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Information about the Demonstration

Title: Primary Care Network
Awardee: Utah Department of Health
Timeline:

December 11, 2001	Waiver submitted
February 8, 2002	Approved
July 1, 2002	Implemented
June 30, 2007	Original expiration date
June 30, 2010	Extension expiration date
June 30, 2013	Extension expiration date
December 31, 2014	Extension expiration date
December 31, 2015	Extension expiration date
December 31, 2016	Extension expiration date

A Brief History of the Demonstration

Utah's 1115 waiver is a statewide demonstration to cover previously uninsured individuals through alternative benefit packages. This demonstration uses increased flexibility with current State plan Eligibles to fund a Medicaid expansion for uninsured adults age 19 to 64 with incomes up to 95 percent of the Federal Poverty Level (FPL) with the 5 % income disregard. It is known as the Primary Care Network (PCN) and also includes coverage for High-Risk pregnant women.

The demonstration also provides an employer-sponsored health insurance option for uninsured adults and children with incomes up to 200 percent of the FPL. This option is known as Utah's Premium Partnership for Health Insurance (UPP). A parent with a child eligible for the Children's Health Insurance Program (CHIP) can elect to enroll that child in UPP if the parent has a qualified plan through work.

In addition, the demonstration includes an insurance subsidy option for uninsured adults and children (up to 200 percent FPL) who are eligible for coverage under COBRA.

The original Utah 1115 waiver was submitted on December 11, 2001, approved on February 8, 2002, implemented on July 1, 2002, and was originally scheduled to expire on June 30, 2007. On December 21, 2006, the waiver was extended through June 30, 2010. On June 23, 2010, the waiver was extended through June 30, 2013. One-year extensions were granted for the next three years, with the most current extension set to expire on December 31, 2016.

Prior to the demonstration, Utah was providing a limited-benefit program for otherwise uninsured adults through the Utah Medical Assistance Program (UMAP). Coverage for UMAP adults was generally provided with 100 percent state funds. At the time of the

waiver's implementation, the UMAP adults were enrolled in PCN and UMAP was discontinued.

Population Groups Impacted

Current Eligibles: This demonstration includes some modifications to benefits received by currently eligible "Non-Traditional Medicaid" clients

Demonstration Population #1 – PCN enrollees: Previously uninsured parents and adults without dependent children who enroll in this limited benefit program.

Demonstration Population #2 – Pregnant women with High-Risk pregnancies: Previously uninsured women who face a $5,000 asset copay to enroll in traditional Medicaid.

Note: The $5,000 asset copay requirement was removed in SFY 2014 effectively discontinuing the High-Risk Pregnancy aid category.

Demonstration Population #3 – UPP adults: Previously uninsured parents and adults without dependent children who use the premium subsidy to enroll in private, employer-sponsored health insurance.

Demonstration Population #4 – Current eligible CHIP Children: UPP children - Previously uninsured children who use the premium subsidy to enroll in private, employer-sponsored health insurance.

Demonstration Population #5 – UPP adults: Previously uninsured parents and adults without dependent children who use the premium subsidy to enroll in COBRA continuation coverage.

Demonstration Population #6 – COBRA eligible children: previously insured children who use a premium subsidy to enroll in COBRA continuation coverage.

Purposes, aims, objectives, and goals of the demonstration

Overarching strategy, principles, goals, and objectives

The primary strategy for this demonstration is to provide valuable benefits to a greater population by slightly reducing benefits to some currently covered populations. The demonstration is founded on the principle that the highest value health care comes from coverage for primary and preventive care. The goal of the demonstration is to reduce the number of uninsured as well as the rate of uninsurance for Utahns while improving the quality, value and access of care received by beneficiaries.

To show that value can be added to the system without increasing costs by shifting some resources from fully indemnified populations to populations that currently have no health care coverage. In addition, the demonstration seeks to increase health insurance coverage without directly providing the coverage through government-managed programs.

State's hypotheses on outcomes of the demonstration

There are five hypotheses in this demonstration that will be evaluated

Hypothesis #1: The demonstration will not negatively impact the overall health well-being of Current Eligibles who experience reduced benefits and increased cost sharing.

Hypothesis #2: The demonstration will improve well-being in Utah by:

a. Reducing the number of Utahns without coverage for primary health care.
b. Improving PCN enrollees' access to primary care.
c. Improving the overall well-being in the health status of PCN enrollees.

Hypothesis #3: The demonstration will reduce the number of unnecessary visits to emergency departments by PCN enrollees.

Hypothesis #4: The demonstration will increase the number of prenatal visits for High-Risk pregnancies in comparison to the general population.

Hypothesis #5: The demonstration will assist previously uninsured individuals in obtaining employer-sponsored health insurance without causing a decrease in employers' contributions to premiums that is greater than any decrease in contributions in the overall health insurance market.

Hypothesis #6: The demonstration will assist individuals currently eligible for or enrolled in COBRA with monthly premium reimbursement to help reduce the number of uninsured while reducing the rate of uninsurance.

Key interventions planned

Implementation and administration of the Primary Care Network program PCN Expansion

Implementation and administration of the Utah's Premium Partnership Program (UPP) for both employer-sponsored insurance and COBRA continuation coverage.

Implementation and administration of the High-Risk Pregnancy Program.

Evaluation Design

General Approach to Evaluation

Data Sources

Claims Data: The State has access to claims data for PCN and High-Risk pregnancy enrollees through the State's Fee for Service system. We will use that data to monitor utilization patterns and costs. The State also has access to claims data for Current Eligibles who are affected by this demonstration. However, it should be noted that Current Eligibles in Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, and Weber counties are enrolled in managed care. Therefore some data on Current Eligibles may not be immediately comparable to that in the State's system.

Outcome Tracking Data: Specialty, charitable care is not an included benefit in the PCN demonstration. Primary care providers may contact PCN administration and request a referral for specialty care. Charitable Care Coordinators endeavor to fill this gap by seeking donated charitable care from providers and institutions. Outcomes of these endeavors are tracked and summarized.

Behavioral Risk Factor Surveillance System: The report is a summary of 2014 Health Insurance Analysis from the Behavioral Risk Factor Surveillance System (BRFSS). This survey is conducted on all states and territories in partnership with the Centers for Disease Control (CDC). Data has been collect in Utah since 1984. Estimates are based on a sample of Utah residents by interviews conducted in English and Spanish via both landline and cell phone. The health insurance questions asked of 7,385 adults about their health insurance coverage at the time of the interview.

Public Health Indicator Based Information System (IBIS): This website gives an overview of the types of data that the Utah Department of Health's Center for Health Data and Informatics provides. Data includes: publications; indicator reports, including public health outcome measures; dataset queries; links and online help; as well as phone and email support.

Comparison groups

Where possible, the State will compare PCN enrollee utilization and health status to similar populations within traditional Medicaid and Non-Traditional Medicaid.

Timelines for Completing and Delivering Elements of the Evaluation

Draft Evaluation Report: April 30, 2016.

Final Evaluation Report: Within 60 days after receipt of CMS feedback on the Draft Report.

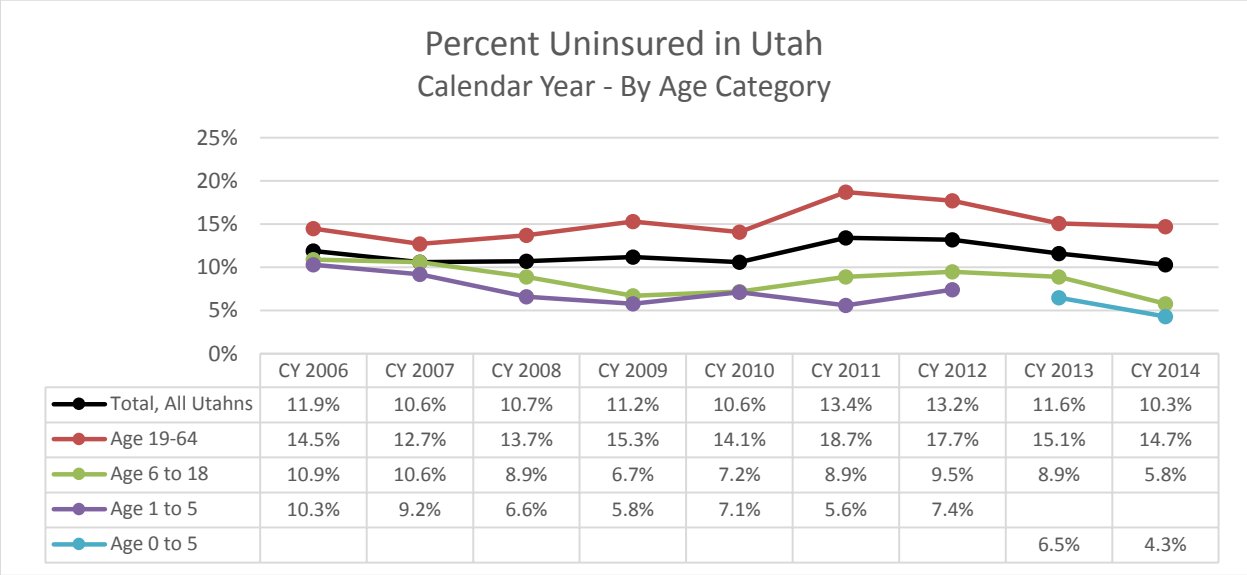
Plan for Analysis

1. Evaluation of performance of the demonstration.
2. Report outcomes.
3. Identify limitations, challenges and opportunities.
4. Identify successes and best practices.
5. Revise strategies or goals.
6. Develop recommendations and implication at the state and federal levels.

Introduction

Historically, Utahns age 19 to 64 have the highest rate of uninsurance in the state.

In calendar year 2014 (the most recent data available), nearly three times as many Utahns age 19 to 64 (14.7 percent) were uninsured. This is for all adults age 19 to 64 regardless of income level or employment stats. By contrast, just 4.3 percent of children age 0 to 5 and 5.8 percent of adolescents age 6 to 18 were uninsured. See Figure 1.



	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Total, All Utahns	11.9%	10.6%	10.7%	11.2%	10.6%	13.4%	13.2%	11.6%	10.3%
Age 19-64	14.5%	12.7%	13.7%	15.3%	14.1%	18.7%	17.7%	15.1%	14.7%
Age 6 to 18	10.9%	10.6%	8.9%	6.7%	7.2%	8.9%	9.5%	8.9%	5.8%
Age 1 to 5	10.3%	9.2%	6.6%	5.8%	7.1%	5.6%	7.4%		
Age 0 to 5								6.5%	4.3%

Figure 1. Summary of 2014 Health Insurance Analysis from the Behavioral Risk Factor Surveillance System (BRFSS), https://ibis.health.utah.gov/pdf/opha/publication/ins/InsHighlights_2014.pdf.

According to the 2014 Health Insurance Analysis from the Behavioral Risk Surveillance System, 18.7 percent of all Utahns age 19-64 declared that they were uninsured in 2011. During that same year (CY 2011), 41.3 percent of Utahns with a household income below 150 percent FPL were uninsured (see Figure 5 on page 13). Overall, uninsurance rates have improved in CY 2014, the percent of uninsured among all Utahns age 19-64 dropped 4.0 points to 14.7 percent; the uninsured rate dropped 13.5 points for Utahns age 19-64 with a household income below 150 percent FPL to 27.8 percent.

Utah's Primary Care Network (PCN) was designed to serve adults in this low-income category, specifically those with an annual household income up to 95 percent of the FPL, by offering limited benefits to cover their day-to-day needs and to encouraging them to use the health care system appropriately. The basic goal of PCN is to serve a larger percentage of this income group with basic benefits than could be served if the coverage were more comprehensive.

During the past ten years (SFY 2006 to SFY 2015), Utah's PCN has served 93,319 distinct individuals, with an average of 25,785 lives being covered each year. See Figure 2.

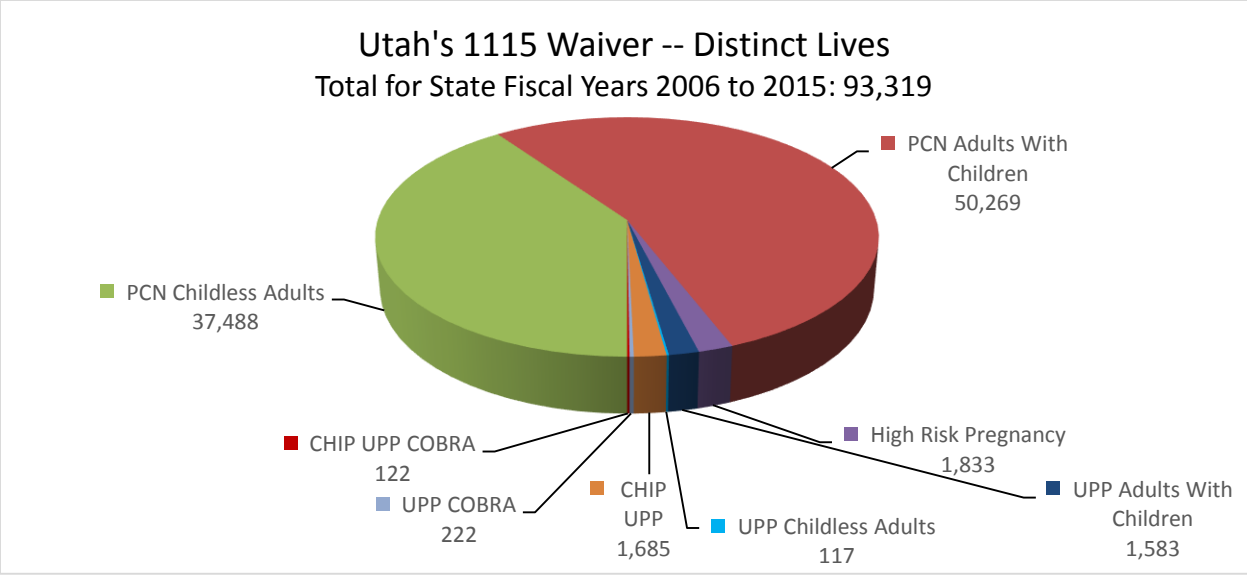


Figure 2 Count of distinct lives enrolled by Utah's 1115 Demonstration Waiver using SFY 2006 to SFY 2015 enrollment data from the Medicaid Data Warehouse. Each individual is counted only once within the aggregate.

Over half of the people served by Utah's 1115 Waiver in the past ten years (54 percent) are adults with children. Childless adults account for 40 percent. The remaining six aid categories comprise six percent of the total lives served by Utah's 1115 Waiver.

Services offered to PCN members include: primary care provider visits; four prescriptions per month; dental exams, dental x-rays, cleanings, and fillings; immunizations; an eye exam (no glasses or contacts); routine lab services and x-rays; limited emergency department visits; emergency medical transportation; and birth control.

Overnight hospital stays, MRIs, CT scans, and similar services, as well as visits to specialists such as orthopedists or cardiologists are not covered under PCN. To assist PCN clients who may be in need of non-covered services, a written request may be made by a participant's primary care provider for a PCN Specialty Care Coordinator to assist in finding providers who are willing to donate services or provide treatment for a minimal copay.

Total enrollment fluctuates as applications are only accepted during open enrollment periods, which are held when sufficient resources are available to cover more people. The federal government requires PCN to enroll more adults with children than people without children. Because of this, PCN may schedule separate enrollment times for parents (adults with children) and those without children. To qualify as a parent, the applicant must have children age 18 or younger living at home. Enrollment can be held at any time throughout the year as space becomes available.

The primary source for applicants to learn about Utah's Primary Care Network is from the Department of Workforce Services (DWS) eligibility workers, as applicants are seeking public assistance.

During SFY 2008 and into SFY 2009, the Utah Department of Health made a concerted effort to increase the awareness of PCN among eligibility workers and ultimately likely PCN candidates resulting in peak enrollment during SFY 2009. During that peak (SFY 2009), a total of over 35,250 distinct individuals were served for at least one month during the year. Moreover, the all-time monthly peak enrollment occurred in June of 2009, with 24,405 individuals participating in the Primary Care Network during the month. See Figure 3.

A renewed edcuation effort with DWS was implemented in SFY 2015 resulting in an increase of 1,946 distinct lives from SFY 2014 (22,687) to SFY 2015 (27,633).

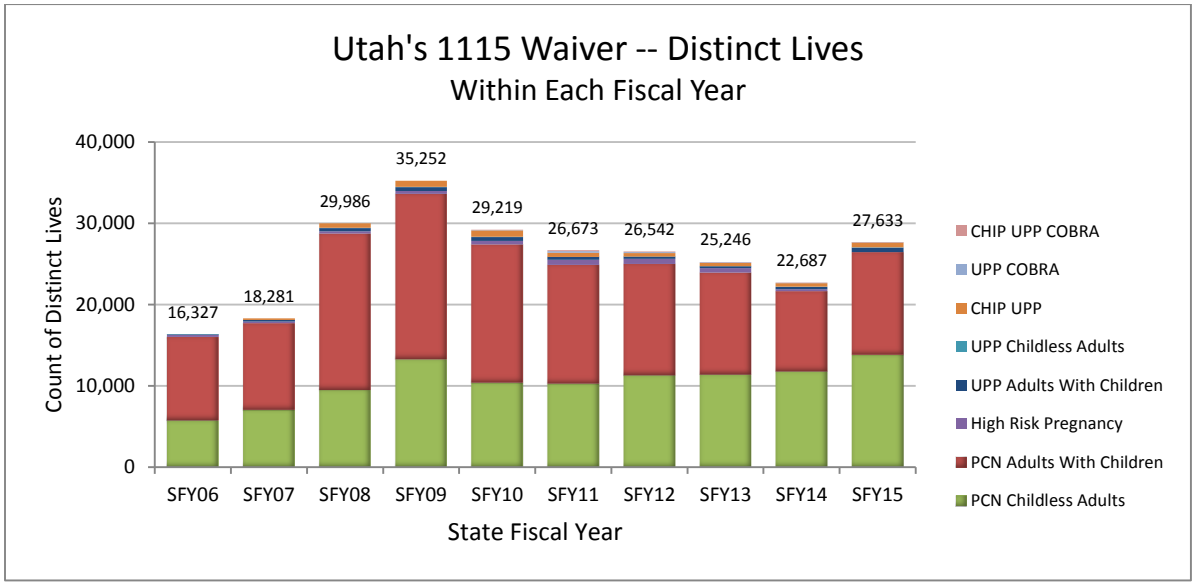


Figure 3. Counts of distinct lives enrolled under Utah's 1115 Demonstration Waiver. Monthly enrollment data is aggregated by state fiscal year from the Medicaid Data Warehouse. "Distinct Lives" counts all individuals enrolled in PCN for at least one month during the fiscal year. An individual is counted only once within each year.

Evaluation of Hypotheses

Hypothesis 1: The demonstration will not negatively impact the overall well-being, in relation to health status, of Current Eligibles (Non-Traditional Medicaid) who experience reduced benefits and increased cost sharing.

According to Medicaid claims data, the rate of Primary Care Network (PCN) recipients who had at least one annual visit with a primary care provider (PCP) peaked at 97 percent in SFY 2006. Non-Traditional Medicaid (NTM) participants with an annual visit to a PCP also peaked in SFY 2006 at 69 percent.

Rates of access to a PCP trended downward for both PCN and NTM from SFY 2006 to SFY 2009. However, with similar rates of decrease for both, one did not adversely affect the other.

During SFY 2009 and SFY 2010, Utah converted to a new eligibility enrollment system resulting in an increase in PCN enrollment. The percent of PCN participants who saw a PCP increased through SFY 2010 (59 percent) and SFY 2011 (68 percent), while NTM participants' rate of seeing a PCP remained steady at 40 percent. Thus the increase in access to care among PCN recipients did not affect the rate of access to care among NTM recipients. See Figure 4.

With the implementation of Accountable Care Organizations (ACO) in SFY 2013, part of the NTM population shifted from Medicaid Fee for Service to the ACOs. Even with this shift, the rate of PCN enrollees who saw a PCP did not adversely affect the rate among NTM enrollees.

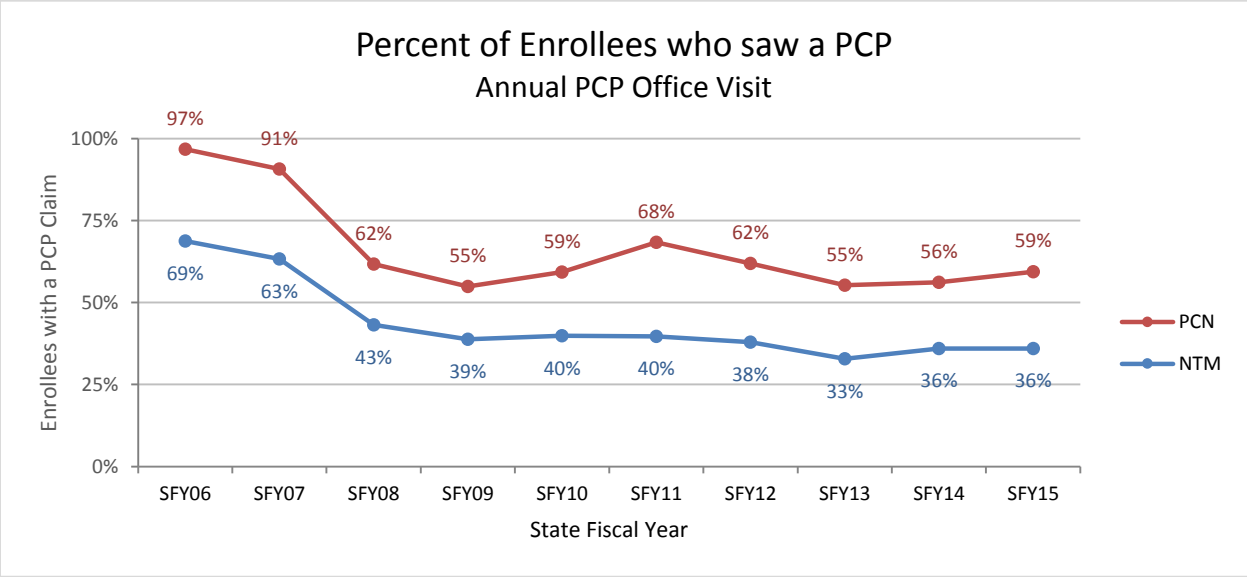


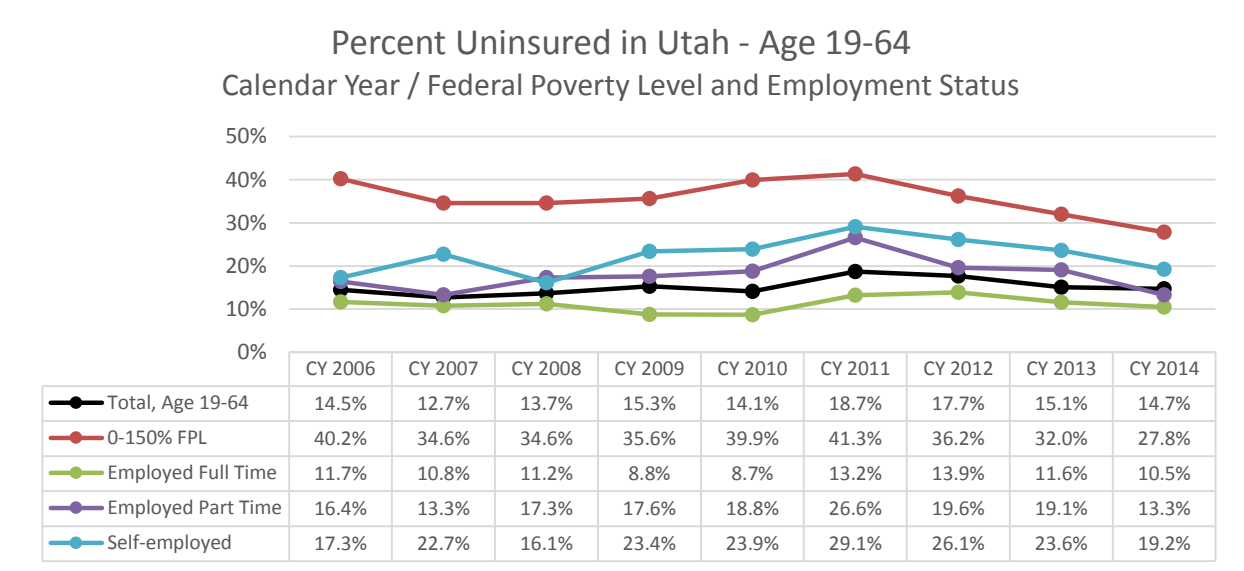
Figure 4. Analysis of claims and encounters from the Medicaid Data Warehouse for PCN and Non-Traditional Medicaid. Claims contained the following Current Procedural Terminology (CPT) billing codes: 99201-99205, 99211-99215, 99381-99385, 99391-99395, 99241-99245, 99354, 99355, G0438, G0439, and/or S5190.

Hypothesis 2a: The demonstration will improve well-being in Utah by reducing the number of Utahns without coverage for primary health care.

According to the Behavioral Risk Surveillance Risk System (BRFSS), the percent of Utahns without health insurance increased among all adults age 19 to 64 between calendar year (CY) 2008 and CY 2011. This increase in uninsurance affected not only the PCN target group—those at 0-150 percent FPL—but the three major employment groups as well: full-time, part-time, and self-employed.

Since CY 2011, uninsurance among Utahns age 19 to 64 has been steadily declining, most markedly among those at 0-150 percent FPL. In CY 2011, 41.3 percent of those with 0-150 percent FPL were uninsured, the highest percentage in the years covered by this study, 0.9 points higher than the previous high in 2006 (40.2 percent). Three years later in CY 2014, the rate among this low-income group had dropped 13.5 points to 27.8 percent, the lowest rate of uninsurance measured in this category during the nine years of data available for by this study.

During this same time period (CY 2011 to CY 2014), the rate of uninsurance for adults employed part time was cut in half (a decrease of 13.3 points; CY 2011: 26.6 percent to 2014: 13.3 percent). Uninsurance for self-employed adults declined 9.9 points from its high (CY 2011: 29.1 percent to CY 2014: 19.2 percent). The uninsurance rate among Utahns age 19-64 employed full time also improved, down 2.7 points from its high of 13.2 percent in CY 2011 to 10.5 percent in CY 2014. Overall, the rate of uninsurance among all Utahns age 19-64 declined 4.0 points from 18.7 percent in CY 2011 to 14.7 percent in CY 2014. See Figure 5.



	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Total, Age 19-64	14.5%	12.7%	13.7%	15.3%	14.1%	18.7%	17.7%	15.1%	14.7%
0-150% FPL	40.2%	34.6%	34.6%	35.6%	39.9%	41.3%	36.2%	32.0%	27.8%
Employed Full Time	11.7%	10.8%	11.2%	8.8%	8.7%	13.2%	13.9%	11.6%	10.5%
Employed Part Time	16.4%	13.3%	17.3%	17.6%	18.8%	26.6%	19.6%	19.1%	13.3%
Self-employed	17.3%	22.7%	16.1%	23.4%	23.9%	29.1%	26.1%	23.6%	19.2%

Figure 5. Summary of 2014 Health Insurance Analysis from the Behavioral Risk Factor Surveillance System (BRFSS), https://ibis.health.utah.gov/pdf/opha/publication/ins/InsHighlights_2014.pdf

In CY 2010, the gap in uninsurance between Utahns employed full time (8.7 percent) and those in the 0-150 percent FPL group (39.9 percent) was at its widest with 31.2 percentage points

separating the two groups. In CY 2014, with a 17.3 point gap between those employed full time (10.5 percent) and Utahns in the 0-150 percent FPL group (27.8 percent), not only is the gap is now at its narrowest, it also marks the only uninsurance rate for the 0-150 percent FPL group that is under 30 percent in the years covered by this data.

It is postulated that improved (lower) rate of uninsurance in the target group is due, at least in part, to the availability of PCN insurance.

Hypothesis 2b: The demonstration will improve well-being in Utah by improving PCN enrollees' access to primary care.

The PCN benefit covers four prescriptions each month or a maximum of 48 per year. The number of prescriptions is not limited in the Traditional Medicaid and Non-Traditional Medicaid programs.

Within the PCN population, Childless Adults have accessed a greater number of prescription medications annually on average than Adults with Children with the highest average number of prescriptions being 22.1 (Childless Adults) in SFY 2006. The highest average among Adults with Children is 9.8 in SFY 2007. While there are certainly PCN recipients who are using their maximum number of annual prescriptions, the average number of prescriptions claimed for Childless adults is 13.5 (average of SFY 2006 to SFY 2015) and 6.9 for Adults with Children. Both of these rates are well below the maximum of 48 allowed each year indicating that overall PCN recipients do have adequate access to prescription medications. See Figure 6.

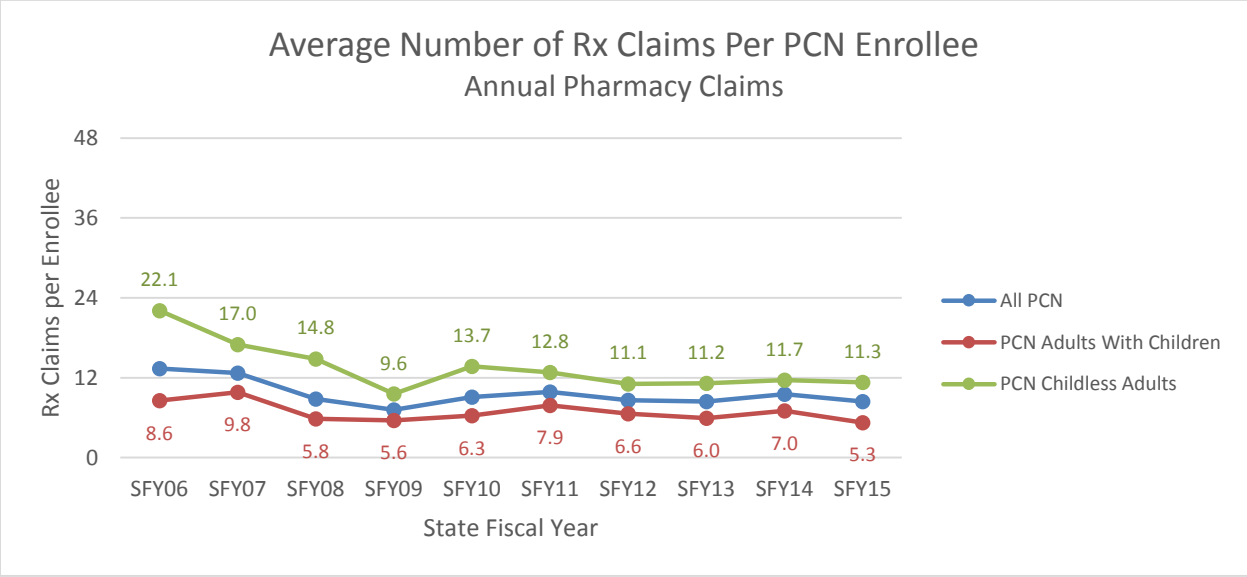


Figure 6. From the Medicaid Data Warehouse: annually, this measures the total number of pharmacy claims divided by the total number of enrollees for PCN Adults with Children and for PCN Childless Adults.

Through PCN, approximately 25,785 individual lives annually since SFY 2006 have been improved by having access to basic primary medical care and a limited number of prescriptions. This is coverage that is not available through any other source for this group of people.

Hypothesis 2c: The demonstration will improve well-being in Utah by improving the overall well-being in the health status of PCN enrollees.

As a primary care program, PCN does not cover inpatient hospital services such as surgery or overnight hospital stays. If it is determined that a client needs to stay in the hospital for more than 24 hours, the client needs to contact the hospital's billing office to determine eligibility for the hospital's charity care program. Likewise, specialty care services such as cardiology, gastroenterology, etc. are not a covered by PCN. However, with a written referral that includes clinical notes from a primary care provider (PCP), PCN Specialty Care Coordinators are committed to assisting with a search for donated services at little or no cost to the client.

From January 2006 to December 2015, PCN Specialty Care Coordinators received a total of 19,190 referrals for specialty care from PCPs. The Care Coordinators voluntarily tracked and categorized the outcomes of these referrals. Outcomes were tracked by quarter for CY 2005 to CY 2010 and then by full year (January to December) for CY 2011 to CY 2015. During a change in the tracking procedure in CY 2011, only successful outcomes were tracked. All outcomes have been summarized into five categories:

Services Rendered: Outcomes include:

- Specialty care was successfully arranged
- Requested service is a covered PCN benefit (specialty care was not required)
- Client arranged their own specialty service
- Client obtained health insurance

In Process: Outcomes include:

- Service is pending
- Client is on a charitable-care waiting list
- Client has been contacted—Care Coordinator is awaiting a response
- Case was transferred
- Duplicate referral

Client's action: Outcomes include:

- Client has not responded to communication
- Service was not required
- Client was not eligible for PCN
- Client refused service

Services Not Rendered: Outcomes include:

- Client cannot pay fee
- Intermountain Healthcare denied charity care
- Service referral was unsuccessful/unavailable

Unspecified: Outcome was not tracked.

The plurality of outcomes (those with the greatest proportion) falls in the "Services Rendered" category, ranging from 32 percent in CY 2008 and CY 2009 to 74 percent in CY 2012. For the three most recent years (CY 2013 to CY 2015), they have been able to petition charitable specialty care for over half of the referrals they received (three-year average is 51 percent).

By comparison, "Services Not Rendered" outcomes range from 8 percent (CY 2012) to 27 percent (CY 2015). The three-year average for these unsuccessful outcomes is 25 percent, half the rate of successful outcomes. See Figure 7.

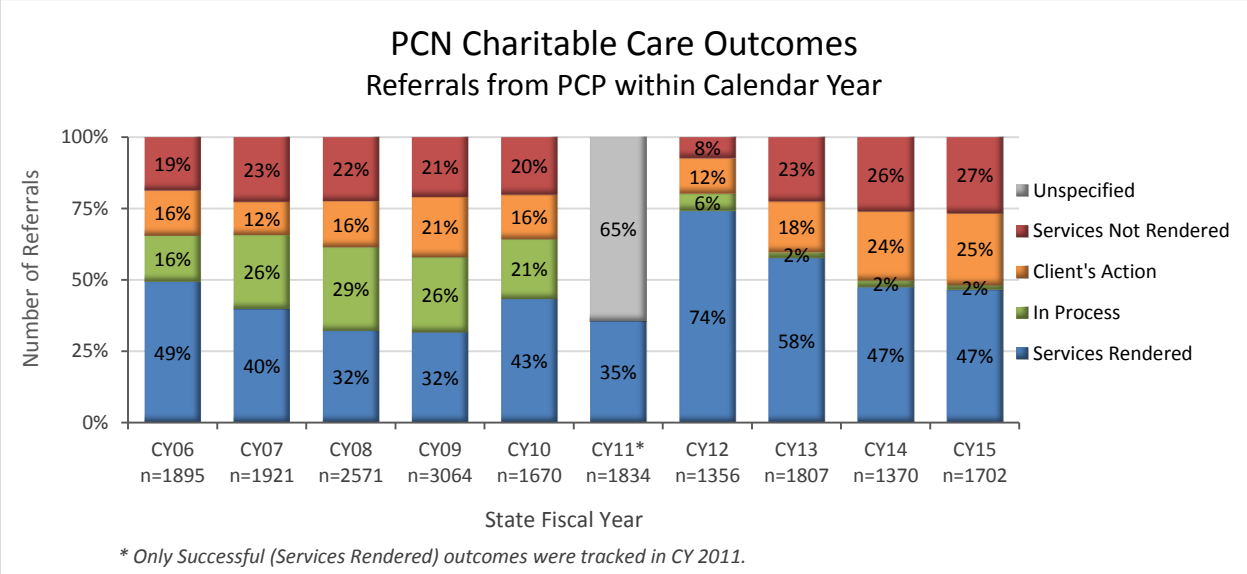


Figure 7. Specialty Care Coordinator's Primary Care Network combined Quarterly Reports from January 2006 to December 2010 and Annual Reports from January 2011 to December 2015. Coordinators tracked requested specialties, outcomes, and geographic area. Outcomes were summarized for this report.

Outcomes identified as "In Process" in most cases were resolved in the following quarter. The group of outcomes categorized as "Client's Action" were out of the Specialty Care Coordinator's control, with the majority of them being a non-response from the client, even after the Coordinator attempted to contact him/her at a variety of times of day and days of the week, using all available contact information (landline, cell phone, email, etc.).

Hypothesis 3: The demonstration will reduce the number of unnecessary visits to emergency departments by PCN enrollees.

Throughout the ten years reviewed for this report, emergency department (ED) claims among PCN Childless Adults and Non-Traditional Medicaid enrollees have been fairly consistent and consistently about three percentage points higher than traditional Medicaid enrollees. With SFY 2015, as PCN Childless Adult enrollment increased by 28 percentage points (see Figure 3 on page 10) over SFY 2014, the rate of ED claims increased by eight percentage points (SFY 2014: 21 percent to SFY 2105: 33 percent). This would indicate that new enrollees are finally able to access services that have been unavailable before enrolling in the PCN program.

As was also evidenced in recipients' use of the prescription drug benefit (see Figure 6 on page 14), PCN Adults with Children access ED services at a much lower rate than PCN Childless Adults, NTM, and Medicaid enrollees. In SFY 2015, 14 percent of PCN Adults with Children had an ED claim, compared to 17 percent of Medicaid, 20 percent of NTM, and 33 percent of PCN Childless Adult enrollees. See Figure 8.

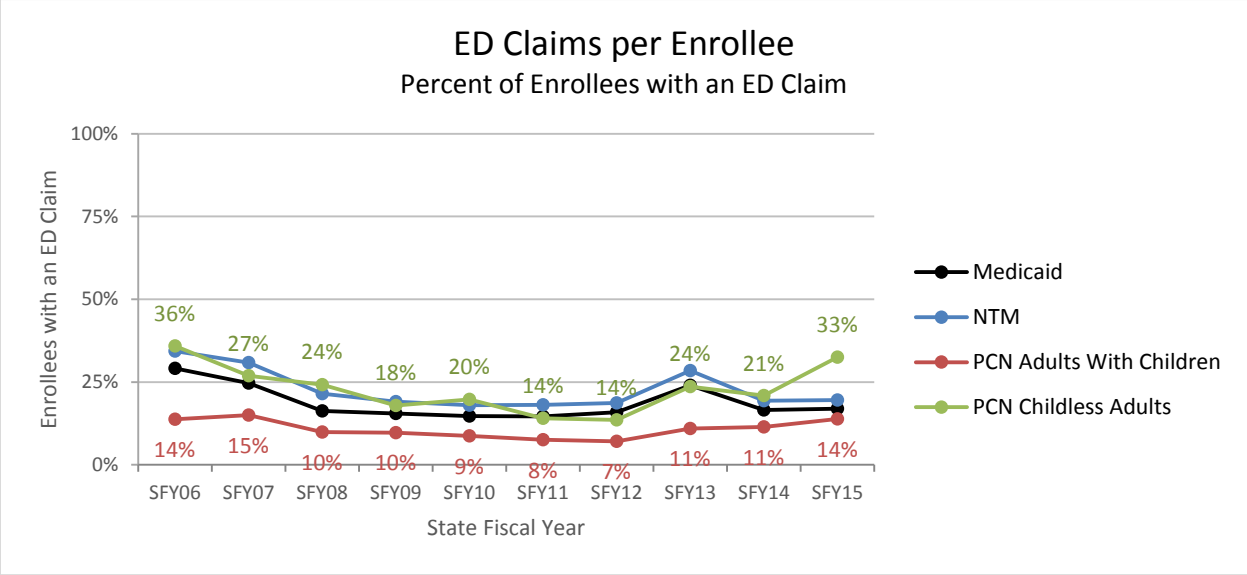


Figure 8. Analysis of Utah Medicaid claims data for emergency department (ED) claims, including counts of enrollees, ED recipients, ED claims, and the emergency indicator.

Looking deeper into the status of ED claims—whether they were coded as emergent or non-emergent by the provider—again reveals different behavior between the two PCN categories. Over the ten state fiscal years reviewed for this study, PCN Childless Adults with claims were consistently had more non-emergent claims than PCN Adults with Children. In SFY 2005, the average number of non-emergent claims per PCN Childless Adult was 1.6 compared to 1.2 for PCN Adults with Children.

In SFY 2007, efforts to educate all Medicaid enrollees, not just those covered through the 1115 Waiver, about appropriate emergency department use increased; likewise the overall number of ED claims decreased as did the incidence of non-emergent claims. This trend for the appropriate use of ED services continued through SFY2011 and shows that education campaigns can be effective. See Figure 9.

Unfortunately, the incidence of non-emergent claims increased in SFY 2012 to 0.91 for PCN Childless Adults and 0.8 for PCN Adults with Children. Non-emergent claims have remained above 0.5 per claimant for the last three years. This, once again, calls for a renewed effort to educate public health recipients about appropriate emergency department use.

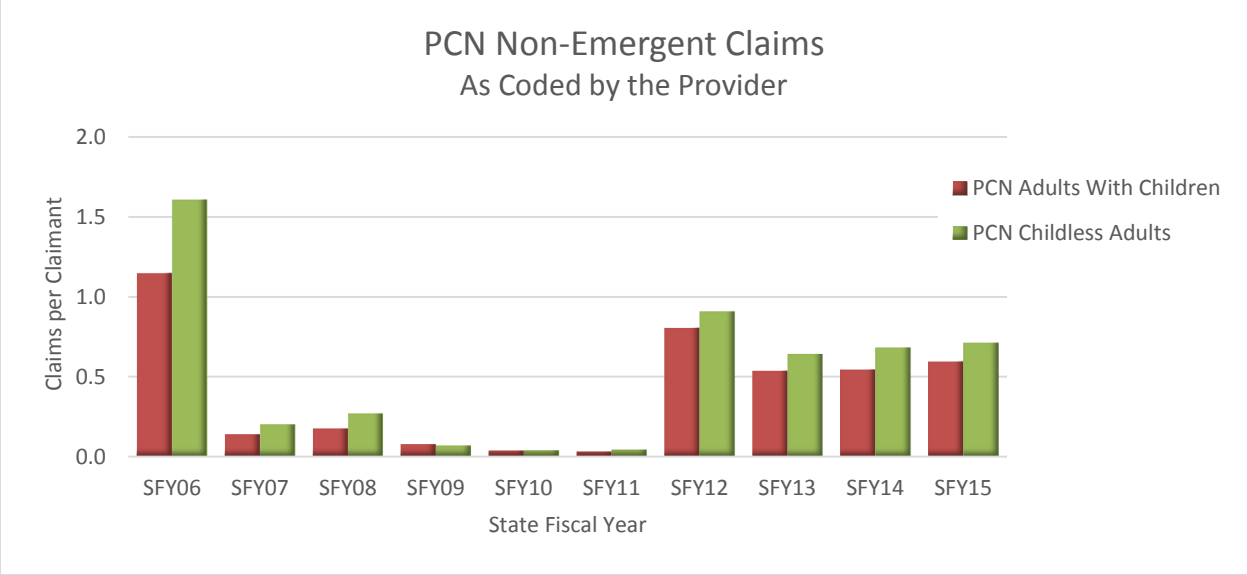


Figure 9. Claims include a field to flag emergent services. Available values are Yes, No, or blank. Non-emergent claims are calculated by counting all claims with a value of No or blank and dividing that by the total number of claimants.

Hypothesis 4: The demonstration will increase the number of prenatal visits for High-Risk pregnancies in comparison to the general population.

According to the Public Health Indicator Based Information System (IBIS), the average number of prenatal visits among all Utah resident mothers with live births in CY 2008 was 11.05, which serves as a baseline for this comparison. This baseline includes all women, regardless of health insurance coverage or risk level. Utah mothers-to-be are encouraged to see their health care provider before the thirteenth week of pregnancy and to go back for at least thirteen visits before birth.

The average number of prenatal visits for the High-Risk Pregnancy (HRP) group within the 1115 Waiver has been consistently higher than the statewide average for all live births. In CY 2009, the first year the HRP data was available, HRP mothers averaged 11.93 prenatal visits, compared to 10.95 for the general population statewide. See Figure 10.

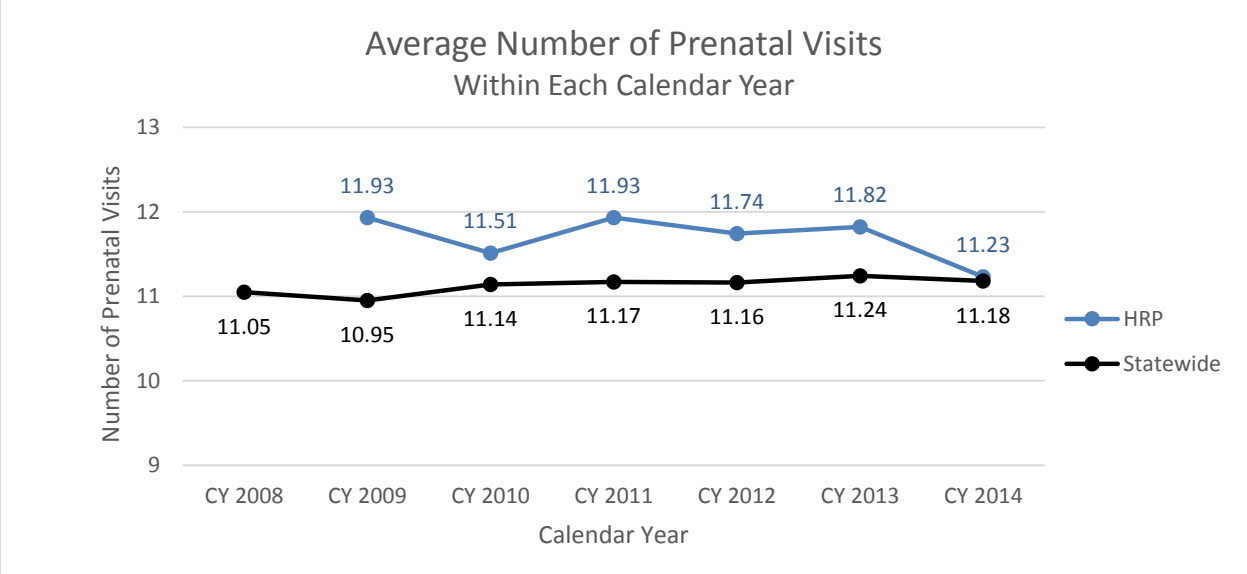


Figure 10. Statewide average of prenatal visits data comes from a query of all live births to Utah resident mothers regardless of where they occurred; data source: Public Health Indicator Based Information System (IBIS): https://ibis.health.utah.gov/query/result/birth/BirthBirthCnty/AvgPNCVisit.html.
The count and average number of prenatal visits data for High-Risk Pregnancy recipients comes from a query of the Utah Medicaid Data Warehouse.

Early in CY 2014, the Affordable Care Act removed the asset test that made the High-Risk Pregnancy aid category necessary, effectively discontinuing the need for the HRP aid category. Therefore, CY 2013 has the last full year of HRP data. In CY 2013, the HRP group continued to have a higher average number of prenatal visits (11.82) than did the general population (11.24). During CY 2014, the women on HRP were transitioned to traditional Medicaid.

Hypothesis 5: The demonstration will assist previously uninsured individuals in obtaining employer-sponsored health insurance without causing a decrease in employers' contributions to premiums that is greater than any decrease in contributions in the overall health insurance market.

In November 2006, Utah's Premium Partnership for Health Insurance (UPP) was implemented to create opportunities for qualified individuals and their family members under age 18 to purchase employer-sponsored health insurance by reimbursing health insurance premiums up to $150 per adult and $120 per child ($140 per child if dental coverage is also purchased) every month.

The Utah Department of Health with the Department of Workforce Services implemented an awareness push for UPP in SFY 2008 and SFY 2009, when total enrollment in UPP reached its peak of 1,393 total participants during the year. In March 2010, President Obama issued an Executive Order that clarified how rules limiting the use of federal funds for abortion services would be applied to health insurance exchanges. It was determined that the Executive Order in conjunction with the intent of state law created new expectations for the UPP subsidy. In April 2010, an emergency rule was filed to prohibit UPP from reimbursing participants who were enrolled in plans covering abortion services beyond the circumstances allowed for the use of federal funds (i.e., life of the mother, rape, or incest). Subsequently, enrollment in UPP in SFY 2013 dropped to 749 participants. See Figure 11.

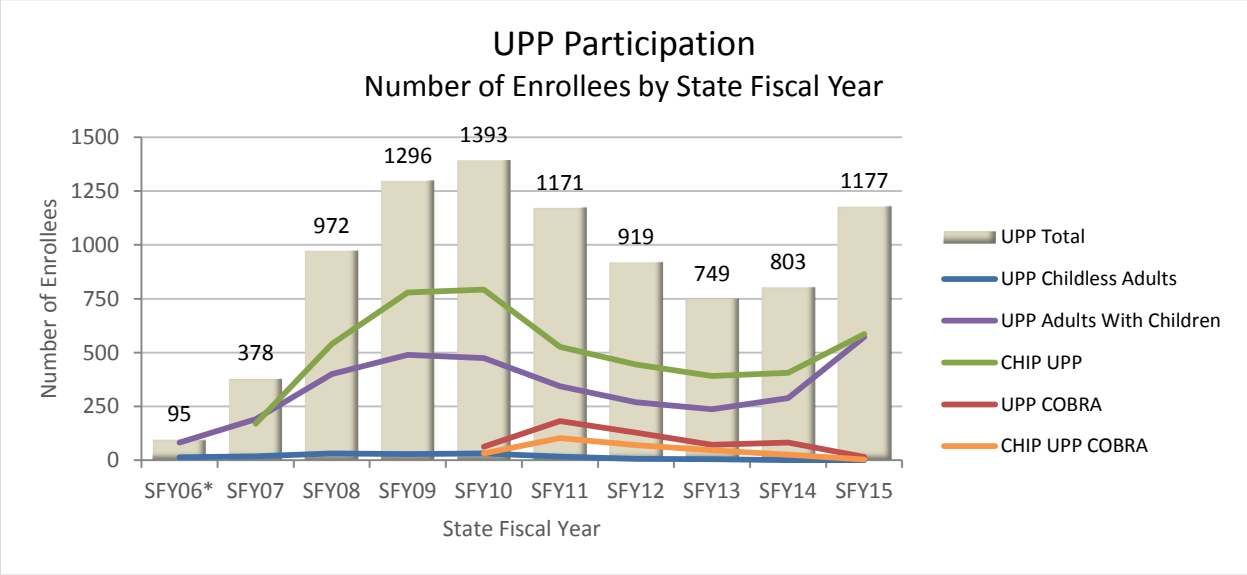


Figure 11. Counts of distinct lives enrolled Utah's Premium Partnership for Health Insurance (UPP). Monthly enrollment data is aggregated by state fiscal year from the Medicaid Data Warehouse. "Distinct Lives" counts all individuals enrolled in UPP for at least one month during the fiscal year. An individual is counted only once within each year.
* SFY 2006 represents a partial year as UPP was introduced in November 2015.

In SFY 2014, the Bureau of Eligibility Policy (BEP) worked with the Department of Workforce Services (DWS) to increase awareness of the UPP benefit. DWS centralized their staff and BEP trained DWS staff on how to identify potential UPP recipients. BEP also educated insurance brokers on the UPP program. This additional training, as well as many employer-based insurance coverages becoming more aligned with the federal definition of abortion coverage, ushered in greater participation in UPP in SFY 2015 when 1,177 distinct lives were covered by the benefit. Awareness efforts to identify appropriate UPP participants continues and enrollment is expected to increase in SFY 2016.

To participate, employers must contribute at least 50 percent of the premium. In SFY 2007, employers were paying 60 percent on average of the employed individual's premium and 86 percent of a dependent's premium. It is expected that employer contributions will settle close to the 50 percent contribution.

Hypothesis 6: The demonstration will assist individuals currently eligible for or enrolled in COBRA with monthly premium reimbursement to help reduce the number of uninsured while reducing the rate of uninsurance.

Utah's 1115 Waiver was amended in SFY 2010 to allow for premium assistance for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage. Based on family size, income, and if the former employer's health insurance coverage meets basic guidelines, UPP COBRA recipients may be reimbursed for up to $150 per adult and up to $120 per child in the family (up to $140 per child, if the child is enrolled in dental coverage) every month.

In SFY 2011, the American Recovery and Reinvestment Act (ARRA) provided an additional subsidy for employers to pay for COBRA benefits resulting in higher UPP COBRA enrollment until the subsidy ended in February 2011. The end of this subsidy, combined with the 2010 executive order limiting which COBRA plans qualify for UPP assistance, resulted in 30 percent fewer UPP COBRA enrollees in SFY 2012. Continued improvement in the state's economy as well as a reduced benefit have almost eliminated participation in the UPP COBRA program.

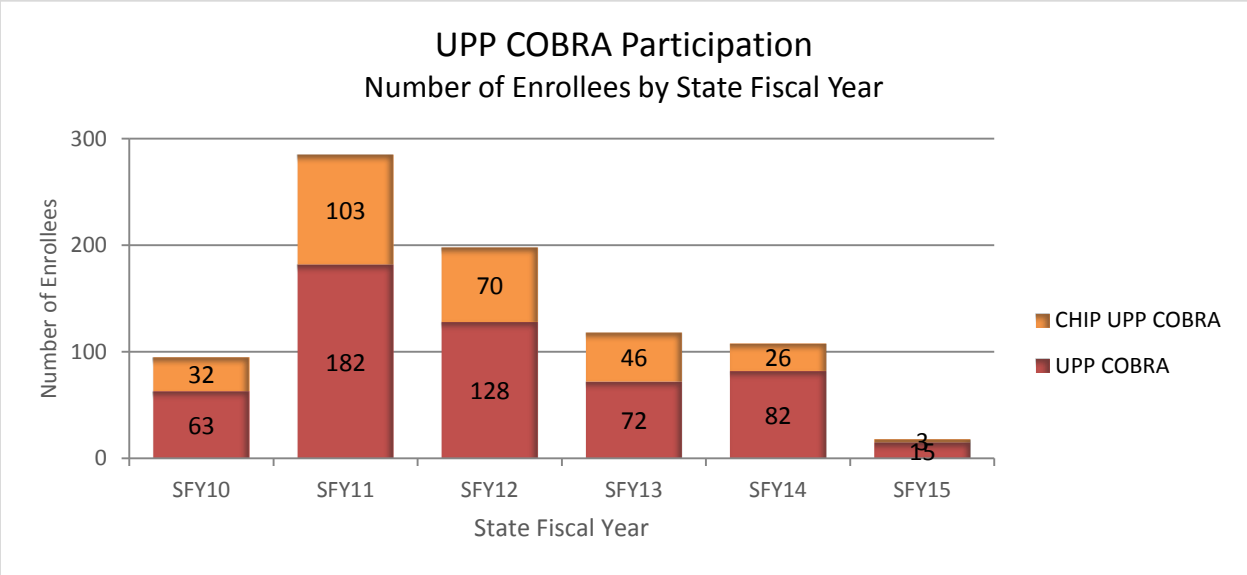


Figure 12. Count of distinct Utah Medicaid UPP COBRA enrollees and their dependents with at least one month of eligibility, aggregated by state fiscal years 2010 to 2012.

Conclusion and Recommendations

Utah's 1115 Demonstration Waiver has proven to provide a significant benefit to Utah residents who would otherwise have no health insurance coverage and would likely go without health care.

With the 2016 Utah Legislative Session, limited Medicaid expansion was approved by the legislature. Upon CMS approval, Medicaid coverage will be offered to up to 16,000 Utahns who are currently uninsured, including parents with income up to 55% of the FPL, those who are chronically homeless, those who are involved in the justice system, and some who are mentally ill. House Bill 437 "Health Care Revisions" (HB437) also allows for substance abuse treatment at facilities with no bed-capacity limits and permits specific waiver enrollees to maintain Medicaid coverage for 12 months. HB437 authorizes the Utah Department of Health to apply for the necessary waivers from CMS to implement the provisions described above.

ATTACHMENT 3

Public Notice

SPECIAL NOTICES

Health
Health Care Financing, Coverage and Reimbursement Policy

Public Hearing to Discuss the 1115 Waiver and H.B. 437 "Health Care Revisions" From the 2016 General Session

The Division of Medicaid and Health Financing (DMHF) will hold public hearings to discuss the renewal of and proposed amendments to the Primary Care Network 1115 Demonstration waiver. Proposed changes to the waiver are required to implement the provisions of H.B. 437 "Health Care Revisions" passed during the 2016 General Session. These amendments include requesting authority to add Medicaid eligibility for additional adults between the ages of 19 and 64 who meet certain criteria. In addition, the State will request a waiver of the Medicaid IMD (institution for mental disease) exclusion. Finally, amendments will be proposed to remove the high risk pregnant woman group, as it is no longer needed due to the Affordable Care Act; making changes to Non-Traditional Medicaid benefits to comply with mental health parity; and removing the EPSDT waiver for 19 and 20 year olds.

These topics will be discussed at public hearings to be held on Thursday, May 19, 2016, from 1:30 p.m. to 3:30 p.m. as part of the monthly Medical Care Advisory Committee (MCAC) meeting, and Wednesday, May 25, 2016, from 1:00 p.m. to 3:00 p.m. Both meetings will be in Room 125 of the Cannon Health Building, 288 North 1460 West, Salt Lake City, Utah.

A conference line is available for those who would like to attend by phone: 1-877-820-7831, passcode 196690#. Individuals requiring an accommodation to fully participate in this meeting should contact Jennifer Meyer-Smart at 801-538-6338 by 5:00 p.m. on May 11, 2016.

End of the Special Notices Section

ATTACHMENT 4

Tribal Consultation

May 13, 2016

Attachment #4

Tribal Consultation

The State conducted Tribal consultation on May 13, 2016. A presentation regarding the 1115 Primary Care Network Demonstration Waiver was given by Nate Checketts. The agenda and minutes from this meeting are attached. Comments provided by the Tribal leaders are also attached.

Below are questions from the Tribal leaders, as well as the State's responses.

Question:

There are AI/AN's in the prison in Utah. Who would enroll them upon their release? Would there be coordination with the Tribe for mental health and substance abuse coverage if they requested it?

Response:

The State will be working with the Department of Corrections to assist these individuals through the normal eligibility process with the Department of Workforce Services. The State will work with the Tribe to determine if any additional coordination is needed.

Question:

How does this proposal work with court referral from some of our Tribal courts to our Tribal behavioral health and substance abuse programs? Are they included in this program?

Response:

The proposal does include Tribal mental health and drug courts. The State will work with the Tribe to determine what additional coordination is needed.

Question:

There is mention of receiving General Assistance from DWS as an eligibility criteria. Would that include Tribal General Assistance?

Response:

The eligibility criteria for Tribal General Assistance and General Assistance through DWS appear to be different enough that we do not plan on including Tribal General Assistance.

Question:

There are many homeless AI/AN brothers, sisters and families living in Salt Lake City. We are very curious about how the homeless are identified. How many AI/AN's would be eligible under this criteria? Are medications included with this coverage?

Response:

The State will work with community partners and shelter providers to identify chronically homeless. The chronically homeless criteria will be verified using the Homeless Management Information System (HMIS) used by the Department of Workforce Services and shelter providers. For individuals who cannot be verified using HMIS, an alternative form will be used to verify eligibility. At this time, we do not know how many AI/AN's will be eligible under this criteria. The new populations that will be covered by this program will receive traditional Medicaid benefits, which includes pharmacy benefits.

Utah Indian Health Advisory Board (UIHAB) Meeting

5/13/2016
9 AM –1 PM
Utah Department of Health
5th Floor Board Room
3760 South Highland Drive
Salt Lake City, UT 84106
(801) 273-6644 or (801) 712-9346

Meeting called by:	UIHAB
Type of meeting:	Monthly
Facilitator:	Melissa Zito
Note taker:	Ginny H Call In **1-877-820-7831** **passcode 299856#**
Please Review:	Board minutes,(March & April), Zikia Virus, ITCA TEC, Medicaid Expansion proposal, Medicaid Rules & SPA document(s), additional materials via presenters.

Agenda topics

9:00 AM	Welcome & Introductions Approval of Minutes	Hunter Timbimboo, Chair
9:15 AM	Committee Updates & Discussion - UDOH Office of Health Disparities (below) - Medicaid State Plan Amendments (SPA) & Rules - DWS Medicaid Eligibility Operations - UT Medicaid Eligibility Policy - Federal and State Health Policy Impacting I/T/U - MCAC - CHIP Advisory Committee (quarterly)	 Dulce Diez Craig Devashrayee Jacoy Richins Jeff Nelson Melissa Zito Donna Singer LeAnna Vankeuren
10:15 AM	ITCA Tribal Epi Center (TEC)	Jamie, Ritchey, PhD, TEC Dir.
10:45 AM	Discussion: MOVING FORWRAD IN 2016: 15 yrs. Hlth Data Trends for AI/AN's	UIHAB, Dulce Diez, M. Zito
11:15 AM	HB – 457 Medicaid Expansion Waiver	Nate Checketts & Tonya Hales
11:45 AM	BREAK	
12:00 PM	Zika Virus Action Plan: Tribal Components	Allyn Nakashima, MD & Dallin Peterson
12:30 PM	Updates - HHS Region VIII qtly. Updates - SIM Grant Update - Health Topics for Gov. AI Summit - June UTL's Cedar City Presentation	UIHAB Representatives & UDOH
1:00 PM	Adjourn	

Utah Indian Health Advisory Board
Tribal Leadership Reporting Tool

DATE: _____

State Agency Updates & Discussions:

Medicaid State Plan Amendments (SPA) & Rules (see Matrices)

DWS Medicaid Eligibility

MCAC

CHIP Advisory Committee

Policy & Legislative Updates

Agenda Item Updates:

I/T/U Program Updates

UIHAB Priorities

Guest Speakers

Tribal leadership Feedback

NOTES

Utah Indian Health Advisory Board

Minutes of Meeting May 13, 2016

Participants

Board Members Present

Allen Pitts, *Health Director, Paiute Indian Tribe of Utah*
Shandiin Webster, *Health Director, Confederate Tribes of Goshute Indians*
Lance Johnson*, Health Director, Sacred Circle Health Center*
Donna Singer, *Consultant, Member at Large*
Lewis Singer*, AI/AN Representative, Utah Commission on Aging*

Board Members Excused

Hunter Timbimboo, *Health Director, Northwestern Band of Shoshone Nation,* ***UIHAB Chairman***
Malcom Lehi, *Councilman, Ute Mt. Ute, White Mesa,* ***UIHAB Vice Chairman***
Michael Jensen*, CEO, Utah Navajo Health Systems*
LeAnna Van Keuren*, Health Director, Urban Indian Center of Salt Lake*
Ed Napia, *Urban Indian Center of Salt Lake*
Jacoy Richens*, Eligibility Specialist, Utah Department of Work Force Services, American Indian Team*

IHS Members Present

Carol Chicharello, Deputy Director OSD, PAO IHS
David Ward, CEO Health Center, Ute Mountain Ute, ABQ Area HIS

Guests

Craig Devashrayee, *Technical Specialist, UDOH Bureau of Coverage and Reimbursement Policy*
Jeff Nelson*, Director Bureau of Eligibility Policy and Director of CHIP*
Amanda Yoshida, *Health Program Manager, UDOH Bureau of Eligibility Policy*
Marc Babitz, MD*, Division Director, UDOH Family Health and Preparedness*
Nate Checketts, *Director, Medicaid, UDOH Division of Health Care Financing*

Welcome and Introductions

Due to the Board not having a majority present, the meeting was designated as informational only. Donna Singer, past UIHAB Chair, volunteered to run the meeting.

Approval of minutes

The minutes for March 11, 2016 and April 3, 2016 will be reviewed and discussed at the next meeting. Members present were asked to review for any corrects for approval at the next meeting.

Committee Updates and Discussion

UDOH Office of Health Disparities

The final Health Status Report is currently being revised. No other report or updates at this time.

Medicaid State Plan Amendments (SPA) & Rules

SPAs: Craig reported and reviewed the State Plan Amendment Matrix (see Matrix attached).

QUESTION: Rule 16-0025-Ut Parents and other Caretaker Relatives the new income limit show as 55% of FPL is this correct?

RESPONSE: The new income limit was 50% and now is 55%. Concern over whether this income limit will make it difficult for people? It was discussed that with the 138% of poverty this will let more people in making it less difficult.

Rules: Craig reported on the DMHF Rules Matrix (see Matrix attached).
Craig clarified a question from April 8th meeting regarding the Credible Health Coverage.

QUESTION: If an individual transferring from FFM would there be interruption in coverage?
RESPONSE: When coverage is terminated from FFM, coverage will continue through PCN and the UP Program as long as they are off FFM when they apply.

Next month Craig will follow-up on the inter-governmental transfer context and also the current American Indian/ Alaska Native assets and will it continue to be exempt under this rule.

DWS Medicaid Eligibility Operations

Jacoy was absent today. Melissa asked if there were any concerns or issues regarding eligibility. It was noted all concerns were already addressed and no questions were asked at this time.

UT Medicaid Eligibility Policy

Jeff reported there are application changes. DOH is working with CMS to merge eligibility with Baby your Baby with DOH's paper applications and will be running soon. Now the focus is the on-line applications relating concerns on questions that are asked on the application and noting there will be slight changes on the language but related nothing was changed to the American Indian language, CMS requested some adjustments to the application language which will also apply to the on-line application. Jeff will send the policy to Melissa to review.

QUESTION: Arizona's application just changed regarding youth who are ageing out of the foster care system either state foster care or under tribal jurisdiction. They are in the new eligibility group up to the until age 26 for Medical coverage (per the ACA 2010). Arizona just got assures from the state Medicaid agency that the question will be included which will also address tribal jurisdiction. How long ago was this question inserted in DOH's application and if tribal jurisdiction was included?
RESPONSE: Jeff indicated around 2013.

It was reported DOH is to extend more benefits to more children. Presently, if a legal status child who enters in the country and applies for coverage it is only for emergency services with a 5 year bar. It was reported the 5 year bar will be removed in July so that the children can have full benefits. This change is scheduled for July 1, 2016 which will effect 200-300 children DOH is using the CHIP match (at 100%) for these children with no cost to the state.

Clarification regarding the ABLE Act was given.

QUESTION: Does the current exemption for American Indians change under this rule?
RESPONSE: It will not change and if someone qualifies for an Able account, the Able account is exempt as well. The standard exemption still exist.

Federal and State Health Policy Impacting I/T/U

FY2017-2018 HIS BUDGE REQUEST TRIBAL RECOMMENDATIONS AND ISSUES

Alida Montiel from the Inter Tribal Council of Arizona (ITCA) gave an update/report on the national and regional tribal health advisory committees with a list of tribal representatives now serving from the Tribes in the Phoenix Area HIS region (Arizona, Nevada and Utah). There are six national DHHS advisory committees and nine HIS committees. Objective: DHHS and HIS and other Federal agencies actively seek individual to serve on behalf of all Tribes in the Phoenix Area (Arizona, Nevada and Utah). Tribal representation is important in advocating for priority health issues and having a voice in the decision making process on the Tribal Health Steering committee for the Phoenix Area IHS.

Medical Care Advisory Committee (MCAC)

No updates at this time.

CHIP Advisory Committee

LeAnna was excused and will provide an update at the next meeting.

I/T/U & UDOH Updates

Due to the presentation and discussion today on Medicaid Expansion/Expansion, updates will be addressed at the next meeting.

UIHAB Priorities for 2016

Due to the guest speakers and follow up items from last month, the priorities will be updated and discussed at the next meeting.

Guest Presentations

INTER TRIBAL COUNCIL OF ARIZONA, INC., (ITCA) Tribal Epi Center (TEC)

Dr. Jamie Ritchey, from the ITC TEC provided an overview and presentation on the year's activities and reporting. The ITCA provides public health technical assistance to Tribes in the Phoenix and Tucson Services areas, funded in part by the IIHS Cooperative Agreement. Forty-five Tribal communities will benefit directly through out Arizona, Nevada and Utah. The program has a potential to continue to serve over 446,000 American Indians at the community level. An overview on the ITCA TEC Tribal Health Department Needs Assessment and IHS ITCA TEC Cooperative Agreement 5 year activity were highlighted from FY2011-2012, to FY2013-2016.

The ITCA TEC is applying for another grant from the IHS to continue the current work just completed that is focusing on epidemiological assistance for the Tribes in Utah. The grant is due mid-June and ITCA TEC would appreciate a letter of support. Members agreed on a letter of support by the Board.

There was a discussion about the Cancer data for AI/AN in UT and the Cancer registry. Utah has poor reporting for AI/AN's. Usually Cancer care is referred out using contract support costs. There is a gap in who is reporting and to whom the reporting goes to; Utah Cancer Control, Cancer Registry, NACP data, etc.

Melissa will email and asked to review the Resolution and return with feedback.

Moving Forward in 2016: 15 years Health data Trends for AI/AN's

Dulce is absent today. Recommendations from ITCA TEC were forwarded and will be reviewed.

Utah Medicaid Expansion Waiver

Nate Checketts presented a handout to review the proposal on the estimated One hundred million dollar Medicaid Adult Expansion. The overview reported during the 2016 General Session of the Utah State Legislature, House Bill 437 passed and was signed into law by Governor Gary Herbert on March 25, 2016. This Bill directed the Department of Health (DOH) to expand coverage for parents and to develop criteria for three new eligibility groups of adults without dependent children. DOH must submit a plan to the Centers for Medicare and Medicaid Services (CMS) to modify the current Utah Medicaid program accordingly. Utah is seeking to increase Medicaid coverage levels for parents up to 60 percent of the federal poverty level (FPL) and to create three new eligibility groups for adults without dependent children. The adults without dependent children can have incomes up to 5 percent FPL. It is estimated that 9,000 – 11,000 adults will be covered through these changes.

The following list (by priority) are the new eligibility groups targeted by this health coverage improvement plan. The definition and criteria of each population were given.

- Chronically homeless
- Involved in the justice systems AND are in need of substance use or mental health treatment.
- Needing substance abuse or mental health treatment.

The additional amendments Utah is requesting to its existing 1115 waivers:

- Three-year extension of the existing Primary Care Network (PCN) Demonstration Waiver.
- Waiver of the Medicaid Institutions for Mental Diseases (IMD) exclusion under Section 1905(a) (29) (B) of the Social Security Act to allow for medically necessary Residential treatment Services for Individuals with substance use disorders.
- Implementation of Mental Health Parity and termination of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Waiver for the Non-Traditional Medicaid recipients.
- Removal of the High-Risk Pregnant Woman Demonstration group.

It was reported DOH has sent out a draft of the waiver and are accepting public comments and has three scheduled public hearings to discuss the waiver. Public comments will close on June 8th. All comments will be reviewed and changes will be considered. DOH will submit to CMS on July 1, 2016 and from there CMS will have a 30-day comment period and will negotiate with DOH the terms and conditions.

QUESTION: Is this waiver guaranteed approval?
RESPONSE: No, the waiver has been approved by the state but there is no guarantee that the Federal government will approve. DOH expects to get approval by October or November to start enrollment on January 1, 2017.

QUESTION: How are the funds distributed to those specific groups?
RESPONSE: The Legislature concern for the waiver program is to operate and stay on budget. DOH asked the Federal government of ways to stay on a budget which the Legislature preference has been (in the past) doing a dollar cap or enrollment cap. CMS stated clearly they would not approve any new programs with dollar or enrollment caps. It was directed either develop a program where the benefits would be cut if the cost was too high or develop a program with limited eligibility. DOH developed a program that established an estimate cost of the individuals and the estimated enrollment eligibility criteria to the estimated level of spending. No closure or no targeted slots will be done to certain groups in this program and as many as is qualified will receive coverage.

QUESTION: Will individuals utilizing substance abuse programs be eligible for this waiver if not eligible for other programs?
RESPONSE: If they meet the eligibility criteria.

QUESTION: If an individual is in tribal court and on a substance abuse program and enrolled in general assistance will they be eligible for this waiver? How will this be incorporated in their judicial system in this process?
RESPONSE: This is a question that needs further clarification. If it looks like drug court or mental health court this is something that needs to be included and additional language.

QUESTION: Does DOH require a Resolution letter?
RESPONSE: Documentation of the minutes will be sufficient to submit to CMS showing the feedback, consultation and discussion process has been met.

There are some public comment meetings on the Medicaid website. Melissa will follow up with the Board and the Utah Tribal Leadership regarding this proposal and forward via e-mail the public comment dates across the state. Melissa clarified with Nate that she would like to get any final comments from the Utah Tribal Leadership at their next meeting June 10, 2016 in Cedar City Utah. Nate stated that would be fine.

Zika Virus Action Plan

Dr. Nakashima gave a PowerPoint presentation reporting on the Zika Virus. There is only about 1 in 5 infected persons report symptom. The history of the Zika Virus was given. Also, reported was the evidence showing association between Zika and Microcephaly affecting pregnant women. Dr. Nakashima report they are applying for the ELC grant and have put in money to local health departments for case investigation as well as to get equipment to collect mosquitos. It was noted this grant includes 3 tribal abatement sites; Confederated Tribes of the Goshute, Utah Navajo Health System, and the Paiute Indian Tribe of Utah; Shivwits Band

Additional handouts were given out on the Zika Virus; blood sample collection procedure, frequently asked questions.

Inter-Tribal Council of Arizona Health and Wellness Grant

Gwenda Gorman presented a PowerPoint on the Inter Tribal Council of Arizona, Inc. (ITCA) five year grant awarded in 2014. This comprehensive approach to good health and wellness in Indian Country is to prevent heart disease, diabetes, stroke, and associated risk factors in American Indian communities, in addition to promoting health and wellness. The grant initiative will support Tribes in Arizona, Nevada, and Utah to implement a variety of effective community-chosen and culturally adapted policies, systems, and environmental changes targeting one or more seven prevention areas. The seven prevention areas were reported on.

Tribal participation are two tribal leaders from Utah, Nevada has four with one vacancy, and Arizona has five tribal leaders with an urban Indian health representative. The activities for the ITCA projects for the next 2 years are; webinars, coordinated meetings, and trainings. Also addressed was on the GHWIC conventional framework and the indigenous framework approach and how to draw from the strengths of tribal communities.

Next steps are:

- Assist tribes in finalizing their Community-Based Action Plans for Year 3
- Identify presenters and partners for Year 3 activities
- Provide training on Dissemination Plan for Tribes in July 2016 in collaboration with ITCA TEC
- Identify opportunities to share project outcomes.

Utah State Innovations Model (USIM) Grant Update

Ying Yang provided an update on the Data of Medicaid claims on the disease population for American Indian; Diabetes, Obesity, Mental Health and End of Life Care. She reviewed the different methods for reporting of the data, including a rough draft for the Geo Mapping component. The collected data given are from SLC County, San Juab County, and Utah County. The enrollment page sent out has a change and Melissa will send the correct page. This data will be used for reporting for the final reporting to CMS. Tribes and the Urban Center can also use the data for their needs. The final SIM grant report is due in June 30th to CMS. Ying and Melissa will share the final report and prepare a report specifically for the UIHAB. Appreciation for the data collection was noted.

Next meeting June 9 or 10, 2016. Location TBA

Meeting adjourned at 1:15 p.m.

Adjourn

With no further business to consider, the meeting was adjourned at pm.

Utah Medicaid Extension Proposal; 1115 Waiver Request

Utah Tribal Leadership Comments

Date:
6-13-2016

Tribal Leadership/Council members:
Hunter Timbimboo-Director of Health

Tribal Contact/Phone Number:
435-734-2286

Comments and Recommendations:
The Northwestern Band of the Shoshone Nation supports the Utah Medicaid Extension Proposal 1115 Waiver Request. The Northwestern Band of Shoshone Nation requires that its tribal members obtain a Primary Provider before they may utilize Tribal Contract Health funds as a Secondary Provider. Though many of our tribal members meet this qualification, there are still a small number that would benefit directly from the proposed expansion. Being that most of the said tribal members live a considerable distance from an IHS Facility, this Waiver would have a great impact on those currently ineligible tribal members. We also realize the many other Natives in Utah whom this action would benefit. We strongly urge that this measure be passed. Again, with no easy access to an IHS Facility along the Wasatch Front, this is an extremely valuable Proposal for our underserved Native population.

Utah Medicaid Extension Proposal; 1115 Waiver Request

Utah Urban Indian Organization Comments

Date: June 27, 2016

UIO Leadership/Board members: Shawn Jimerson, Executive Director/Laura G. Gross, Board Chair

UIO Contact/Phone Number: LeAnna VanKeuren/801-486-4877

Comments and Recomendations: Other than increasing Medicaid eligibility to 60% for parents, I recommend verbiage include guardians. For adults' w/dependents in Medicaid, what is the current FPL level for a parent/guardian to be eligible for Medicaid? As is now, DWS provides an amount for eligibility. How many more parents/guardians will be eligible if eligibility is moved to 60% FPL? Though employed, the AI/AN population generally fall under the 100% FPL levels due to underemployment or PT status, the increase may benefit a few more parents/guardians.

The other populations targeted: The chronically homeless and individuals involved in the justice system; include or specify Tribal supportive housing, BH treatment program, and jail system as well.

Utah Medicaid Extension Proposal; 1115 Waiver Request

Utah Tribal Leadership Meeting Comments

Date:
June 10, 2016

Tribal Leadership/Council members:
Utah Tribal Leaders meeting, Cedar City UT

Tribal Contact/Phone Number:
Chairman Virgil Johnson, Confederated Tribes of the Goshute Reservation and UTL's Chairman
435-234-1194

Comments and Recommendations:
The Utah Tribal Leaders are supportive of any effort to increase access to their members. The Primary Care Network (PCN) Program is very well utilized program for the adults, and supported by the Leaders and health programs.

There are AI/AN's in the prison here in Utah at the Point of the Mountain site. Who would enroll them upon their release and would there be coordination with the Tribe on that for mental health and substance abuse coverage if they requested it? We would also like to know how this proposal would work with court referral from some of our Tribal courts to our Tribal behavioral health and substance abuse programs. Are they included in the programs? Some of our tribal members live in the Salt Lake Area. The Urban Indian Center has a Substance Abuse program. It would be very helpful to have more coordination and inclusion of our programs as options for AI/AN's who may be eligible. There is mention of the General Assistance from DWS. Would that include Tribal General Assistance? There are many homeless AI/AN brothers, sisters and families living in SLC. We were also very curious about how the Homeless are identified. How will Medicaid locate them to enroll them? Do you know how many AI/AN's would be eligible for this proposal overall? Are medications included with this coverage?

ATTACHMENT 5

Public Hearing-MCAC

May 19, 2016

Agenda and Minutes

UTAH DEPARTMENT OF HEALTH

Medical Care Advisory Committee Agenda

Meeting:	Medical Care Advisory Committee
Date:	May 19, 2016
Start Time:	1:30 p.m.
End Time:	3:30 p.m.
Location:	Room 125 Cannon Health Building 288 North 1460 West Salt Lake City, UT, 84114

Agenda Items

1.	Welcome - **Approve Minutes of March 17, 2016 MCAC** - Appointment of Jenifer Lloyd to the MCAC	Russ Elbel	5 Minutes
2.	New Rulemakings - *Information*	Craig Devashrayee	5 Minutes
3.	Eligibility Update - *Information*	Jeff Nelson	5 Minutes
4.	PRISM – Provider Enrollment Update	Melanie Wallantine	5 Minutes
5.	Mental Health and Parity Final Rule for Medicaid and CHIP	Emma Chacon	10 Minutes
6.	Medicaid Expansion	Emma Chacon	90 Minutes

* Informational handout in the packet sent to Committee members
** Action Item - MCAC Members must be present to vote (substitutes are not allowed to vote)
*** Please send meeting topics or other correspondence to Josip Ambrenac (jambrena@utah.gov)
**** If unable to attend in person, the phone # is (800) 319-9003 guest passcode 202989#****

Next Meeting: June 16, 2016
4:00 p.m. – 6:00 p.m.
Room 125
Cannon Health Building
288 North 1460 West

Medical Care Advisory Committee

Minutes of May 19, 2016

Participants

Committee Members Present

Russ Elbel (Chair), Andrew Riggle (Vice-Chair), RyLee Curtis, Debra Mair, Mark Brasher, Kevin Burt, Sara Carbajal-Salisbury, Jenifer Lloyd, Steven Mickelson, Mark Ward, Jonathan George, Pete Ziegler, Via Phone: Adam Cohen, Emma Chacon, Nate Checketts,

Committee Members Excused

Tina Persels, Danny Harris

Committee Members Absent

Jason Horgesheimer, Michelle McOmber, Jackie Rendo, Donna Singer

Guests

Nancy Ortiz, UDOH-SIM Grant, W. E. Cosgrove, MD, Representing AARP, Samantha Easthope, Constituent, Todd Wood, Select Health, Tracy Altman, UUHP, Joyce Dolcourt, LCPD, Jermey Christensen, DSAMH, Dan Davidson, Citizen, Kris Fawson, USILC

Welcome

Russ Elbel called the meeting to order at 1:04 p.m. Russ introduced the newest MCAC member, Jennifer Lloyd. Jennifer is the Deputy Director of Association of Utah Community Health and will be representing Community Health Center providers.

Approval of Minutes

Mark Ward moved to approve the March 27, 2016 minutes. Steve Mickelson seconded the motion. All approved. None opposed.

New Rulemakings

CRAIG DEVASHRAYEE

DMHF Rules posted also online at: http:/health.utah.gov/mcac

R414-505 Participation in the Nursing Facility Non-State Government-Owned Upper Payment Limit Program (Emergency Rule). This ruling was filed April 25, 106 and will become effective April 15, 2016

R414-513 Intergovernmental Transfers (Emergency Rule. This ruling was filed April 25, 106 and will become effective April 15, 2016

R414-1-5 Incorporations by Reference; Subsection 26-18-3(2)(a). This ruling was filed April 25, 106 and will become effective April 15, 2016.

R382-10-6 Citizenship and Alienage. This ruling was filed May 2, 2016 and will become effective July 1, 2016.

R414-302-3 Citizenship and Alienage. This ruling was filed May 2, 2016 and will become effective July 1, 2016.

R414-303 Coverage Groups. This ruling was filed May 2, 2016 and will become effective July 1, 2016.

R414-304 Income and Budgeting. This ruling was filed May 2, 2016 and will become effective July 1, 2016.

R414-305 Resources. This ruling was filed May 2, 2016 and will become effective July 1, 2016.

R414-4013 Assessment. This ruling was filed May, 2016 and will become effective July 1, 2016.

No questions from the committee were asked.

Eligibility Update JEFF NELSON

Jeff presented a handout on the growth of Medicaid. First point given on the chart was the enrollment showing people with disabilities over age 65 increased 3.6% and 1.5 % compared over a year ago. Children and adult enrollment has grown to 2.6% and 9%, pregnant women declined 8% between March 2015 and 2016. According to the Utah data unemployment rate is 3.6% being 6th best in the nation compared with the nation at 4.9%. Question is why Medicaid continues to increase month over month. Utah may be the job leaders in job growth but lacks in wage growth when compared to the nation. The most recent Bureau of Labor statistics shows Utah average weekly wage ranked thirty-fifth in the nation.

PCN numbers were reported on. Parents with children on PCN were 8,574 and parents without dependents was 8,397. Historically, over time there was a 2 to 1 ration, enrolling more parents than those without dependent children. A member of the committee asked where the requirement came from or what authority supported this position. Emma clarified that it is part of the waiver.

PRISM – Provider Enrollment Update MELANIE WALLANTINE

To prepare for the new PRISM enrollment on July 1, 2016 there will be a freeze on new enrollment starting June 1, 2016.

If providers apply for new enrollment in June, applications will be mailed back with a message stating that Medicaid is not accepting enrollment and asking them to apply in PRISM beginning July 1, 2016.

Since providers will not be able to apply in the month of June, applications may be made retroactive at the request of the provider. Messages were communicated to providers in early May with a publication in an interim Medicaid Information Bulletin, information on the Medicaid customer service line, website notification and by email.

Mental Health and Parity Final Rule EMMA CHACON

A summary of the primary purpose of the Rule was given. The regulation doesn't require Medicaid or CHIP to provide certain mental health or substance abuse benefits. However, if you do provide these benefits you will have to go through a process to assure that you are not putting any greater restrictions or requirements on these benefits, than you do for medical and surgical benefits. The final rule for Medicaid and CHIP will include review of four basic benefit categories: in-patient; out-patient; emergency care; and prescription drugs. In contrast to the regulations issued to the commercial marketplace, there are no increased cost exemptions for Medicaid, CHIP, or alternative benefit plans.

The Division made several changes to CHIP benefits a couple of years ago to come into compliance with mental health parity. This presented challenges since there is an exemption in the regulation for small

employer plans. The benchmark for CHIP is a small employer plan. Additional changes need to be made regarding the current residential treatment benefit available in CHIP.

A question regarding the analysis that is due Sept 2017, is there a waiting period after submitting?
The assumption is that the Division will submit our analysis and provide CMS assurance that DOH is in compliance. Looking at things like co-pays, prior authorizations for health services; etc., it was felt there will be no significant parity issues.

A question was asked on if a person may be eligible for Medicaid when they have been released from incarceration and are now residing in a half-way house. CMS clarified and those that work and are allowed to come and go from the facility while in these situations may be eligible for Medicaid. This is now in effect.

A question asked if there will be any public input or public comment on the parity review?
There is no provision in the regulation for public input or comment on the analysis, but the Division will take that under consideration.

Because mental health is also included in the access to care adequacy review, will these two processes be worked together? Emma confirmed that there will likely be coordination with these processes.

Medicaid Expansion

NATE CHECKETTS

An overview on the handout of the proposal on the Medicaid Adult Expansion was given. During the 2016 General Session House Bill 437. This Bill directed the Department of Health (DOH) to expand coverage for adults and to develop criteria for three new eligibility groups of adults without dependent children. DOH must submit a plan to the Centers for Medicare and Medicaid Services (CMS) to modify the current Utah Medicaid program accordingly. Utah is seeking to increase Medicaid coverage levels for parents up to 60 percent of the federal poverty level (FPL) and to create three new eligibility groups for adults without dependent children. The adults without dependent children can have incomes up to 5 percent FPL. It is estimated that 9,000 – 11,000 adults will be covered through these changes.

The following list (by priority) are the new eligibility groups targeted by this health coverage improvement plan. The definition and criteria of each population were given.

- Chronically homeless
- Involved in the justice system AND are in need of substance use or mental health treatment
- Needing substance abuse or mental health treatment

The additional amendments Utah is requesting to its existing 1115 waivers:

- Three-year extension of the existing Primary Care Network (PCN) Demonstration Waiver.
- Waiver of the Medicaid Institutions for Mental Diseases (IMD) exclusion under Section 1905(a)(29) (B) of the Social Security Act to allow for medically necessary Residential treatment Services for Individuals with substance use disorders.
- Implementation of Mental Health Parity and termination of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Waiver for the Non-Traditional Medicaid recipients.
- Removal of the High-Risk Pregnant Woman Demonstration group.

The Department has sent out a draft of the waiver and is accepting public comments along with three scheduled public hearings to discuss the waiver. Public comments will be accepted until June 8th. All comments will be reviewed and changes will be considered. The Department will submit the waiver to CMS on July 1, 2016 and from there CMS will have a 30-day comment period and will negotiate the terms and conditions with the Department.

Medicaid Expansion – Public Testimony

MEMBERS OF THE PUBLIC

An opportunity was afforded to members of the public to provide their comments and concerns related to the Medicaid Expansion proposal.

Adjournment

With no additional public comment received, the meeting concluded at 3:05 p.m.

ATTACHMENT 6

Public Hearing

May 25th and May 31st 2016

Waiver Overview Document

UTAH DEPARTMENT OF HEALTH MEDICAID

Medicaid Adult Expansion Overview
May 2016

Executive Summary

During the 2016 General Session of the Utah State Legislature, House Bill 437 passed and was signed into law by Governor Gary Herbert on March 25, 2016. This bill directs the Department of Health (DOH) to expand coverage for parents and to develop criteria for three new eligibility groups of adults without dependent children. DOH must submit a plan to the Centers for Medicare and Medicaid Services (CMS) to modify the current Utah Medicaid program accordingly. It is estimated that 9,000-11,000 adults will be covered through these changes.

1115 Demonstration Waiver Proposal Overview

Utah is seeking to increase Medicaid coverage levels for parents up to 60 percent FPL. In addition, the proposed Demonstration will create three new eligibility groups for adults without dependent children. All adults without dependent children must meet the following eligibility criteria:

- Age 19-64
- U.S. citizen or qualified alien
- Resident of Utah and not in a public institution
- Household income up to five percent FPL
- Ineligible for any other Medicaid program (without a spenddown or MWI premium)

The following, listed by priority, are the criteria for the new eligibility groups targeted by this health coverage improvement plan:

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

2. **Involved in the justice system AND in need of substance use or mental health treatment** – Defined as an individual:
    1) Who has successfully completed a behavioral health treatment program while incarcerated in jail or prison (requirements regarding the type and length of qualifying programs will be established in Utah Administrative Code); or

2) Discharged from the State Hospital who was admitted to the hospital due to an alleged criminal offense; or
3) Involved in a Drug Court or Mental Health Court. Drug courts require frequent testing and court supervision, and focus upon eliminating drug addiction as a long-term solution to crime. Many drug court participants have co-occurring mental and physical health problems. Mental health courts combine judicial supervision with community health treatment and other support services in order to reduce criminal activity. They seek to address the underlying problems that contribute to criminal behavior.

3. **Needing substance abuse or mental health treatment** – Defined as an individual:
   1) Receiving General Assistance from DWS, who has been diagnosed with a substance use or mental health disorder. The General Assistance Program provides time limited cash assistance and case management services to adults that have no dependent children. General Assistance customers must verify they have a physical or mental health impairment that prevents them from working; or
   2) Discharged from the State Hospital who was civilly committed.

Additional Amendments

In addition, Utah is requesting the following amendments to its existing 1115 waiver:

- Three-year extension of the existing Primary Care Network Demonstration Waiver.
- Waiver of the Medicaid Institutions for Mental Diseases (IMD) exclusion under Section 1905(a)(29)(B) of the Social Security Act to allow for medically necessary Residential Treatment Services for individuals with substance use disorders.
- Implementation of Mental Health Parity and termination of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Waiver for the Non-Traditional Medicaid recipients.
- Removal of the High-Risk Pregnant Woman Demonstration group.

Implementation Schedule

The State is required to obtain approval from CMS before implementing the proposed plan. The full 1115 waiver proposal draft is available online at: http://health.utah.gov/MedicaidExpansion.

You may provide comment and feedback on this draft until June 8th. The web site has a form to submit commits and lists dates and times for public hearings. After collecting and responding to public comments, the State will finalize the waiver and submit it to CMS on July 1, 2016. If approved, the State expects to begin enrolling new members on January 1, 2017.

ATTACHMENT 7

External Quality Review Report

The most recent External Quality Review Report can be found at:

https://sites.google.com/a/utah.gov/cqm/home/external-quality-review-2015-2016

ATTACHMENT 8

CAHPS Report

The most recent Utah 2014 and 2015 Customer Satisfaction Survey (CAHPS) Report can be found at:

Children- https://health.utah.gov/myhealthcare/reports/cahps/2014/index.php

Adults- https://health.utah.gov/myhealthcare/reports/cahps/2015/

ATTACHMENT 9

Amendment #16

Adults without Dependent Children-Medicaid

Attachment 9

Section 1115 Demonstration Application

Amendment #16

Adults without Dependent Children

Section I- Program Description and Objectives

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

Under this Demonstration, the State seeks to implement a health coverage improvement program that will cover targeted populations of adults without dependent children. Some of these individuals may currently be covered under the existing Primary Care Network (PCN) program, Section 1115 Demonstration. This Demonstration will cover adults without dependent children age 19-64 years of age, with income at zero percent of the Federal Poverty Level (FPL) using the Modified Adjusted Gross Income (MAGI) methodology. The MAGI methodology includes a five percent FPL income disregard. In addition to the current eligibility criteria, these adults must meet one of the following additional criteria:

1) Be chronically homeless, defined as:

- An individual who has been continuously homeless for at least 12 months or on at least 4 separate occasions in the last 3 years; and has a disabling condition (further defined in Section II below); or
- An individual currently living in supportive housing who has previously met the definition of chronically homeless above.

2) Involved in the justice system AND in need of substance use or mental health treatment, defined as:

- An individual who has successfully completed a substance use disorder treatment program while incarcerated in jail or prison; or
- An individual involved in a Drug Court or Mental Health Court; or
- An individual discharged from the State Hospital who was admitted to the hospital due to an alleged criminal offense.

3) Needing substance use or mental health treatment, defined as:

- 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
- An individual discharged from the State Hospital who was civilly committed.

Individuals eligible under the Demonstration will receive the traditional benefit package available under the State plan. If approved, this group will also receive 12-months of continuous eligibility. With few exceptions, changes that occur during the 12-month certification period will not impact eligibility. In addition, if future waiver amendments would cause a recipient to be ineligible, members currently enrolled through this amendment will be able to complete their original 12-month eligibility period under this waiver.

Utah is also seeking authority to modify the definition of these populations through Utah Administrative Code. For example, if there is a need to change the chronically homeless criteria from 12-months of continuous homelessness to 6 or 18-months, this would be done through a revision to the Utah Administrative Code.

The Demonstration program furthers the objectives of Title XIX of the Social Security Act by promoting continuity of coverage for individuals, improving access to providers, supporting the triple AIM, and providing medical assistance for some of the neediest Utahns.

2) Include the rationale for the Demonstration.

This Demonstration waiver request supports implementation of House Bill 437- "Health Care Revisions", which was signed into law by Governor Gary Herbert on March 25, 2016. After years of deliberation and research, the State has developed a plan for a Utah-specific approach to reduce the number of uninsured adults in the state. This approach targets specific high-need populations.

According to surveys conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), 4.8 percent of Utah adults suffer from serious mental illness, which equates to approximately 97,000 residents. In addition 7.8 percent abuse alcohol or illicit drugs. Without medical coverage, these populations will not be able to access the treatment they need to find and sustain employment, secure housing and avoid re-hospitalization or incarceration. Higher rates of mental and physical illness among individuals who abuse drugs or alcohol are important contributors to health care expenditures. In addition, individuals who abuse drugs or alcohol use expensive forms of acute care more often than others. Many times individuals who are released from incarceration are not able to get the care and treatment they need to curtail certain behaviors that are driven by substance abuse and mental illness.

In crafting this Demonstration, the Utah Department of Health (UDOH) worked with many stakeholders to determine how to best meet the intent of House Bill 437. Stakeholders involved in discussions included other state agencies such as the Department of Corrections, Department of Workforce Services, Administrative Office of the Courts, Division of Substance Abuse and Mental Health within the Department of Human Services, and the Commission on Criminal and Juvenile Justice. In addition, UDOH met with county and city government representatives, local mental health agencies, treatment providers, homeless shelter providers and the Association for Utah Community Health. UDOH also held four informal public discussions to gather public feedback prior to drafting this request. Feedback provided by stakeholders was carefully considered in defining the groups to include in the Demonstration.

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.

The Demonstration will authorize the delivery of medical benefits to a targeted group of low-income adults. By providing access to needed medical care, mental health treatment and substance use treatment, the Demonstration will improve health outcomes for participants. The following hypotheses will be tested during the approval period:

Hypothesis	Evaluation Approach	Data Sources
The Demonstration will reduce the number of uninsured Utahns.	Comparison and trending of measures. This will include setting a baseline (when available) and analyzing trends in measures over the length of the Demonstration.	Uninsured rates from the Utah Behavioral Risk Factor Surveillance System (BRFSS)
The Demonstration will improve access to primary care, while also improving the overall health status of the target population.	Comparison and trending of measures. This will include setting a baseline (when available) and analyzing trends in measures over the length of the Demonstration. Specifically, the number of primary care physician office visits and emergency room visits will be used.	Claims/encounter data from the State's system

The demonstration will reduce the number of non-emergent Emergency Room visits for the chronically homeless population.	Comparison and trending of measures. This will include setting a baseline (when available) and analyzing trends in measures over the length of the Demonstration.	Claims and encounter data
The Demonstration will reduce uncompensated care provided by Utah hospitals.	Comparison and trending of measures. This will include setting a baseline (when available) and analyzing trends in measures over the length of the Demonstration.	Hospital Costs Report

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate.

The Demonstration will operate statewide.

5) Include the proposed timeframe for the Demonstration.

January 1, 2017 - December 31, 2021

6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

The Demonstration will not affect and/or modify other components of the State's current Medicaid and CHIP programs. Individuals eligible under this amendment will receive traditional State plan benefits. In addition, services will be provided through Utah's current delivery system.

Section II- Demonstration Eligibility

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration (note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included).

The Demonstration will target individuals who meet the following eligibility criteria, listed by priority:

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

    - Stays in institutional care facilities for fewer than 90-days will not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility.

2. Involved in the justice system AND in need of substance use or mental health treatment- this is defined as: (1) an individual who has successfully completed a substance use disorder treatment program while incarcerated in jail or prison, including Tribal jails (requirements regarding the type and length of qualifying programs will be established in Utah Administrative Code); (2) an individual discharged from the State Hospital who was admitted to the hospital due to an alleged criminal offense; or (3) an individual involved in a Drug Court or Mental Health Court, including Tribal courts. Drug courts require frequent testing and court supervision, and focus upon eliminating drug addiction as a long-term solution to crime. Many drug court participants have co-occurring mental and physical health problems. Mental Health Courts combine judicial supervision with community health treatment and other support services in order to reduce criminal activity. They seek to address the underlying problems that contribute to criminal behavior.

3. Needing substance abuse or mental health treatment- this is defined as: (1) an individual receiving General Assistance from DWS, who has been diagnosed with a substance use or mental health disorder. The General Assistance program provides time limited cash assistance and case management services to adults that have no dependent children. General Assistance customers must verify they have a physical or mental health impairment that prevents them from working; (2) an individual discharged from the State Hospital who was civilly committed.

In addition to the criteria above, the individual must also meet ALL of the requirements below to be eligible for the Demonstration. Individuals must be:

- Adults, age 19-64 years old, without dependent children;
- A U.S. citizen or qualified alien;
- A resident of Utah and not in a public institution;

- Have household income of 0 percent of the Federal Poverty Level (FPL) using the MAGI methodology which includes a five percent FPL income disregard;
- Ineligible for other Medicaid programs that do not require a spenddown to qualify.

Retroactive coverage will be allowed, but may not begin prior to the effective date of the Demonstration program.

Pursuant to 42 CFR 435.1110(c)(1), the Demonstration group will not be eligible for presumptive eligibility.

Expansion Populations

Eligibility Group Name	N/A	Income Level
Adult Expansion	N/A	0% FPL after 5% income disregard

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.

When determining eligibility under the Demonstration, Utah will apply the same eligibility standards and methodologies described in the State plan. MAGI methodology will be used and there will be no asset limit.

The state will work with various state agencies and community partners to verify factors of eligibility, whenever possible. For example, the primary verification source for the chronically homeless criteria will be the HMIS system maintained by the Housing and Community Development division of DWS.

3) Specify any enrollment limits that apply for expansion populations under the Demonstration.

There are no caps on enrollment in the Demonstration.

Description	Income	Age	Exceptions
Adult Expansion	0% after 5% disregard	19-64	Ineligible if disabled per SSA

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan,

or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.

We are anticipating approximately 6,000-7,000 individuals will be eligible under this amendment. This is based on an analysis of the eligibility criteria defined under #1 above, using data provided by stakeholders.

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).

For individuals with a community spouse, we will apply the Spousal Impoverishment rules under Sec. 1924 of the Social Security Act to determine eligibility. We will also apply the Sec. 1924 post-eligibility treatment of income rules. For individuals who do not have a community spouse, we will apply the regular post-eligibility treatment of income rules defined in 42 CFR 435.725.

6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).

Upon approval, individuals eligible under the Demonstration will have 12-months of continuous eligibility. Changes during the certification period will not affect eligibility with the exception of the following:

- Moved out of state
- Death
- Determined eligible for another State plan program
- Fraud
- Client request

If the State changes eligibility rules for this targeted population, the changes will not apply to an individual during the 12-month certification period.

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.

Not applicable. MAGI methodology will be used.

Section III- Demonstration Benefits and Cost Sharing Requirements

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

___ Yes __X__ No (if no, please skip questions 3 – 7)

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

____Yes __X__No (if no, please skip questions 8 - 10)

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration:

Not applicable.

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:
___ Federal Employees Health Benefit Package
___ State Employee Coverage
___ Commercial Health Maintenance Organization
___ Secretary Approved

Not applicable.

5) In addition to the Benefit Specifications and Qualifications form: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan.

Not applicable. The benefits under the Demonstration are the same as the State plan.

6) Indicate whether Long Term Services and Supports will be provided.
___ Yes (if yes, please check the services that are being offered) ___ No

Benefits under the Demonstration will not differ from those provided under the State plan.

In addition, please complete the: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf, and the: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf.)

Homemaker
Case Management
Adult Day Health Services
Habilitation – Supported Employment
Habilitation – Day Habilitation
Habilitation – Other Habilitative
Respite
Psychosocial Rehabilitation
Environmental Modifications (Home Accessibility Adaptations)
Non-Medical Transportation
Home Delivered Meals Personal
Emergency Response
Community Transition Services
Day Supports (non-habilitative)
Supported Living Arrangements
Assisted Living
Home Health Aide
Personal Care Services
Habilitation – Residential Habilitation
Habilitation – Pre-Vocational
Habilitation – Education (non-IDEA Services)
Day Treatment (mental health service)
Clinic Services
Vehicle Modifications
Special Medical Equipment (minor assistive devices)
Assistive Technology
Nursing Services
Adult Foster Care
Supported Employment
Private Duty Nursing
Adult Companion Services
Supports for Consumer Direction/Participant Directed Goods and Services
Other (please describe)

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

___ Yes (if yes, please address the questions below)
___ No (if no, please skip this question)

8) If different from the State plan, provide the premium amounts by eligibility group and income level.

There are no premiums under the Demonstration.

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan:

Not applicable. This will not differ from the State plan.

10) Indicate if there are any exemptions from the proposed cost sharing.

Not applicable. This will not differ from the State plan.

Section IV- Delivery System and Payment Rates for Services

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:
___ Yes
__X_ No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:
Managed care
Managed Care Organization (MCO)
Prepaid Inpatient Health Plans (PIHP)
Prepaid Ambulatory Health Plans (PAHP)
Fee-for-service (including Integrated Care Models) Primary Care Case Management (PCCM)
Health Homes
Other (please describe)

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in

the Demonstration. Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:

5) If the Demonstration will utilize a managed care delivery system:

a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state.

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state).

d) Describe how the state will assure choice of MCOs, access to care and provider network adequacy.

e) Describe how the managed care providers will be selected/procured.

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration.

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.

Not applicable. There is no deviation from the State plan.

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

Capitation payments for the populations covered under this amendment will be actuarially certified in accordance with 42 CFR Part 438. The contract provisions for these populations will comply with the requirements of 42 CFR 438.

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.

Not applicable.

Section V- Implementation of Demonstration

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

The anticipated implementation date of the Demonstration is January 1, 2017. Current PCN eligibles who qualify for the Demonstration, and who can be identified in the eligibility system without further verification, will be moved to the program effective January 1, 2017. All newly eligible individuals can begin receiving benefits effective January 1, 2017.

Milestone	Timeframe
Move current PCN individuals who are eligible for Demonstration to new program	January 1, 2017
Approve newly eligible individuals	January 1, 2017

2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.

Adults without Dependent Children- Current PCN Eligibles

Individuals in this group who can be identified as eligible for the Demonstration program, using existing information in their case file, will be moved to the Demonstration program as of January 1, 2017. No further action will be needed by these individuals. They will be notified of their enrollment in the Demonstration program.

Current PCN eligible individuals who cannot be identified as eligible for the Demonstration program, will be sent notification informing them of the new program. They will be directed to contact DWS (the department that makes Medicaid eligibility determinations) to request an eligibility determination for the Demonstration program. Any PCN eligible individuals who do not request an eligibility determination will have their case reviewed at their recertification date. DWS will then determine if the individual is eligible under this amendment.

New applicants

Eligibility for the Demonstration program will begin on January 1, 2017, with an enrollment date of no earlier than January 1, 2017. Eligibility for the Demonstration program will be determined with any application submitted as early as December 2016.

The State will coordinate with community partners and other state agencies to identify and verify eligibility for the following criteria: (1) chronically homeless; (2) justice system involved with a substance abuse disorder or mental health disorder; and (3) individuals with a substance abuse disorder or mental health disorder. These partners and agencies include: homeless shelters, Adult Probation and Parole, county criminal justice partners and the State Hospital.

Managed Care Enrollment

Enrollment in managed care plans for the Demonstration group will occur as it does for those covered under the State plan. Individuals eligible for the Demonstration who reside in one of the thirteen managed care counties will be notified of the requirement to choose a managed care plan. If they do not choose one, one will be assigned. All eligibles will also be enrolled in a prepaid mental health plan.

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.

The state of Utah currently operates two approved 1915 (b) waivers: the Choice of Health Care Delivery Program & Hemophilia Disease Management program and the Utah Prepaid Mental Health Plan.

The Choice of Health Care Delivery Program waiver allows the State to mandate enrollment in a Medicaid Accountable Care Organization (ACO) in thirteen mandatory enrollment counties. ACOs are responsible to provide physical health benefits to their enrollees except for specific carve outs. Utah currently has four ACOs on contract, HealthChoice Utah, Healthy U, Molina Healthcare of Utah and SelectHealth. These plans will also provide services and care management for the populations addressed in this amendment. The State is not required to go through a separate procurement process. The State intends to also amend its 1915 (b) waiver to include these populations.

Utah's Prepaid Mental Health Plan allows the State to automatically enroll Medicaid members in a prepaid mental health/substance use disorder plan. These plans are administered through local county mental health and SUD authorities who have a statutory obligation to provide behavioral health services to the residents in their counties. The State is not required to conduct a procurement action to allow us to contract with these entities. The State will enroll the populations addressed in this waiver in a Medicaid prepaid mental health plan to receive their mental health and SUD services. The State intends to also amend its 1915 (b) waiver to include these populations.

HB 437 envisions that ACOs and counties will work together to integrate behavioral health care into ACOs. Where there is interest in integration and to the extent feasible within established timeframes, the appropriate 1915(b) waivers will be amended to accomplish this integration.

Section VI- Demonstration Financing and Budget Neutrality

See Attachment 1.

Section VII- List of Proposed Waivers and Expenditure Authorities

1) Provide a list of proposed waivers and expenditure authorities.

The state does not intend to request any additional waivers for this population that are beyond what are in the current 1115 waiver.

Proposed Waivers

- Section 1902(a)(1)- Statewideness/Uniformity
- Section 1902(a)(10)(B)- Amount, Duration, and Scope of Services and Comparability
- Section 1902(a)(23)(A)- Freedom of Choice

Expenditures

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

2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

Waiver Authority	Reason and Use for Waiver
Section 1902(a)(1)	To enable the State to provide differing types of managed care plans in certain geographical areas of the state for the Title XIX populations affected by this Demonstration.
Section 1902(a)(10)(B)	To enable the State to provide benefits to Title XIX State plan populations affected by this Demonstration that are less than those available to other individuals under the State

	plan. In addition this waiver enables the State to include additional benefits for Demonstration eligibles, who are enrolled in managed care delivery system, such as case management and health education, compared to the benefits available to individuals eligible under the State plan that are not affected by the Demonstration.
Section 1902(a)(23)(A)	To enable the State to restrict freedom of choice of providers for Title XIX populations affected by this Demonstration. This does not apply to family planning providers.

Section VIII- Public Notice

1) Start and end dates of the state's public comment period.

The State's public comment period was May 9, 2016 through June 8, 2016. A second public comment period was held July 16, 2016 through August 15, 2016, specifically to request comments related to budget neutrality.

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

Utah certifies that it provided public notice of the application on the State's Medicaid website at http://health.utah.gov/MedicaidExpansion, beginning May 9, 2016. A news release was also issued on May 9, 2016. A news release was also issued on July 16, 2016 for the second public comment period, and can be found at http://www.utahlegals.com/notice.php?id=283846.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

Utah certifies that it convened three public hearings at least twenty days prior to submitting the application to CMS. Utah held the following hearings:

- Salt Lake City- May 19, 2016, 1:30-3:30 p.m. This hearing was held during the State's Medical Care Advisory Committee meeting. Nate Checketts, Deputy Director, provided an overview of the Demonstration. Individuals who requested to provide public comments were able to do so. Individuals were also able to participate by teleconference.

- Salt Lake City- May 25, 2016, 1:00-3:00 p.m. Nate Checketts, Deputy Director, provided an overview of the Demonstration. Individuals who requested to provide public comments were able to do so. Individuals were also able to participate by teleconference.

- Logan- May 31, 2016, 11:30 a.m. - 1:00 p.m. Nate Checketts, Deputy Director, provided an overview of the Demonstration. Individuals who requested to provide public comments were able to do so. Individuals were also able to participate by teleconference.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)

The State certifies that electronic notification was issued on the State's website for posting public hearings at http://pmn.utah.gov. This website automatically notifies statewide newspapers when public hearing notices are posted. The public hearings were also listed in the Utah State Bulletin at: http://www.rules.utah.gov/publicat/bull_pdf/2016/b20160501.pdf

5) Comments received by the state during the 30-day public notice period.

See Attachment 12.

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

See Attachment 12.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

Utah certifies that the State conducted tribal consultation in accordance with the consultation process outlined in the State's approved Medicaid State plan. A presentation regarding the Demonstration was given at the Utah Indian Health Advisory Board (UIHAB) meeting held on May 13, 2016. See Attachment 4.

Section IX Demonstration Administration

Name and Title: Nate Checketts, Deputy Director, Utah Department of Health

Telephone Number: (801) 538-6689

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ATTACHMENT 10

Amendment #17

Residential Treatment Services for Substance Use Disorders

Attachment # 10

Section 1115 Demonstration Application

Amendment # 17

Substance Use Disorder Treatment and Residential Treatment Services

Background

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 Utahns 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.

Comprehensive Evidence-Based 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 Addiction Medicine (ASAM) Patient Placement Criteria. Utah is planning to add coverage for SBIRT (Screening, Brief Intervention and Referral to Treatment) as a state plan covered service. With the submission of this waiver amendment, Utah is also seeking to obtain expenditure authority to add short term residential treatment for substance use disorder for adults and youth. Utah anticipates that providing this service to individuals with SUD needs will result in greater and more appropriate clinical treatment options for Medicaid beneficiaries and reductions in hospital and Emergency Department admissions. Short term residential treatment for SUD is a current gap in Utah's continuum of care. Individuals with SUD are often seen in EDs due for detoxification. In other cases they are brought to the ED by law enforcement due to their behavior which makes them a danger to themselves or others. The individual is admitted to the hospital until the individual is at least medically stable. For adults, the individual is often released with the expectation that they will immediately seek and comply with outpatient treatment. However for many of these individuals, that expectation is unrealistic. Rather the individual needs to move to a structured environment such as residential treatment that is more clinically appropriate before they move to lower levels of care. Youth often times linger in a high cost hospital bed, because their family home, or former foster care placement is not able to provide a safe and appropriate structure with clinical treatment. Again, the availability of short term residential treatment would allow a transition that will lead to them returning home and utilizing outpatient treatment. This is certainly more cost effective than a continued hospital stay.

SUD services under the Utah State Plan are available to all Medicaid members in all counties of the state. In Utah's 1115 PCN Demonstration Waiver, Amendment No. 15, Utah is seeking approval to provide Medicaid covered services to adults without dependent children between the ages of 19 and 64, many of whom have an SUD. A full continuum of SUD treatment becomes even more critical in an effort to address the needs of current Medicaid members, as well as any additional adult populations.

Attachment # 11 ***"Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services"*** describes Utah's SUD services in detail.

Hypothesis

Utah will demonstrate how organized substance use disorder care increases the success of Utah Medicaid members while decreasing the cost of health care for these individuals in other health care systems. Critical elements of Utah's continuum of care are modeled after the American Society of Addiction Medicine (ASAM).

Partners

The Division of Substance Abuse and Mental Health (DSAMH), in the Department of Human Services, 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 is available throughout the state. The Utah Department of Health (DOH) is the single state agency for Medicaid. By state statute, Division of Medicaid and Health Financing, DOH (DMHF) is responsible for the administration of Utah's Medicaid program. Pursuant to state statute, local county mental health and substance abuse authorities are responsible to develop SUD and mental health prevention and treatment services plans and provide these services to the residents of their counties. The local authorities are also responsible to work with and are accountable to the DSAMH and the DOH (DMHF).

Delivery System

DMHF administers a 1915(b) waiver called the Prepaid Mental Health Plan. The majority of SUD services are provided through full risk prepaid inpatient health plans (PIHP.) These are entities that either operate under the authority of or an extension of the local substance abuse and mental health authorities. Two locations in the state continue to provide services on a fee for service basis. Utah uses the delivery system created and operationalized under our existing 1915(b) waiver to provide SUD services.

Standards of Care

In addition to using the ASAM criteria as a basis for continuum of care, the Division of Substance Abuse and Mental Health (DSAMH) issues annual directives to the local metal health

and substance use authorities and in turn requires Local authorities to b comply with the Division directives each year. A copy of the DSAMH directives for State Fiscal year 2017 can be found at:

http://dsamh.utah.gov/pdf/contracts_and_monitoring/Divison_Directives_FY17_Final.pdf

As stated above, in an effort to fill a gap in Utah's continuum of care, the Utah is requesting expenditure authority to provide ASAM Level 3 residential treatment in a non-institutional 24 – hour non-medical, short-term residential program for all Medicaid members. These residential treatment programs provide rehabilitation services to Medicaid members with a substance use disorder diagnosis when determined medically necessary by a Medical Doctor or a Licensed Practitioner of the Healing Arts and in accordance with an individualized treatment plan. This may be the Medicaid beneficiary's provider, a provider within the network of the beneficiary's Medicaid prepaid mental health plan (PMHP). These services are intended to be individualized to treat the functional deficits identified in the ASAM criteria.

Medicaid members in need of residential treatment will live on the premises and will be supported in their efforts to restore, maintain and apply interpersonal and independent living skills. The goal is to quickly transition individuals in residential treatment to outpatient services with access to community supports. Community supports can include training and supportive employments, respite, assistance to find housing, skills development services, peer support, emergency counseling, etc. Please refer to Utah Local Authority/County area Plans for more details at http://dsamh.utah.gov/provider-information/local-authoritycounty-area-plans/. Individuals in residential treatment will continue to be enrolled in a pre-paid mental health plan administered under the jurisdiction of the local authority. Each PMHP provides case management services for their enrollees. The PMHP will be expected to monitor the enrollee's medical needs and develop a plan to transition the individual from residential treatment to the community and to outpatient services as quickly as medically appropriate

Residential treatment facilities are licensed by the Department of Human Services, Office of Licensing, and certified by the DSAMH, in accordance with ASAM criteria. Residential treatment servicing providers are licensed by the Department of Commerce, Division of Occupational and Professional Licensing. All residential treatment facilities and providers of services must be enrolled as Medicaid providers and properly screened and credentialed.

Utah proposes to allow residential treatment services in facilities without a bed capacity limit as follows:

Adults

Residential treatment may range from 1-90 days with a maximum of 90 days. Two 90 day stays per year may be approved with the appropriate order for treatment and individualized treatment plan. A review must be completed every two weeks during any stay to assure continued residential treatment is medically necessary.

Adolescents/Youth

Residential treatment will be limited to no more than 30 days. Up to an additional 30 day stay may be authorized if determined to be medically necessary on an annual basis. A review must be completed every two weeks during any stay to assure continued residential treatment is medically necessary. Adolescents require shorter lengths of stay and should be stabilized and moved to less intensive level of treatment as medically appropriate.

The components of Residential Treatment Services include:

A. Evaluation and Treatment Planning
B. Individual and Group Therapy/Counseling
C. Family Therapy
D. Safeguarding Medications: Facilities will store all resident medication and facility staff members may assist resident's self-administration of medication
E. Collateral Services
F. Crisis Intervention Services
G. Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment

Table One ASAM Criteria Continuum of Care Services and the Utah Medicaid System

ASAM Level of Care	Title	Description	Provider	Existing Medicaid	New Medicaid	Needed Authority for Service

				Service Y/N	**Service Y/N**	
0.5	Early Intervention	Screening, Brief Intervention and Referral for Treatment (SBIRT)	Managed care or Fee for Services provider	N	Y	State Plan
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		State Plan
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		State Plan
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		State Plan
3.1	Clinically Managed Low-Intensity	24 hour structure with trained personnel; at least 5 hours of clinical	DHS/OL Licensed and DHS/		N	CNOM authority

	Residential Services	service/week and prepare for outpatient treatment, MAT, TCM	ASAM Designated Residential Providers			
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		State Plan
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		State Plan
3.7	Medically Monitored Intensive	24 hour nursing care with physician availability for	Chemical Dependency Recovery	Y		State Plan

	Inpatient Services	significant problems in Dimensions 1, 2 or 3. 16 hour/day counselor availability, MAT, TCM	Hospitals; Hospital, Free Standing Psychiatric Hospitals			
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		State Plan
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		State Plan

Table Two- ASAM Criteria for Withdrawal Services

Level of Withdrawal Management	**Level**	**Description**	**Provider**	**Existing Medicaid**	**New Medicaid**	**Needed Authority**

				Service Y/N	Service Y/N	for New Services
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		Y	State Plan
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		State Plan
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		Y	State Plan

The continuum of care for SUD services outlined in the foregoing tables are modeled after the levels identified in the ASAM criteria. Utah's Prepaid Mental Health Plans (PMHP) are responsible for the oversight and implementation of all levels of continuum of care with the exception of ASAM Level 4 which is a medical benefit covered under the Utah Medicaid Accountable Care Organization (ACO) Contracts.

References:

DMHF 2015 Annual Report: https://medicaid.utah.gov/Documents/pdfs/annual%20reports/medicaid%20annual%20reports/MedicaidAnnualReport_2015.pdf

DSAMH 2015 Annual Report: http://dsamh.utah.gov/data/annual-reports/

Local Human Services Act: http://le.utah.gov/xcode/Title17/Chapter43/17-43.html

DSAMH Local Authority/County Plans: http://dsamh.utah.gov/provider-information/local-authoritycounty-area-plans/

ATTACHMENT 11

Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services

SECTION 2

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1 GENERAL POLICY

1 - 1 Authority

Rehabilitative mental health and substance use disorder services are provided under the authority of §1905(a)(13) of the Social Security Act and 42 CFR §440.130, Diagnostic, Screening, Preventive, and Rehabilitative Services. In accordance with §1905(a)(13) of the Social Security Act, outpatient rehabilitative mental health and substance use disorder services may be provided in settings other than the provider's office, as appropriate.

In this manual, the term 'behavioral health' will include both mental health and substance use disorders (SUDs) unless otherwise specified. When mental health disorders or substance use disorders are referred to separately, the term 'mental health' or 'substance use' will be used.

Rehabilitative mental health and substance use disorder services are designed to promote the individual's behavioral health and to restore the individual to the highest possible level of functioning. Services must be provided to or directed exclusively toward the treatment of the Medicaid individual.

Rehabilitative behavioral health services may be provided to individuals with a dual diagnosis of a mental health and/or substance use disorder and an intellectual disability, developmental disorder or related condition when the services are directed to the treatment of the mental health or substance use disorder.

1 - 2 Definitions

Behavioral health disorders means mental health and substance use disorders.

Behavioral health services means the rehabilitative services directed to the treatment of the mental health and/or substance use disorder.

CMS means the Centers for Medicare and Medicaid Services, the federal Medicaid agency within the Department of Health and Human Services.

Children in Foster Care means children and youth under the statutory responsibility of the Utah Department of Human Services identified as such in the Medicaid eligibility (eREP) system.

Division of Medicaid and Health Financing (DMHF) means the organizational division in the Utah Department of Health which administers the Medicaid program in Utah (herein after referred to as Medicaid).

Division of Occupational and Professional Licensing (DOPL) means the division within the Utah State Department of Commerce responsible for occupational and professional licensing.

Early Periodic Screening Diagnosis and Treatment (EPSDT) means the federal preventive health care services program for children, which is known in Utah as the Child Health Evaluation and Care (CHEC) Program.

Enrollee means any Medicaid eligible individual enrolled in the Prepaid Mental Health Plan (PMHP).

Fee-for-Service means Medicaid covered services that are billed directly to and paid directly by Medicaid based on an established fee schedule.

Habilitation Services typically means interventions for the purpose of helping individuals acquire new functional abilities whereas rehabilitative services are for the purpose of restoring functional losses. (See Rehabilitative Services definition below.)

Healthy Outcomes Medical Excellence Program (HOME), operated by the University of Utah, means a voluntary managed care program for Medicaid recipients who have a developmental disability and mental health or behavioral challenges. HOME is a coordinated care program that provides to its enrollees medical services, mental health/substance use disorder services, and targeted case management services specified in the Utah Medicaid provider manual titled *Utah Medicaid Provider Manual for Targeted Case Management for Individuals with Serious Mental Illness*. When Medicaid recipients enroll in HOME, they are removed from their PMHP and physical health plan, if enrolled.

Medically Necessary Services means any rehabilitative service that is necessary to diagnose, correct, or ameliorate a behavioral health disorder or prevent deterioration or development of additional behavioral-health problems, and there is no other equally effective course of treatment available or suitable that is more conservative or substantially less costly.

Non-Traditional Medicaid means, pursuant to the 1115 Primary Care Network Demonstration Waiver, the reduced benefits plan provided to Medicaid recipients age 19 through 64 who:

1) are not blind, not disabled, not pregnant, or not within 60 days postpartum;

2) are in a medically needy aid category and are not blind, not disabled, not pregnant, or not within 60 days postpartum); or

3) are in a transitional Medicaid aid category.

Services covered under Non-Traditional Medicaid are similar to Traditional Medicaid with some limitations and exclusions.

Prepaid Mental Health Plan (PMHP) means the Medicaid mental and substance use disorder managed care plan that covers inpatient and outpatient mental health services and outpatient substance use disorder services for PMHP-enrolled Medicaid members.

Presumptive Eligibility means temporary Medicaid coverage for qualified low income individuals prior to establishing eligibility for ongoing Medicaid.

Rehabilitative Services means any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts (i.e. licensed mental health therapist) for maximum reduction of an individual's behavioral health disorder and restoration of the individual to his/her best possible functional level.

Traditional Medicaid means the scope of services contained in the State Plan provided to Medicaid recipients who fall under one of the following Medicaid aid groups:

1) Section 1931 children and related poverty-level populations under age 19;

2) Section 1931 pregnant women (including 60 days postpartum);

3) Blind or disabled children and related populations;

4) Blind or disabled adults and related populations under age 65;

5) Aged adults age 65 and older and related populations (SSI, QMB and Medicaid, Medicare and Medicaid);

6) Children in Foster Care;

7) Individuals who qualify for Medicaid by paying a spenddown and are under age 19; or

8) Individuals who qualify for Medicaid by paying a spenddown and are also blind or disabled.

Treatment goals means measures of progress decided jointly with the client whenever possible and may also be referred to as measurable goals or measurable objectives. For purposes of this provider manual, the term 'treatment goals' will be used to specify the measures contained in treatment plans.

1 -3 Medicaid Behavioral Health Service Delivery System

In most areas of the state, rehabilitative behavioral health services are covered under Medicaid's Prepaid Mental Health Plan (PMHP).

The table below shows PMHP coverage by contractor and by county.

Mental Health and Substance Use Disorder Service Coverage

Prepaid Mental Health Plan (PMHP)	Counties Covered Under the PMHP	Inpatient & Outpatient Mental Health Services	Outpatient Substance Use Disorder Services
Bear River Mental Health	Box Elder, Cache, Rich	Yes	No
Southwest Utah Behavioral Health	Beaver, Garfield, Kane, Iron, Washington	Yes	Yes
Four Corners Community Behavioral Health Center	Carbon, Emery, Grand	Yes	Yes
Northeastern Counseling Center	Daggett, Duchesne, Uintah, San Juan	Yes	Yes
Davis Behavioral Health	Davis	Yes	Yes
Central Utah Counseling Center	Piute, Juab, Wayne, Millard, Sanpete, Sevier	Yes	Yes
Salt Lake County Division of Behavioral Health Services/OptumHealth	Salt Lake	Yes	Yes

Valley Mental Health	Summit & Tooele	Yes	Yes
Wasatch Mental Health	Utah	Yes	No
Utah County Department of Drug & Alcohol Prevention & Treatment	Utah	No	Yes
Weber Human Services	Weber, Morgan	Yes	Yes
Fee-for-Service Counties	**Rehabilitative Services Reimbursed on a Fee-for-Service Basis**		
Box Elder, Cache, Rich	Outpatient substance use disorder services only		
Wasatch	Outpatient mental health and substance use disorder services		

Additional Options:

All Medicaid members enrolled in the PMHP may also get behavioral health services directly from a federally qualified health center (FQHC). PMHP authorization is not required. Medicaid reimburses FQHCs directly.

In addition, American Indian and Alaska Native Medicaid members enrolled in the PMHP may get behavioral health services directly from Indian health care providers, including an Indian Health Program or an Urban Indian Organization. PMHP authorization is not required. Medicaid reimburses providers directly.

Exceptions:

Children in Foster Care

Children in Foster Care are enrolled in the PMHP for mental health inpatient hospital care only. They are not enrolled in the PMHP for outpatient behavioral health services. Qualified providers may bill Medicaid on a Fee-for-Service basis for outpatient behavioral health services provided to Children in Foster Care.

Children with State Adoption Subsidy

Children with state adoption subsidy are enrolled in the PMHP. However, an exemption from PMHP enrollment for outpatient behavioral health services may be granted on a case-by case basis. Children with state adoption subsidy who are exempted from the PMHP for outpatient behavioral health services remain enrolled in the PMHP for mental health inpatient hospital care only.

Medicaid Recipients Enrolled in HOME

Medicaid recipients enrolled in HOME are not enrolled in the PMHP. They must receive all behavioral health services through HOME. (See Chapter 1-2, Definitions.) Providers must follow HOME's network and prior authorization requirements and obtain reimbursement directly from HOME.

Presumptive Eligibility
Individuals with presumptive eligibility are not enrolled in the PMHP. Medicaid reimburses providers on a Fee-for-Service basis.

Evaluations Not Covered by the PMHP for the Following Individuals

1. Evaluations for Individuals with Intellectual Disabilities, Developmental Disorders or Related Conditions

   Psychiatric diagnostic evaluations and psychological testing related to these disorders may be performed in accordance with Chapter 2. If the Medicaid recipient is enrolled in HOME, providers must refer to the section above on HOME enrollment. For Medicaid recipients not enrolled in HOME, providers may bill Medicaid on a Fee-for-Service basis.

   Note: Additional provider requirements apply when evaluations may be used to qualify an individual to receive Medicaid-covered autism spectrum disorder (ASD)-related services. For information on these requirements and on ASD-related services, refer to the Utah Medicaid Provider Manual for Autism Spectrum Disorder Related Services for EPSDT Eligible Individuals.

2. Evaluations for Individuals with Conditions Requiring Chronic Pain Management

   Evaluations for individuals with a condition requiring chronic pain management services must be performed and billed to Medicaid in accordance with the Utah Medicaid Provider Manual for Physician Services, Chapter 2, Covered Services.

1 - 4 Scope of Services

Behavioral health services are limited to medically necessary services directed to the treatment of behavioral health disorders (see Chapter 1-2 for definition of behavioral health disorders). Services must be provided to the Medicaid individual or directed exclusively toward the treatment of the Medicaid individual.

The scope of rehabilitative behavioral health services includes the following:

- Psychiatric Diagnostic Evaluation
- Mental Health Assessment by a Non-Mental Health Therapist
- Psychological Testing
- Psychotherapy with Patient and/or Family Member
- Family psychotherapy with Patient Present and Family Psychotherapy without Patient Present
- Group Psychotherapy and Multiple Family Group Psychotherapy
- Psychotherapy for Crisis

- Psychotherapy with Evaluation and Management (E/M) Services
- Evaluation and Management (E/M) Services (Pharmacologic Management)
- Therapeutic Behavioral Services
- Psychosocial Rehabilitative Services
- Peer Support Services

See Chapter 2, Scope of Services, for service definitions and limitations.

1 - 5 Provider Qualifications

When applicable to a provider in A. or B. below, providers are responsible to ensure supervision is provided in accordance with requirements set forth in Title 58 of the Utah Code, and the applicable profession's practice act rule as set forth by the Utah Department of Commerce and found at the Department of Administrative Services, Division of Administrative Rules, at: www.rules.utah.gov/publicat/code.htm.

A. Providers Qualified to Prescribe Services

Rehabilitative services must be prescribed by an individual defined below:

1. Licensed mental health therapist practicing within the scope of his or her license in accordance with Title 58, Chapter 60, Mental Health Professional Practice Act, of the Utah Code:

    a. physician and surgeon or osteopathic physician engaged in the practice of mental health therapy;

    b. psychologist qualified to engage in the practice of mental health therapy;

    c. certified psychology resident qualifying to engage in the practice of mental health therapy under the supervision of a licensed psychologist;

    d. clinical social worker;

    e. certified social worker or certified social worker intern under the supervision of a licensed clinical social worker;

    f. advanced practice registered nurse (APRN), either as a nurse specialist or a nurse practitioner, with psychiatric mental health nursing specialty certification;

    g. marriage and family therapist;

    h. associate marriage and family therapist under the supervision of a licensed marriage and family therapist;

    i clinical mental health counselor; or

j. associate clinical mental health counselor under supervision of a licensed mental health therapist.

2. An individual working within the scope of his or her certificate or license in accordance with Title 58 of the Utah Code:

   a. licensed APRN formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification; or

   b. licensed APRN intern formally working toward psychiatric mental health nursing specialty certification and accruing the required clinical hours for the specialty nursing certification under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification.

3. An individual exempted from licensure (as a mental health therapist) including:

   a. in accordance with Section 58-1-307 of the Utah Code, a student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL to the extent the activities are supervised by qualified faculty, staff, or designee and the activities are a defined part of the training program; or

   b. in accordance with Subsection 58-61-307(2)(h) of the Utah Code, an individual who was employed as a psychologist by a state, county or municipal agency or other political subdivision of the state prior to July 1, 1981, and who subsequently has maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of his official duties for that agency or political subdivision.

B. Providers Qualified to Render Services

In accordance with the limitations set forth in Chapter 2, Scope of Services, rehabilitative services may be provided by:

1. an individual identified in A. of this chapter;

2. an individual working within the scope of his or her certificate in accordance with Title 58 of the Utah Code:

   a. licensed physician and surgeon or osteopathic physician regardless of specialty, or other medical practitioner licensed under state law (most commonly licensed physician assistants when practicing within their scope of practice and under the delegation of services agreement required by their practice act);

   b. licensed APRN or licensed APRN intern regardless of specialty;

   c. licensed substance use disorder counselor, including licensed advanced substance use disorder counselor (ASUDC), certified advanced substance use disorder counselor (CASUDC) or certified advanced substance use disorder counselor intern (CASUDC-I), licensed substance use disorder counselor (SUDC), certified substance use disorder counselor (CSUDC) or certified substance use disorder counselor intern (CSUDC-I);

d. licensed social service worker;

e. licensed registered nurse;

f. licensed practical nurse; or

g. individual working toward licensure as a social service worker; or a registered nursing student, engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, or an individual enrolled in a qualified substance use disorder education program, exempted from licensure in accordance with Section 58-1-307 of the Utah Code and under required supervision;

3. other trained individual; or

4. peer support specialist who has been certified as a peer support specialist under rules promulgated by the Utah Department of Human Services.

C. Training Requirements for Other Trained Individuals

Other trained individuals may provide psychosocial rehabilitative services (see Chapter 2-11) and for Prepaid Mental Health Plans, the services included in Chapter 3.

These individuals must receive training in order to be a qualified provider. The hiring body must ensure the following minimum training requirements are met:

1. Individuals shall receive training on all administrative policies and procedures of the agency, and the program as applicable, including:

   - Fraud, waste or abuse detection and reporting;
   - HIPAA and confidentiality/privacy policy and procedures;
   - Emergency/crisis procedures; and
   - Other relevant administrative-level subjects.

2. Individuals shall also receive information and training in areas including:

   - Philosophy, objectives, and purpose of the service(s) the individual will be delivering;
   - Medicaid definition of the service(s) the individual will be delivering;
   - Specific job duties;
   - Treatment plans and development of treatment goals;
   - Role and use of clinical supervision of the other trained individual;

- Population(s) served and the functional impacts of diagnoses that result in the need for the service;
- Healthy interactions with clients to help them obtain goals;
- Management of difficult behaviors;
- Medications and their role in treatment;
- Any formal programming materials used in the delivery of the service (the individual shall understand their use and receive training on them as required); and
- Other relevant subjects as determined by the agency.

3. The hiring body shall maintain documentation of training including dates of training, agendas and training/educational materials used.

4. The supervising provider must ensure individuals complete all training within 60 calendar days of the hiring date, or for existing providers within 60 calendar days from the date of enrollment as a Medicaid provider.

1 - 6 Evaluation

In accordance with state law, individuals identified in Chapter 1 – 5, A. are qualified to conduct an evaluation (psychiatric diagnostic evaluation). Evaluations are performed for the purpose of assessing and determining diagnoses, and as applicable, identifying the need for behavioral health services. (See Chapter 2-2, Psychiatric Diagnostic Evaluation.)

1 - 7 Treatment Plan

A. If based on an evaluation it is determined that behavioral health services are medically necessary, an individual identified in Chapter 1-5, A. is responsible for the development of a treatment plan.

B. The treatment plan is a written, individualized person-centered plan which contains measurable treatment goals related to problems identified in the psychiatric diagnostic evaluation. The development of the treatment plan should be a collaborative effort with the client.

C. If the treatment plan includes psychosocial rehabilitative services as a treatment method, there must be measurable goals specific to each issue being addressed with this treatment method.

D. The treatment plan must include the following:

1. measurable treatment goals;
2. the treatment regimen–the specific treatment methods (as contained in Chapter 1-4 and Chapter 2) that will be used to meet the measurable treatment goals;
3. a projected schedule for service delivery, including the expected frequency and duration of each treatment method;
4. the licensure or credentials of the individuals who will furnish the prescribed services; and

5. the signature and licensure or credentials of the individual defined in Chapter 1-5, A., who is responsible for the treatment plan.

E. An individual identified in Chapter 1-5, A. is responsible to conduct reassessments/treatment plan reviews with the client as clinically indicated to ensure the client's treatment plan is current and accurately reflects the client's rehabilitative goals and needed behavioral health services.

1 - 8 Documentation

A. The provider must develop and maintain sufficient written documentation for each service or session for which billing is made to support the procedure and the time billed. See Chapter 2, Scope of Services, for documentation requirements specific to each service.

B. As specified in Chapter 2, documentation of the start and stop time of the service is required.

C. To ensure accurate documentation and high quality of care, services should be documented at the time of service.

D. The clinical record must be maintained on file in accordance with any federal or state law or state administrative rule, and made available for state or federal review, upon request.

1 - 9 Collateral Services

Collateral services must be directed exclusively toward the treatment of the Medicaid individual and may be billed if the following conditions are met:

1. the service is provided face-to-face to an immediate family member (for example, parent or foster parent) on behalf of the identified client and the client is not present;
2. the identified client is the focus of the session; and
3. the progress note specifies the service was a collateral service and documents how the identified client was the focus of the session. Other documentation requirements under the 'Record' section of the applicable service also apply.
4. if the collateral service is <u>not</u> psychotherapy that qualifies for coding under procedure codes 90832-90838 or 90846, use the procedure code applicable to the service.

1-10 Billings

A range of dates should not be billed on a single line of a claim (e.g., listing on the claim the 1st through the 30th or 31st as the service date). Each date of service should be billed on a separate line of the claim.

1-11 Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI)

The Centers for Medicare and Medicaid Services has implemented a correct coding initiative that includes two editing modules: the Procedure-to-Procedure (PTP) module and the Medically Unlikely Edits (MUE) module.

Procedure-to-Procedure (PTP) Editing

This editing applies when two services are provided by the same servicing provider on the same day. This module contains a list of procedure code combinations where generally the second service is considered incident to the first service in the procedure code combination. Unless otherwise specified, the provider may not receive separate reimbursement for the second service. When the second service in the code combination cannot be reimbursed separately, the two procedure codes are followed by a '0' in the third column.

For some procedure code combinations, NCCI will allow reimbursement of the second procedure in the combination if the two services are actually separate and distinct services. When CMS allows reimbursement for both procedure codes in the combination, the two procedure codes are followed by a '1' in the third column. In these instances, a provider must use a modifier on the claim to indicate the two services provided were separate and distinct.

When NCCI also allows the second procedure in the procedure combination to be reimbursed, providers must include the '59' modifier on the claim in order to obtain reimbursement for the second service. Please refer to Appendix A of the Current Procedural Terminology (CPT) manual for information on the 59 modifier.

Medically Unlikely Edits

The MUE module contains units-of-service edits. For specified procedure codes, NCCI has set a limit on the number of units of service that Medicaid may reimburse.

NCCI Editing Updates

CMS may update these two modules quarterly. To review the PTP and MUE modules, providers may go to the CMS website at: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Index.html. For information on procedure-to-procedure editing, select the NCCI Coding Edits link, then under Related Links, select the Physician CCI Edits link for the effective quarter. For information on medically unlikely edits, select the Medically Unlikely Edits link, and then under Related Links, select the Practitioner Services MUE Table link for the effective quarter. Follow the prompts to access the files.

For information on quarterly additions, deletions and revisions to these modules, select the Quarterly NCCI and MUE Version Update Changes link for the effective quarter. For procedure-to-procedure editing updates, under Related Links, select the Quarterly Additions, Deletions, and Modifier Indicator Changes to NCCI Edits for Physicians/Practitioners link for the effective quarter. For medically unlikely editing updates, under Related Links, select the Quarterly Additions, Deletions, and Revisions to Published MUEs for Practitioner Services, for the effective quarter. Since CMS can update the PTP and MUE modules quarterly, providers are responsible to be familiar with the edits in these modules.

2 SCOPE OF SERVICES

Behavioral health services are covered benefits when the services are medically necessary services. Behavioral health services include psychiatric diagnostic evaluation, mental health assessment by a non-mental health therapist, psychological testing, psychotherapy with patient and/or family member, family psychotherapy with patient present and family psychotherapy without patient present, group psychotherapy, multiple family group psychotherapy, psychotherapy for crisis, psychotherapy with evaluation and

management (E/M) services, evaluation and management (E/M) services (i.e., pharmacologic management), therapeutic behavioral services, psychosocial rehabilitative services and peer support services.

2 - 1 General Limitations

1. Rehabilitative services do not include:

   a. Services provided to inmates of public institutions or to residents of institutions for mental diseases;

   b. Habilitation services;

   c. Educational, vocational and job training services;

   d. Recreational and social activities;

   e. Room and board; and

   f. Services where the therapist or others during the session use coercive techniques (e.g., coercive physical restraints, including interference with body functions such as vision, breathing and movement, or noxious stimulation) to evoke an emotional response in the child such as rage or to cause the child to undergo a rebirth experience. Coercive techniques are sometimes also referred to as holding therapy, rage therapy, rage reduction therapy or rebirthing therapy. This also includes services wherein the therapist instructs and directs parents or others in the use of coercive techniques that are to be used with the child in the home or other setting outside the therapy session.

2. Medicaid recipients with Non-Traditional Medicaid getting services for mental health disorders have the following limitation:

   There is a maximum of 30 outpatient days per client per year for outpatient mental health care for a mental health disorder. Targeted case management services for individuals with serious mental illness also count toward the outpatient maximum. (See the *Utah Medicaid Provider Manual for Targeted Case Management for Individuals with Serious Mental Illness*.) This 30-day limitation does not apply to services provided to treat substance use disorders.

   There is also a maximum of 30 inpatient days per client per year for inpatient mental health care.

   Substitutions– Unused inpatient mental health care days, up to 30 days, can be used for additional outpatient mental health days per client per year for a mental health disorder.

3. Service Coverage and Reimbursement Limitations

   Information on Utah Medicaid service coverage and reimbursement limitations is available in Utah Medicaid's web-based lookup tool entitled 'Coverage & Reimbursement Lookup Tool,' located at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php. The Coverage & Reimbursement Lookup Tool contains up-to-date information on coverage, limits, prior authorization requirements, etc. The tool also includes a special notes section that includes any additional information regarding the service, including any manual review requirements associated with the

service. This tool allows providers to search for coverage and reimbursement information by HCPCS/Current Procedural Terminology (CPT) procedure code, date of service and provider type. The 'Limits' sections in Chapter 2 in this manual will address other types of limits and clarifications related to the services.

Fee-for-service claims submitted for neurobehavioral status exams, procedure code 96116, and neuropsychological testing, procedure code 96118, require manual review.

Payment for neurobehavioral status exams is limited to three hours (three units) per year and payment for neuropsychological testing is limited to eight hours (eight units) per year unless additional time is approved based on manual review.

If additional time is billed, providers must submit documentation for the manual review. Documentation consists of medical records that give evidence of and support the billing as correct and valid. The Medicaid reviewer assesses the documentation to determine if additional payment will be made. If supporting documentation is not submitted, no additional payment will be made.

To submit the documentation, either attach it to the claim or submit via FAX to the Bureau of Medicaid Operations at 801-536-0463. If submitting the documentation via FAX, include a cover sheet that specifies whether it is for neurobehavioral status exam manual review or neuropsychological testing manual review.

2 - 2 Psychiatric Diagnostic Evaluation

Psychiatric diagnostic evaluation means a face-to-face evaluation with the individual for the purpose of assessing and determining diagnoses, and as applicable identifying the need for behavioral health services. The evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations, with interpretation and report. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies. In certain circumstances one or more other informants (family members, guardians or significant others) may be seen in lieu of the individual.

Psychiatric diagnostic evaluation with medical services also includes medical assessment and other physical examination elements as indicated and may be performed only by qualified medical providers specified in the 'Who' section of this chapter below.

In accordance with the Current Procedural Terminology (CPT) manual, codes 90791 (psychiatric diagnostic evaluation) and 90792 (psychiatric diagnostic evaluation with medical services) are used for the diagnostic assessment(s) or reassessment(s), if required.

Because ongoing assessment and adjustment of psychotherapeutic interventions are part of psychotherapy, reassessments including treatment plan reviews occurring in psychotherapy session may be coded as such. (See definition of psychotherapy and the 'Record' section of Chapter 2-5, Psychotherapy.

If based on the evaluation it is determined behavioral health services are medically necessary, an individual qualified to perform this service is responsible for the development of an individualized treatment plan. An individual qualified to perform this service also is responsible to conduct reassessments/treatment plan reviews with the client as clinically indicated to ensure the client's treatment plan is current and accurately reflects the client's rehabilitative goals and needed behavioral health services. (See Chapter 1-7, Treatment Plans.)

See Chapter 2-6, Psychotherapy for Crisis, for information on billing urgent assessments of a crisis state as defined under Psychotherapy for Crisis.

Who:

1. **Psychiatric diagnostic evaluation** may be performed by a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure as a mental health therapist. (See Chapter 1-5, B. 1.)

2. **Psychiatric diagnostic evaluation with medical services** may be performed only by:

   a. a licensed physician and surgeon or osteopathic physician engaged in the practice of mental health therapy;

   b. a licensed advanced practice registered nurse (APRN), either as a nurse specialist or a nurse practitioner, with psychiatric mental health nursing specialty certification;

   c. a licensed APRN formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification; or

   d. a licensed APRN intern formally working toward psychiatric mental health nursing specialty certification and accruing the required clinical hours for the specialty certification under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification.

   When this service is performed to determine the need for medication prescription only, it also may be performed by:

   e. a licensed physician and surgeon or osteopathic physician regardless of specialty;

   f. a licensed APRN regardless of specialty when practicing within the scope of their practice act and competency;

   g. a licensed APRN intern regardless of specialty when practicing within the scope of their practice act and competency, under the supervision of a licensed APRN regardless of specialty when practicing within the scope of their practice act and competency, or a licensed physician and surgeon or osteopathic physician regardless of specialty; or

   h. other medical practitioner licensed under state law when acting within the scope of his/her license, most commonly licensed physician assistants when practicing within their scope of practice and under the delegation of services agreement required by their practice act.

Limits:

1. According to the Psychiatry section of the Current Procedural Terminology (CPT) manual, the following limits apply:

   a. Psychiatric diagnostic evaluation with medical services may not be reported on the same day as an E/M service when performed by the same servicing provider; and

   b. Codes 90791, 90792 are used for the diagnostic assessment(s) or reassessment(s), if required, and do not include psychotherapeutic services. Psychotherapy services, including psychotherapy for

crisis, may not be reported on the same day (when performed by the same servicing provider). See the CMS NCCI PTP Module for additional information on this limitation.

2. Evaluations requested by a court of the Utah Department of Human Services, Division of Child and Family Services, solely for the purpose of determining if a parent is able to parent and should therefore be granted custody or visitation rights, or whether the child should be in some other custodial arrangement are not billable to the Medicaid under any service/procedure code.

3. Additional provider requirements apply when evaluations may be used to qualify an individual to receive Medicaid-covered autism spectrum disorder (ASD)-related services. For information on these requirements and on ASD-related services, refer to the *Utah Medicaid Provider Manual for Autism Spectrum Disorder Related Services for EPSDT Eligible Individuals.*

4. Evaluations for individuals with a condition requiring chronic pain management services must be performed and billed to Medicaid in accordance with the *Utah Medicaid Provider Manual for Physician Services*, Chapter 2, Covered Services.

Procedure Codes and Unit of Service:

90791 - Psychiatric Diagnostic Evaluation - per 15 minutes

90792 - Psychiatric Diagnostic Evaluation with Medical Services, by physician or APRN - per 15 minutes

The following time rules apply for converting the duration of the service to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

+90785 – Interactive Complexity Add-On Code - per service

In accordance with the CPT manual, CPT code 90785 is an add-on code for interactive complexity. It may be reported in conjunction with 90791 and 90792. There is no additional reimbursement for this add-on code.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e., psychiatric diagnostic evaluation);
4. report of findings from the biopsychosocial assessment that includes:
   a. history, symptomatology and mental status (mental status report may be based on formal assessment or on observations from the evaluation process); and
   b. disposition, including diagnosis(es) as appropriate, and recommendations. If the client does not need behavioral health services, this must be documented in the assessment (along with any other recommended services as appropriate). If behavioral health services are medically necessary, then a provider qualified to perform this service is responsible for the development of a treatment plan and the prescription of the behavioral health services that are medically necessary for the individual. (See treatment plan requirements in Chapter 1-7); or
5. report of findings from a reassessment that includes:
   a. the applicable components in 4.a. and/or b.; and/or
   b. For reviews of the client's treatment plan documentation will include an update of the client's progress toward treatment goals contained in the treatment plan, the appropriateness of the services being prescribed, and the medical necessity of continued behavioral health services; and
6. signature and licensure or credentials of the individual who rendered the service.

2 - 3 Mental Health Assessment

Mental Health Assessment means providers listed below, participating as part of a multi-disciplinary team, assisting in the psychiatric diagnostic evaluation process defined in Chapter 2-2, Psychiatric Diagnostic Evaluation. Through face-to-face contacts with the individual, the provider assists in the psychiatric diagnostic evaluation process by gathering psychosocial information including information on the individual's strengths, weaknesses and needs, and historical, social, functional, psychiatric, or other information and assisting the individual to identify treatment goals. The provider assists in the psychiatric diagnostic reassessment/treatment plan review process specified in Chapter 2-2 by gathering updated psychosocial information and updated information on treatment goals and assisting the client to identify additional treatment goals. Information also may be collected through in-person or telephonic interviews with family/guardians or other sources as necessary. The information obtained is provided to the individual identified in Chapter 2-2 who will perform the assessment, reassessment or treatment plan review.

Who:

The following individuals when under the supervision of a licensed mental health therapist identified in Chapter 1-5, A. 1:

1. licensed social service worker or individual working toward licensure as a social service worker;
2. licensed registered nurse;
3. licensed ASUDC, CASUDC, SUDC, CSUDC or ASUDC-I or SUDC-I;

4. licensed practical nurse; or

5. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, or an individual enrolled in a qualified substance use disorder education program, exempted from licensure in accordance with state law, and under required supervision.

Although these individuals may perform this service and participate as part of a multi-disciplinary team, under state law, qualified providers identified in Chapter 2 -2 are the only providers who may diagnose a behavioral health disorder and prescribe behavioral health services determined to be medically necessary to treat the individual's behavioral health disorder(s).

Limits:

1. This service is meant to accompany the psychiatric diagnostic evaluation (see Chapter 2-2). If a psychiatric diagnostic evaluation (assessment or reassessment) is not conducted after this service is performed, this service may be billed if all of the documentation requirements in the 'Record' section are met and the reason for non-completion of the psychiatric diagnostic evaluation is documented.

2. If the provider conducting the psychiatric diagnostic evaluation defined in Chapter 2-2 obtains all of the psychosocial information directly from the client, only that service is billed. The provider does not also bill this service.

Procedure Code and Unit of Service:

H0031 – Mental Health Assessment by a Non-Mental Health Therapist – per 15 minutes

The following time rules apply for converting the duration of the service to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;

2. setting in which the service was rendered;
3. specific service rendered (i.e., assessment);
4. information gathered; and
5. signature and licensure or credentials of the individual who rendered the service.

2 - 4 Psychological Testing

Psychological testing means a face-to-face evaluation to determine the existence, nature and extent of a mental illness or disorder using psychological tests appropriate to the client's needs, with interpretation and report.

Who:

1. licensed physician and surgeon, or osteopathic physician engaged in the practice of mental health therapy;
2. licensed psychologist qualified to engage in the practice of mental health therapy;
3. certified psychology resident qualifying to engage in the practice of mental health therapy under the supervision of a licensed psychologist;
4. a student who is a licensed psychologist candidate due to enrollment in a predoctoral education/degree program exempted from licensure in accordance with state law and under required supervision; or
5. an individual exempted from licensure in accordance with Subsection 58-61-307(2)(h) of the Utah Code who was employed as a psychologist by a state, county or municipal agency or other political subdivision of the state prior to July 1, 1981, and who subsequently has maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of his official duties for that agency or political subdivision.

Limits:

There are coverage and reimbursement limitations on neurobehavioral status exams, procedure code 96116, and neuropsychological testing, procedure code 96118. These services require manual review. Refer to Chapter 2-1, General Limitations, #3, regarding the procedure for accessing information on Utah Medicaid coverage and reimbursement limitations and procedures related to manual review.

Procedure Codes and Unit of Service:

96101 - Psychological Testing - includes psychodiagnostic assessment of emotionality, intellectual abilities, and psychopathology, e.g., MMPI, Rorschach, WAIS, with interpretation and report - per hour

96105 - Assessment of Aphasia - includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading spelling, writing, e.g., by Boston Diagnostic Aphasia Examination, with interpretation and report - per hour

96110 - Developmental Screening - with interpretation and report, per standardized instrument form - per hour

96111 - Developmental Testing, includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, with interpretation and report - per hour

96116 - Neurobehavioral Status Exam - Clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities, with interpretation and report - per hour (Requires manual review. Limited to 3 hours (3 units) per year unless additional time is approved based on the manual review. More than 3 hours (3 units) require supportive documentation for the manual review.)

96118 - Neuropsychological Testing - e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test, with interpretation and report - per hour (Requires manual review. Limited to 8 hours (8 units) per year unless additional time is approved based on the manual review. More than 8 hours (8 units) require supportive documentation for the manual review.)

The following time rules apply for converting the duration of the service to the specified number of units:

Less than 31 minutes equals 0 units;

31 minutes through 90 minutes of service equals 1 unit;

91 minutes through 150 minutes of service equals 2 units;

151 minutes through 210 minutes of service equals 3 units; and

211 minutes through 270 minutes of service equals 4 units; etc.

Record:

Documentation must include:

1. date(s), start and stop time, and duration of testing;
2. setting in which the testing was rendered;
3. specific service rendered (i.e., psychological testing);
4. written test reports which include:
    a. brief history;
    b. tests administered;
    c. test scores;
    d. evaluation of test results;
    e. current functioning of the individual;
    f. diagnoses;
    g. prognosis; and
    h. specific treatment recommendations for behavioral health services if applicable, and other recommended services as appropriate; and

5. signature and licensure or credentials of the individual who rendered the service.

2 - 5 Psychotherapy

Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development so that the client may be restored to his/her best possible functional level. Services are based on measurable treatment goals identified in the client's individualized treatment plan.

Psychotherapy codes 90832-90838 include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or others in the treatment process.

Psychotherapy includes psychotherapy with the client and/or family member, family psychotherapy with patient present, family psychotherapy without patient present, group psychotherapy and multiple-family group psychotherapy.

Individual psychotherapy means in accordance with the definition of psychotherapy face-to-face interventions with the client and/or family member.

Family psychotherapy with patient present means in accordance with the definition of psychotherapy face-to-face interventions with family members and the identified client with the goal of treating the client's condition and improving the interaction between the client and family members so that the client may be restored to their best possible functional level.

Family psychotherapy without patient present means in accordance with the definition of psychotherapy face-to-face interventions with family member(s) without the identified client present with the goal of treating the client's condition and improving the interaction between the client and family member(s) so that the client may be restored to their best possible functional level.

Group psychotherapy means in accordance with the definition of psychotherapy face-to-face interventions with two or more clients or two or more families in a group setting so that the clients may be restored to their best possible functional level.

Who:

1. All psychotherapy may be performed by a licensed mental health therapist, an individual working within the scope of his or her certificate or license, or an individual exempted from licensure as a mental health therapist. (See Chapter 1-5, B. 1.)

2. In accordance with Subsection 58-60-502(10) of the Utah Code, substance use disorder counselors may co-facilitate group psychotherapy with a licensed mental health therapist identified in Chapter 1-5, A.1; and individuals enrolled in a qualified substance use disorder counseling education program exempted from licensure in accordance with state law, may co-facilitate group psychotherapy with a licensed mental health therapist identified in Chapter 1-5, A. 1.

Psychotherapy with patient and/or family member

Limits:

In accordance with the CPT manual, the following limits apply:

1. Psychotherapy times are for face-to-face services with the client and/or family member. The client must be present for all or some of the service. Procedure codes for psychotherapy with patient and/or family member are used when individual psychotherapy is being provided.

2. If family psychotherapy is prescribed as a service, use the procedure codes for family psychotherapy with patient present or family psychotherapy without patient present. See section below on procedure codes for family psychotherapy.

Procedure Codes and Unit of Service:

90832 – Psychotherapy, 30 minutes, with patient and/or family member – per encounter

90834 – Psychotherapy, 45 minutes, with patient and/or family member - per encounter

90837 – Psychotherapy, 60 minutes, with patient and/or family member – per encounter

The following time rules apply for converting the duration of the service to the appropriate procedure code:

90832 - 16 through 37 minutes;

90834 - 38 through 52 minutes; and

90837 - 53 minutes through 89 minutes.

Prolonged Services Add-On Codes:

In accordance with the CPT manual, for psychotherapy services not performed with an E/M service of 90 minutes or longer face-to-face with the patient, providers may use the appropriate prolonged services add-on code(s) with psychotherapy code 90837 depending on the duration and place of the psychotherapy service.

+99354 – first hour (60 additional minutes with patient); and

+99355 – each additional 30 minutes with patient (beyond the 60 additional minutes that are coded with 99354)

In accordance with the CPT coding requirements for prolonged services, if the psychotherapy is provided in a nursing facility or other setting where the Nursing Facility Services range of E/M services codes would be used for E/M services (E/M codes 99304-99310), then prolonged services add-on codes 99356/99357 are used for the additional psychotherapy time. (In the event psychotherapy is provided to a client in an inpatient setting, these prolonged services codes would also be used.)

+99356 – first hour (60 additional minutes with the patient); and

+99357 – each additional 30 minutes with patient (beyond the 60 additional minutes that are coded with 99356)

In accordance with CPT requirements, prolonged service of less than 30 minutes total duration on a given date is not separately reported. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately. The following time rules apply for converting the duration of the service to the appropriate prolonged services add-on procedure code(s):

+99354 or +99356 – 90 minutes through 134 minutes (1 hour 30 minutes through 2 hours 14 minutes) equals 1 unit;

+99355 or +99357 - 135 minutes through 164 minutes (2 hours 15 minutes through 2 hours 44 minutes) equals 1 unit (in addition to the unit of 99354 or 99356); and

165 minutes through 194 minutes (2 hours 45 minutes through 3 hours 14 minutes) equals 2 units (in addition to the unit of 99354 or 99356), etc.

+90785 – Interactive Complexity Add-On Code - per service

In accordance with the CPT manual, CPT code 90785 is an add-on code for interactive complexity. It may be reported in conjunction with 90832, 90834 and 90837. There is no additional reimbursement for this add-on code.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e, psychotherapy with patient and/or with family member);
4. clinical note that documents:
    a. individual(s) present in the session;
    b. in accordance with the definition of psychotherapy, the focus of the psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, encouragement of personality growth and development); and
    c. the treatment goal(s) addressed in the session and the client's progress toward the treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers; or
5. If the focus of a psychotherapy visit with patient and or family member is a crisis or a reassessment /review of the client's overall treatment plan and 4.b. and/or 4.c. are not applicable, then the clinical note must summarize the crisis visit, including findings, mental status and disposition; or must summarize the reassessment findings and/or the review of the treatment plan. Documentation for reviews of the treatment plan will include an update of the client's progress toward treatment goals contained in the treatment plan, the appropriateness of the services being prescribed, and the medical necessity of continued behavioral health services; and
6. signature and licensure or credentials of the individual who rendered the service.

Family psychotherapy with patient present and family psychotherapy without patient present

Procedure Codes and Unit of Service:

90846 - Family Psychotherapy - without patient present – per 15 minutes

90847 - Family Psychotherapy - with patient present – per 15 minutes

The following time rules apply for converting the duration of the service to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e., family psychotherapy with patient present or family psychotherapy without patient present)
4. clinical note that documents:
    a. family members present in the session;
    b. in accordance with the definition of psychotherapy, the focus of the family psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, encouragement of personality growth and development); and
    c. the treatment goal(s) addressed in the session and progress toward the treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers; or
5. If the focus of a family psychotherapy visit is a crisis or a reassessment/review of the overall treatment plan and 4.b. and/or 4.c. are not applicable, then the clinical note must summarize the crisis visit, including findings, mental status and disposition; or must summarize the reassessment findings and/or the review of the treatment plan. Documentation for reviews of the treatment plan will include an update of the client's progress toward treatment goals contained in the treatment plan, the appropriateness of the services being prescribed, and the medical necessity of continued behavioral health services; and
6. signature and licensure or credentials of the individual who rendered the service.

Group psychotherapy and multi-family group psychotherapy

Limits:

1. Psychotherapy groups (90853) are limited to twelve clients in attendance unless a co-provider is present; then psychotherapy groups may not exceed 16 clients in attendance.

2. Multiple-family psychotherapy groups (90849) are limited to ten families in attendance and a maximum group size of 24 clients. Groups up to and including 15 clients may have one provider. For groups with 16 to 24 clients, a co-provider must be present.

3. Co-providers must meet the provider qualifications outlined in the 'Who' section above.

Procedure Codes and Unit of Service:

90849 - Multiple-Family Group Psychotherapy - per 15 minutes per Medicaid client 90853 - Group Psychotherapy - per 15 minutes per Medicaid client

The following time rules apply for converting the duration of the service to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

+90785 – Interactive Complexity Add-On Code - per service

In accordance with the CPT manual, CPT code 90785 is an add-on code for interactive complexity. It may be reported in conjunction with 90853. There is no additional reimbursement for this add-on code.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;

2. setting in which the service was rendered;

3. specific service rendered (i.e., group psychotherapy or multiple-family group psychotherapy);

4. per session clinical note that documents:

    a. the focus of the group psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, encouragement of personality growth and development); and

b. the treatment goal(s) addressed in the session and progress toward the treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers; or

5. If the focus of the group psychotherapy visit is a crisis or a reassessment/review of the client's overall treatment plan and 4.b. and/or 4.c. are not applicable, then the clinical note must summarize the crisis visit, including findings, mental status and disposition; or must summarize the reassessment findings and/or the review of the treatment plan. Documentation for reviews of the treatment plan will include an update of the client's progress toward treatment goals contained in the treatment plan, the appropriateness of the services being prescribed, and the medical necessity of continued behavioral health services; and

6. signature and licensure or credentials of the individual who rendered the service. If a co-provider is present for the group psychotherapy session, the note must contain the co-provider's name and licensure or credentials.

2 - 6 Psychotherapy for Crisis

Psychotherapy for crisis means a face-to-face service with the client and/or family and includes an urgent assessment and history of a crisis state and disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to an individual in high distress. Providers may use CPT coding for this service if the crisis and interventions qualify for this coding.

Who:

Licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure as a mental health therapist. (See Chapter 1-5, B. 1.)

Limits:

In accordance with the CPT manual, the following limits apply:

1. Procedure codes for this service are used to report the total duration of time face-to-face with the individual and/or family spent by the provider, even if the time spent on that date is not continuous.

2. For any given period of time spent providing this service, the provider must devote his or her full attention to the individual and, therefore, cannot provide services to any other individual during the same time period. The individual must be present for all or some of the service.

3. This service cannot be reported in conjunction with procedure code 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services or 90785-90899. Under CMS' NCCI, this means this service and these other services cannot both be reimbursed when provided on the same day by the same servicing provider. See the January 2013 CMS NCCI PTP Module for additional information on this limitation.

4. If the visit is 30 minutes or less total duration on a given date, the service is reported with psychotherapy code 90832, 30 minutes, with patient and/or family member, or with add-on psychotherapy code 90833, 30 minutes, with patient and/or family member (when provided with E/M

services). See Chapter 2-5 for information on psychotherapy procedure code 90832, and Chapter 2-7 for information on E/M add-on psychotherapy procedure code 90833.

Procedure Codes and Unit of Service

90839 – Psychotherapy for crisis, first 60 minutes, with patient and/or family member - per encounter

The following time rules apply for converting the total duration of the service to the appropriate procedure code:

90839 - 31 through 75 minutes total duration

(If the total duration of the crisis visit is 30 minutes or less– use procedure code 90832, psychotherapy with patient and/or family member, 30 minutes [see Chapter 2-5].)

Crisis for Psychotherapy Add-On Code: 90840 –

In accordance with the CPT manual, for psychotherapy for crisis services 76 minutes or longer, use add-on procedure code 90840 in addition to 90839:

+90840 – additional 30-minute increments – per encounter

The following time rules apply for converting the total duration of the service to the psychotherapy for crisis add-on code:

+90840 – 76 minutes through 105 minutes (1 hour 16 minutes through1 hour 45 minutes) equals 1 unit (in addition to the unit of 90839);

106 minutes through 135 minutes (1 hour 46 minutes through 2 hours 15 minutes) equals 2 units (in addition to the unit of 90839); and

136 minutes through 165 minutes (2 hours 16 minutes through 2 hours 45 minutes) equals 3 units (in addition to the unit of 90839), etc.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e, psychotherapy for crisis);
4. clinical note that documents the crisis visit, including findings, mental status and disposition; and
5. signature and licensure or credentials of the individual who rendered the service.

2 - 7 Psychotherapy with Evaluation and Management (E/M) Services

Psychotherapy with E/M services means psychotherapy with the patient and/or family member when performed with an E/M service on the same day by the same provider. (See Chapter 2-8 for information on E/M services.)

Who:

1. licensed physician and surgeon or osteopathic physician engaged in the practice of mental health therapy;
2. licensed APRN with psychiatric mental health nursing specialty certification;
3. licensed APRN formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification; or
4. licensed APRN intern formally working toward psychiatric mental health nursing specialty certification and accruing the required clinical hours for the specialty certification under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification.

Limits:

In accordance with the CPT manual, the two services must be significant and separately identifiable and may be separately identified as follows:

1. The type and level of E/M service is selected first based upon the key components of history, examination, and medical decision-making;

   Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service (i.e., time spent on history, examination and medical decision-making when used for the E/M service is not psychotherapy time). Time may not be used as the basis of E/M code selection and prolonged services may not be reported when psychotherapy with E/M (psychotherapy add-on codes 90833, 90836, 90838) are reported; and

2. A separate diagnosis is not required for the reporting of E/M and psychotherapy on the same date of service.

Procedure Codes and Unit of Service:

In accordance with the CPT manual, psychotherapy performed with an E/M service is coded using the applicable psychotherapy add-on code specified below with the applicable E/M code (E/M codes are specified in Chapter 2-8). The psychotherapy add-on code must be on the same claim as the E/M service procedure code.

+90833 – Psychotherapy, 30 minutes, with patient and/or family member – per encounter

+90836 – Psychotherapy, 45 minutes, with patient and/or family member - per encounter

+90838 – Psychotherapy, 60 minutes, with patient and/or family member – per encounter

The following time rules apply for converting the duration of the service to the appropriate procedure code:

+90833 - 16 through 37 minutes;

+90836 - 38 through 52 minutes; and

+90838 - 53 minutes and longer

+90785 – Interactive Complexity Add-On Code- per service

In accordance with the CPT manual, CPT code 90785 is an add-on code for interactive complexity. It may be reported in conjunction with psychotherapy when performed with an E/M service (90833, 90836 and 90838). There is no additional reimbursement for this add-on code.

Record:

For the psychotherapy portion of the service, documentation must include:

1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e, psychotherapy with patient and/or with family member);
4. clinical note that documents:
    a. individual(s) present in the session;
    b. in accordance with the definition of psychotherapy, the focus of the psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, encouragement of personality growth and development); and
    c. the treatment goal(s) addressed in the session and the client's progress toward the treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers; or
5. If the focus of the psychotherapy is a crisis or a reassessment/review of the client's overall treatment plan and 4.b. and/or 4.c. are not applicable, then the clinical note must summarize the crisis visit, including findings, mental status and disposition; or must summarize the reassessment findings and/or the review of the treatment plan. Documentation for reviews of the treatment plan will include an update of the client's progress toward treatment goals contained in the treatment plan, the appropriateness of the services being prescribed, and the medical necessity of continued behavioral health services; and
6. signature and licensure or credentials of the individual who rendered the service.

Refer to Chapter 2-8 for documentation requirements for the E/M portion of the service.

2 - 8 Pharmacologic Management (Evaluation and Management (E/M) Services)

Pharmacologic management means a service provided face-to-face to the client and/or family to address the client's health issues. This service is provided in accordance with the CPT definitions and coding for E/M services. (Please refer to the E/M services section of the CPT manual for complete information on E/M services definitions.)

Who:

1. licensed physician and surgeon or osteopathic physician regardless of specialty;

2. licensed APRN regardless of specialty when practicing within the scope of their practice act and competency;

3. licensed APRN intern regardless of specialty when practicing within the scope of their practice act and competency under the supervision of a licensed APRN regardless of specialty when practicing within the scope of their practice act and competency, or licensed physician and surgeon or osteopathic physician regardless of specialty; or

4. other medical practitioner licensed under state law who can perform the activities defined above when acting within the scope of his/her license (e.g., licensed physician assistants when practicing within their scope of practice and under the delegation of services agreement required by their practice act).

Limits:

1. Prescribers must directly provide all psychiatric pharmacologic management services (including any services that qualify for coding under E/M code 99211).

2. To ensure correct adjudication of the E/M claim, always use the **CG modifier** with the E/M code. This modifier will identify that the service provided was pharmacologic management covered under this program.

Procedure Codes and Unit of Service:

Office or Other Outpatient Services E/M Codes -

The following codes are used to report E/M services provided in the office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs.

Established Patient Codes

99211 – per encounter - E/M of an established patient; usually the presenting problems are minimal. Typically, 5 minutes are spent performing this service.

99212- per encounter - E/M of an established patient, which requires at least 2 of these 3 key components:

- A problem focused history;
- A problem focused examination;
- Straightforward medical decision making.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99213 – per encounter - E/M of an established patient, which requires at least 2 of these 3 key components:

- An expanded problem focused history;
- An expanded problem focused examination;
- Medical decision making of low complexity.

*Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99214 – per encounter - E/M of an established patient, which requires at least 2 of these 3 key components:

- A detailed history;
- A detailed examination;
- Medical decision making of moderate complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99215 – per encounter – E/M of an established patient, which requires at least 2 of these 3 key components:

- A comprehensive history;
- A comprehensive examination;
- Medical decision making of high complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

Subsequent Nursing Facility Care E/M Codes

The following codes are used to report E/M services to patients in nursing facilities (formerly called skilled nursing facilities [SNFs], intermediate care facilities [ICFs], or long-term care facilities [LTCFs]).

These codes should also be used to report evaluation and management services provided to a patient in a psychiatric residential center (a facility or a distinct part of a facility for psychiatric care, which provides 24-hour therapeutically planned and professionally staffed group living and learning environment).

Established Patient Codes

99307- per encounter - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- A problem focused interval history;
- A problem focused examination;
- Straightforward medical decision making.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the patient is stable, recovering or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99308 – per encounter- Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- An expanded problem focused interval history;
- An expanded problem focused examination;
- Medical decision making of low complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99309 – per encounter - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- A detailed interval history;
- A detailed examination;
- Medical decision making of moderate complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99310 – per encounter – Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- A comprehensive interval history;
- A comprehensive examination;
- Medical decision making of high complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

Home Services E/M Codes

The following codes are used to report E/M services provided in a private residence.

Established Patient Codes

99347- per encounter - E/M of an established patient, which requires at least 2 of these 3 key components:

- A problem focused interval history;
- A problem focused examination;
- Straightforward medical decision making.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99348 – per encounter - E/M of an established patient, which requires at least 2 of these 3 key components:

- An expanded problem focused interval history;
- An expanded problem focused examination;
- Medical decision making of low complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99349 – per encounter - E/M of an established patient, which requires at least 2 of these 3 key components:

- A detailed interval history;
- A detailed examination;
- Medical decision making of moderate complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99350 – per encounter – E/M of an established patient, which requires at least 2 of these 3 key components:

- A comprehensive interval history;
- A comprehensive examination;
- Medical decision making of moderate to high complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

<u>E/M Code Selection When More Than 50 Percent of Time Is Counseling and/or Coordination of Care</u>

In accordance with the CPT manual, when counseling and or coordination of care with the client and/or family comprises more than 50% of the encounter, then time is considered the "key or controlling factor to qualify for a particular level of E/M services." Also in accordance with time rules specified in the CPT manual, the following applies to E/M code selection: "When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used."

Prolonged Services Add-on Codes:

In accordance with the CPT manual, prolonged services add-on codes may be reported in addition to the designated E/M services at any level.

If the duration of the E/M service with the client and/or family is longer than the typical time associated with an E/M services code, then prolonged services add-on coding may apply.

For example, in accordance with rules for prolonged services add-on codes, if the E/M service qualifying for coding as 99215 is 70 minutes or longer, then the E/M code plus the applicable prolonged services add-on code(s) would be billed depending on the duration and the place of service. Refer to the time rules below and to the Prolonged Services section of the CPT manual for additional information.

Limits:

In accordance with the CPT manual, the following limits apply to prolonged services:

1. Either prolonged service code 99354 or 99356 should be used only once per date, even if the time spent by the physician or other qualified provider is not continuous on that date.
2. Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the E/M codes.
3. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Procedure Codes and Unit of Service:

In accordance with the CPT manual, the following prolonged services codes are used depending on the E/M place of service and duration:

Office or Other Outpatient Services and Home E/M codes:

+99354- first hour (60 additional minutes with patient); and

+99355- each additional 30 minutes with the patient (beyond the 60 additional minutes that are coded with 99354)

Subsequent Nursing Facility Care E/M codes (and any inpatient-based E/M codes in the event the E/M service is provided to a client in an inpatient setting):

+99356 – first hour (60 additional minutes with patient); and

+99357- each additional 30 minutes with the patient (beyond the 60 additional minutes that are coded with 99356)

The following time rules apply for converting the duration of the service to the appropriate prolonged services add-on procedure code:

Less than 30 minutes equals 0 units;

30 minutes through 74 minutes (30 minutes through 1 hour 14 minutes) equals 1 unit of 99354 or 99356;

75 minutes through 104 minutes (1 hour 15 minutes through 1 hour 44 minutes) equals 1 unit of 99354 or 99356 plus 1 unit of 99355 or 99357; and

105 minutes through 134 minutes (1hour 45 minutes through 2 hours 14 minutes) equals 1 unit of 99354 or 99356 plus 2 units of 99355 or 99357, etc.

Record:

1. For all E/M services, E/M documentation requirements apply. Please refer to the E/M section of the CPT manual. Providers can also refer to CMS' 1997 publication on documenting E/M services entitled *1997 Documentation Guidelines for Evaluation and Management Services* at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97docguidelines.pdf

   In accordance with the CPT manual, when counseling and/or coordination of care dominates (more than 50 percent) the encounter with the patient and/or family, and is the basis of E/M code selection, the extent of counseling and/or coordination of care must be documented in the medical record;

2. In addition, documentation must include:

   a. date, start and stop time, and duration of the service;

   b. setting in which the service was rendered; and

   c. specific service rendered (i.e, E/M services);

3. If not already addressed in E/M-required documentation referenced in #1:

   a. health issues and medications reviewed/monitored, results of the review and progress toward related treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers;

   b. dosage of medications as applicable;

   c. summary of information provided; and

   d. if medications are administered, documentation of the medication(s) and method and site of administration; and

4. Signature and licensure or credentials of the individual who rendered the service.

2 - 9 Nurse Medication Management

Nurse medication management is provided face-to-face to a client and/or family and includes reviewing/monitoring the client's health issues, medication(s) and medication regimen, providing information, and administering as appropriate. The review of the client's medications and medication regimen includes dosage, effect the medication(s) is having on the client's symptoms, and side effects. The provision of appropriate information should address directions for proper and safe usage of medications.

Who:

1. licensed registered nurse; or registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, exempted from licensure in accordance with state law and under required supervision; and

2. licensed practical nurse under the supervision of a licensed physician and surgeon or osteopathic physician, a licensed APRN, a licensed physician assistant or a licensed registered nurse.

Limits:

1. Distributing medications (i.e., handling, setting out or handing medications to clients) is not a covered service and may not be billed to Medicaid.

2. Solely administering medications (i.e., giving an injection only) is covered only when using the procedure code specified below (96372).

3. Performance of ordering labs, including urine analyses (UAs), is not a covered service and may not be billed to Medicaid.

Procedure Code and Unit of Service:

T1001- Nurse Evaluation and Assessment – per encounter

96372- Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular – per encounter (use this code when an injection is administered with minimal monitoring only)

When billing these procedure codes, bill one unit regardless of the length of the service as the service is based on an encounter.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;

2. setting in which the service was rendered;

3. specific service rendered (i.e, medication management or injection);

4. note that documents as applicable:

   a. health issues and medications reviewed/monitored, results of the review and progress toward related treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers;

   b. dosage of medications;

   c. summary of information provided; and

   d. if medications are administered, documentation of the medication(s) (i.e., specify substance or drug) and method and site of administration; and

5. signature and licensure or credentials of the individual who rendered the service.

2 -10 Therapeutic Behavioral Services

Therapeutic behavioral services are provided face-to-face to an individual or a group and is coded when the service provided does not fully meet the definition of psychotherapy. Instead, the provider uses behavioral

interventions to assist clients with a specific behavior problem. This service may be provided to an individual or a group.

Who:

1. Licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure as a mental health therapist. (See Chapter 1-5, B. 1.)

2. This service may also be performed by:

   a. licensed social service worker or individual working toward licensure as a social service worker in accordance with state law under supervision of a licensed mental health therapist;

   b. licensed registered nurse;

   c. licensed ASUDC or SUDC under the general supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 qualified to provide supervision;

   d. licensed CASUDC or a CASUDC-I under direct supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 or a licensed ASUDC qualified to provide supervision;

   e. CSUDC or CSUDC-I under direct supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 or a licensed ASUDC or SUDC qualified to provide supervision; or

   f. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, or individual enrolled in a qualified substance use disorder counselor education program, exempted from licensure in accordance with state law, and under required supervision.

Limits:

1. Groups are limited to twelve clients in attendance unless a co-provider is present; then groups may not exceed 24 clients in attendance.

2. Multiple family therapeutic behavioral services groups are limited to ten families in attendance.

3. Co-providers must meet the provider qualifications outlined in the 'Who' section above.

4. Therapeutic behavioral services do not include DUI classes.

Procedure Codes and Unit of Service:

H2019 - Individual/Family Therapeutic Behavioral Services - per 15 minutes

H2019 with HQ modifier - Group Therapeutic Behavioral Services - per 15 minutes per Medicaid client

The following time rules apply for converting the duration of the service to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e., therapeutic behavioral services);
4. treatment goal(s);
5. clinical note per session that documents:
   a. the nature of the interventions used to address the behavior problem; and
   b. the client's progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and
6. signature and licensure or credentials of the individual who rendered the service. If a co-leader is present for therapeutic behavioral services groups, the note must contain the co-leader's name and licensure or credentials.

2 - 11 Psychosocial Rehabilitative Services

Psychosocial rehabilitative services (PRS) are provided face-to-face to an individual or a group and are designed to restore the client to his or her maximum functional level through the use of face-to-face interventions such as cueing, modeling, and role-modeling of appropriate fundamental daily living and life skills. This service is aimed at maximizing the client's basic daily living and life skills, increasing compliance with the client's medication regimen as applicable, and reducing or eliminating symptomatology that interferes with the client's functioning, in order to prevent the need for more restrictive levels of care such as inpatient hospitalization. Intensive psychosocial rehabilitative services may be coded when a ratio of no more than five clients per provider is maintained during a group rehabilitative psychosocial service.

Who:

1. licensed social service worker or individual working toward licensure as a social service worker in accordance with state law under supervision of a licensed mental health therapist;

2. licensed registered nurse;

3. licensed practical nurse under the supervision of a licensed registered nurse or a licensed mental health therapist identified in paragraph A. 1 of Chapter 1-5;

4. licensed ASUDC or SUDC under the general supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 qualified to provide supervision;

5. licensed CASUDC or a CASUDC-I under direct supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 or a licensed ASUDC qualified to provide supervision;

6. CSUDC or CSUDC-I under direct supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 or a licensed ASUDC or SUDC qualified to provide supervision; or

7. other trained individual (but not including foster parents or other proctor parents) under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.3(b) of Chapter 1-5, a licensed social service worker or a licensed registered nurse; or a licensed ASUDC or SUDC when the service is provided to individuals with an SUD; or

8. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, or individual enrolled in a qualified substance use disorder counselor education program, exempted from licensure in accordance with state law, and under required supervision.

9. The above are the core providers of this service. In addition, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure as a mental health therapist may also perform this service. (See Chapter 1-5, B. 1.)

Limits:

1. In group psychosocial rehabilitative services, a ratio of no more than twelve clients per provider up to a maximum of 36 clients must be maintained during the entire service.

2. In accordance with 42 CFR 440.130, and the definition of rehabilitative services, the following do not constitute medical or remedial services and may not be billed to Medicaid:

   a. activities in which providers are not present and actively involved helping individuals regain functional abilities and skills;

   b. routine supervision of clients, including routine 24-hour care and supervision of clients (or clients' children) in residential settings. Routine supervision includes care and supervision-level providers who may have informal, sporadic interactions with a client that are helpful; however, these types of interactions do not constitute a billable structured, pre-planned psychosocial rehabilitative individual or group session. Individual and group PRS must be provided in accordance with a formal schedule for the client and must be documented in accordance with the requirements in the 'Record' section below. Otherwise intermittent unplanned communications with the client are part of the routine supervision and are not billable;

   c. activities in which providers perform tasks for the client, including activities of daily living and personal care tasks (e.g., grooming and personal hygiene tasks, etc.);

d. time spent by the client in the routine completion of activities of daily living, including chores, in a residential setting; this time is part of the routine 24-hour supervision;

e. habilitation services;

f. job training, job coaching and other vocational activities, and educational services and activities such as lectures, presentations, conferences, other mass gatherings, etc.;

g. social and recreational activities, including but not limited to routine exercise, farming, gardening & animal care activities, etc. Although these activities may be therapeutic for the client, and a provider may obtain valuable observations for processing later, they do not constitute billable activities. However, time spent before and after the activity addressing the clients' skills and behaviors related to the clients' rehabilitative goals is allowed);

h. routine transportation of the client or transportation to the site where a psychosocial rehabilitative service will be provided; and

i. any type of child care (including therapeutic child care).

3. Intensive PRS groups are limited to five clients per provider, with a maximum of ten clients per intensive PRS group. Intensive PRS groups are planned, structured groups independent from other PRS groups, and are designed to address the clinical needs of clients who, if in regular PRS groups would be distracting to other group members and/or require more individualized attention, including one on one, to maintain their focus on their clinical issues and treatment goals. Intensive PRS cannot be coded based solely on the number of clients in attendance.

   The psychiatric diagnostic evaluation or other clinical documentation must document the need for an intensive PRS group, the individual's diagnoses, severity of symptoms and behaviors, and why an intensive PRS group is required. The treatment plan must prescribe intensive PRS and contain goals to ameliorate the symptoms and behaviors that necessitate intensive PRS group.

Procedure Codes and Unit of Service:

H2014 – Individual Skills Training and Development - per 15 minutes (This procedure code is used when providing PRS to an individual.)

H2017 - Group Psychosocial Rehabilitative Services - per 15 minutes per Medicaid client

H2017 with U1 modifier - Group Psychosocial Rehabilitative Services – Intensive - per 15 minutes per Medicaid client (See #3 of 'Limits' section above.) The following time rules apply for converting the duration of the service to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

*Psychosocial rehabilitative services provided in licensed day treatment or licensed residential treatment programs:

Because clients may leave and return later in the day (e.g., to attend other services, for employment, etc.), if attendance in each group meets the minimum time requirement for billing (i.e., at least eight minutes), then time spent throughout the day may be totaled to determine units of service provided for billing purposes. If attendance in some groups does not meet the eight minute minimum, then those groups may not be included in the daily total for determining the amount of time spent and the number of units to be billed.

Record:

A. Group Psychosocial Rehabilitative Services Provided in Licensed Day Treatment Programs, Licensed Residential Treatment Programs, and Licensed or Unlicensed Day Treatment Programs in Schools

   1. For each date of participation in the program, documentation must include:

      a. name of each group in which the client participated (e.g., anger management, interpersonal relations, etc.);

      b. date, start and stop time, and duration of each group; and

      c. setting in which each group was rendered (e.g., day treatment program).

   2. Because rehabilitation is a process over time requiring frequent repetition and practice to achieve goals, progress is often slow and intermittent. Consequently, there must be sufficient amounts of time for progress to be demonstrated.

      Therefore, at a minimum, one summary note for each unique type of psychosocial rehabilitative group the client participated in during the immediately preceding two-week period must be prepared at the close of the two-week period. The required summary note may be written by the provider who provided the group, or by a provider who is most familiar with the client's involvement and progress across groups.

      The summary note must include:

      a. name of the group;

      b. treatment goal(s) related to the group;

      c. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

      d. signature and licensure or credentials of the individual who prepared the documentation. If a co-leader is present for the group, the note must contain the co-leader's name and licensure or credentials.

If the provider prefers, the provider may follow the documentation requirements listed under the next section, section B.

B. Psychosocial Rehabilitative Services Provided to a Group of Individuals in Other Settings

When psychosocial rehabilitative services are provided to groups of clients outside of an organized day treatment or residential treatment program, for each unique type of psychosocial rehabilitative group and for each group session, documentation must include:

1. date, start and stop time, and duration of the group;
2. setting in which the group was rendered;
3. specific service rendered (i.e., psychosocial rehabilitative services) and the name of the group (e.g., relationship skills group, etc.);
4. treatment goal(s) related to the group;
5. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and
6. signature and licensure or credentials of the individual who rendered the service. If a co-leader is present for group, the note must contain the co-leader's name and licensure or credentials.

C. Psychosocial Rehabilitative Services Provided to an Individual

When provided to an individual, for each service documentation must include:

1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e., psychosocial rehabilitative services)
4. treatment goal(s);
5. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and
6. signature and licensure or credentials of the individual who rendered the service.

If psychosocial rehabilitative services goals are met as a result of participation in the service, then if applicable, new individualized goals must be added to the treatment plan.

2 - 12 Peer Support Services

Peer support services means face-to-face services for the primary purpose of assisting in the rehabilitation and recovery of individuals with mental health and/or substance use disorders. For children, peer support services are provided to their parents/legal guardians as appropriate to the child's age when the services are directed exclusively toward the treatment of the Medicaid-eligible child. Peer support services are provided to an individual, a group of individuals or parents/legal guardians. On occasion, it may be impossible to meet with the peer support specialist in which case a telephone contact with the client or parent/legal guardian of a child would be allowed.

Peers support services are designed to promote recovery. Peers offer a unique perspective that clients find credible; therefore, peer support specialists are in a position to build alliances and instill hope. Peer support specialists lend their unique insight into mental illness and substance use disorders and what makes recovery possible.

Using their own recovery stories as a recovery tool, peer support specialists assist clients with creation of recovery goals and with goals in areas of employment, education, housing, community living, relationships and personal wellness. Peer support specialists also provide symptom monitoring, assist with symptom management, provide crisis prevention, and assist clients with recognition of health issues impacting them.

Peer support services must be prescribed by a licensed mental health therapist identified in paragraph A of Chapter 1-5. Peer support services are delivered in accordance with a written treatment/recovery plan that is a comprehensive, holistic, individualized plan of care developed through a person-centered planning process. Clients lead and direct the design of their plans by identifying their own preferences and individualized measurable recovery goals.

Who:

Peer support services are provided by certified peer support specialists.

To become a certified peer support specialist, an individual must:

1. be at least age 18 and:
    a. a self-identified individual who is in recovery from a mental health and/or substance use disorder; or
    b. parent of a child with a behavioral health disorder; or
    c. other adult who has or has had an ongoing and personal relationship with an individual with a behavioral health disorder; and
2. successfully complete a peer support specialist training curriculum designed to give peer support specialists the competencies necessary to successfully perform peer support services. Curriculums are developed by the State of Utah, Department of Human Services, Division of Substance Abuse and Mental Health (DSAMH), in consultation with national experts in the field of peer support. Training is provided by DSAMH or a qualified individual or organization sanctioned by DSAMH. At the end of the training individuals must successfully pass a written examination. An individual who successfully completes the certification training will receive a written peer support specialist certification from the DSAMH and also will successfully complete any continuing education requirements the DSAMH requires to maintain certification.

Certified peer support specialists are under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.3(b) of Chapter 1-5, or a licensed ASUDC or SUDC when peer support services are provided to individuals with an SUD.

Supervisors must provide ongoing weekly individual and/or group supervision to the certified peer support specialists they supervise.

Limits:

1. Peer support groups are limited to a ratio of 1:8.

2. Medicaid clients or Medicaid-eligible children's parents/legal guardians may participate in a maximum of four hours of peer support services a day.

3. With the exception of older adolescents (adolescents age 16-18) for children, peer support services are provided to their parents/legal guardians and the services are directed exclusively to the treatment of the Medicaid-eligible child (i.e., toward assisting the parents/legal guardians in achieving the rehabilitative treatment goals of their children.

4. In accordance with 42 CFR 440.130, and the definition of rehabilitative services, the following do not constitute medical or remedial services and may not be billed to Medicaid:

   a. Job training, job coaching, and vocational and educational services. These activities are not within the scope of a peer support specialist's role; however, helping individuals with the emotional and social skills necessary to obtain and maintain employment is within the scope of peer support services;

   b. Social and recreational activities (although these activities may be therapeutic for the client, and the peer support specialist may obtain valuable observations for processing later, they do not constitute reportable services. However, time spent before and after the activity addressing the clients' behaviors related to the clients' peer support goals is allowed); and

   c. Routine transportation of the client or transportation to a site where a peer support services will be provided.

Procedure Code and Unit of Service:

H0038 – Individual Peer Support Services - per 15 minutes

H0038 with HQ modifier - Group Peer Support Services - per 15 minutes per Medicaid client

The following time rules apply for converting the duration of the service to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;

2. setting in which the service was rendered;
3. specific service rendered (i.e., peer support services);
4. treatment goal(s);
5. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and
6. signature and licensure or credentials of the individual who rendered the service.

If peer support services goals are met as a result of participation in the service, then if applicable, new individualized goals must be added to the treatment plan.

3 1915(b)(3) SERVICES – FOR PREPAID MENTAL HEALTH PLAN (PMHP) CONTRACTORS ONLY

This section applies to PMHP contractors only. The services included in this section are not available to children in foster care, or children with adoption subsidy exempted from the PMHP for outpatient behavioral health services.

In accordance with 1915 (b)(3) of the Social Security Act, services in addition to the scope of Medicaid State Plan-covered services may be provided to enrollees in a managed care plan. The services specified in this chapter may be provided to PMHP enrollees, with the following exceptions.

Exceptions

1. 1915(b)(3) services are a benefit for PMHP enrollees with Traditional Medicaid only. They are not a benefit for Medicaid recipients age 19 and older with Non-Traditional Medicaid.
2. 1915(b)(3) services are not a benefit for individuals enrolled in the PMHP for only inpatient psychiatric care. This includes children in foster care, and children with adoption subsidy exempted from the PMHP for outpatient behavioral health services.
3. 1915(b)(3) services are not covered for PMHP enrollees getting services for SUDs only.

In accordance with Chapter 1-7, Treatment Plan, 1915(b)(3) services must be included on the client's treatment plan and meet requirements of Chapter 1-7.

3 - 1 Personal Services

Personal Services are recommended by a physician or other practitioner of the healing arts (see paragraph A of Chapter 1-5) and are furnished for the primary purpose of assisting in the rehabilitation of clients with serious and persistent mental illness (SPMI) or serious emotional disorder (SED). These services include assistance with instrumental activities of daily living (IADLs) that are necessary for individuals to live successfully and independently in the community and avoid hospitalization. Personal services include assisting the client with varied activities based on the client's rehabilitative needs: picking up prescriptions, income management, maintaining the living environment including cleaning and shopping, and the transportation related to the performance of these activities, and representative payee

activities when the PMHP has been legally designated as the client's representative payee. These services assist clients to achieve their goals for remedial and/or rehabilitative IADL adequacy necessary to restore them to their best possible functioning level.

Who:

1. licensed social service worker or individual working toward licensure as a social service worker in accordance with state law under supervision of a licensed mental health therapist;

2. licensed registered nurse;

3. licensed practical nurse under the supervision of a licensed registered nurse, or a licensed mental health therapist identified in Chapter 1-5, A. 1;

4. other trained individual (but not including foster parents or other proctor parents) under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.3(b) of Chapter 1-5, a licensed social service worker or a licensed registered nurse; or

5. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, exempted from licensure in accordance with state law and under required supervision.

The providers identified above are the core providers of this level of service; however, in accordance with Chapter 1-5, B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure may also perform this service.

Procedure Code and Unit of Service:

H0046 – per 15 minutes

The following time rules apply for converting the duration of the service to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;

2. setting in which the service was rendered;
3. specific service rendered;
4. treatment goal(s);
5. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and
6. signature and licensure or credentials of the individual who rendered the service.

3 - 2 Respite Care

Respite care is recommended by a physician or practitioner of the healing arts (see Chapter 1-5, A) and is furnished face-to-face to a child for the primary purpose of giving the parent(s)/guardian(s) temporary relief from the stresses of caring for a child with a serious emotional disorder (SED). Respite care can prevent parent/guardian burn-out, allow for time to be spent with other children in the family, preserve the family unit, and minimize the risk of out-of-home placement by reducing the stress families of children with SED typically encounter.

Who:

1. licensed social service worker or individual working toward licensure as a social service worker in accordance with state law under supervision of a licensed mental health therapist;
2. licensed registered nurse;
3. licensed practical nurse under the supervision of a licensed registered nurse or a licensed mental health therapist identified in Chapter 1-5, A. 1;
4. other trained individual under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.3(b) of Chapter 1-5, a licensed social service worker or a licensed registered nurse; or
5. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, exempted from licensure in accordance with state law and under required supervision.

The providers identified above are the core providers of this level of service; however, in accordance with Chapter 1-5, B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure may also perform this service.

Procedure Code and Unit of Service:

S5150 – per 15 minutes

The following time rules apply for converting the duration of the service to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Record:

Each provider delivering respite care must provide documentation as follows:

1. For each date of respite care:

   a. date, start and stop time, and duration of the service;
   b. setting in which the service was rendered; and
   c. specific service rendered.

2. For each preceding two-week period during which the client received respite services, at a minimum, one summary note that includes:

   a. the name of the service;

   b. treatment goal(s);

   c. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

   d. signature and licensure or credentials of the individual who rendered the service(s).

3 - 3 Psychoeducational Services

Psychoeducational Services are recommended by a physician or practitioner of the healing arts (see Chapter 1-5, A) and are provided face-to-face to an individual or a group and are furnished for the primary purpose of assisting in the rehabilitation of Enrollees with serious and persistent mental illness (SPMI) or serious emotional disorders (SED). This rehabilitative service includes interventions which help clients achieve goals of remedial and/or rehabilitative vocational adequacy necessary to restore them to their best possible functioning level.

Who:

1. licensed social service worker or individual working toward licensure as a social service worker in accordance with state law under supervision of a licensed mental health therapist;

2. licensed registered nurse;

3. licensed practical nurse under the supervision of a licensed registered nurse or a licensed mental health therapist identified in Chapter 1-5, A. 1;

4. other trained individual under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.3(b) of Chapter 1-5, a licensed social service worker or a licensed registered nurse; or

5. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, exempted from licensure in accordance with state law and under required supervision.

The providers identified above are the core providers of this level of service; however, in accordance with Chapter 1-5, B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure may also perform this service.

Procedure Code and Unit of Service:

H2027 – Psychoeducational Services - per 15 minutes per Medicaid client

The following time rules apply for converting the duration of the service to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Record:

A. Psychoeducational Services Provided in Licensed Day Treatment Programs, Licensed Residential Treatment Programs, and Licensed or Unlicensed Day Treatment Programs in Schools

   1. For each date of participation in psychoeducational services, documentation must include:

      a. name of the service;

      b. date, start and stop time, and duration of the service; and

      c. the setting in which the service was rendered.

   2. Because rehabilitation is a process over time requiring frequent repetition and practice to achieve goals, progress is often slow and intermittent. Consequently, there must be sufficient amounts of time for progress to be demonstrated.

Therefore, at a minimum, one summary note for each preceding two-week period during which the client received psychoeducational services must be prepared at the close of the two-week period.

The summary note must include:

a. name of the service;

b. treatment goal(s);

c. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

d. signature and licensure or credentials of the individual who rendered the service.

If the provider prefers, the provider may follow the documentation requirements listed under the next section, section B.

B. Psychoeducational Services Provided to a Group of Individuals in Other Settings

When psychoeducational services are provided to groups of clients outside of an organized day treatment or residential treatment program, for each psychoeducational group session, documentation must include:

1. date, start and stop time, and duration of the psychoeducational group;

2. setting in which the group was rendered;

3. specific service rendered;

4. treatment goal(s);

5. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

6. signature and licensure or credentials of the individual who rendered the service.

C. Psychoeducational Services Provided to an Individual

When provided to an individual, for each service documentation must include:

1. date, start and stop time, and duration of the service;

2. setting in which the service was rendered;

3. specific service rendered;

4. treatment goal(s);

5. progress toward treatment goal(s) or if there was no reportable progress, documentation of barriers; and

6. signature and licensure or credentials of the individual who rendered the service.

If psychoeducational services goals are met as a result of participation in the service, then if applicable, new individualized goals must be added to the treatment plan.

Psychoeducational services provided in licensed day treatment or licensed residential treatment programs:

Because clients may leave and return later in the day (e.g., to attend other services, for employment, etc.), in accordance with Chapter 1-12, if attendance in each psychoeducational services group meets the minimum time requirement for reporting (i.e., at least eight minutes), then time spent throughout the day may be totaled to determine units of service provided for reporting purposes. If attendance in some groups does not meet the eight minute minimum, then those groups may not be included in the daily total for determining the amount of time spent and the number of units to be reported.

3 - 4 Supportive Living

Supportive Living means costs incurred in residential treatment/support programs when Enrollees are placed in these programs in lieu of inpatient hospitalization. Costs include those incurred for 24-hour staff, facility costs associated with providing discrete Covered Services (e.g., individual psychotherapy, pharmacologic management, etc.) at the facility site, and apportioned administrative costs. Costs do not include the Covered Services costs or room/board costs. This level of care is recommended by a physician or other practitioner of the healing arts (see Chapter 1-5, A), and helps to restore clients with SPMI or SED to their best possible functioning level. Whenever possible, the PMHP will provide this level of care in lieu of inpatient hospitalization so that individuals may remain in a less restrictive community setting.

Who:

1. licensed social service worker or individual working toward licensure as a social service worker in accordance with state law under supervision of a licensed mental health therapist;

2. licensed registered nurse;

3. licensed practical nurse under the supervision of a licensed registered nurse or a licensed mental health therapist identified in Chapter 1-5, A. 1;

4. other trained individual (but not including foster parents or other proctor parents) under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.3(b) of Chapter 1-5, a licensed social service worker or a licensed registered nurse; or

5. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, exempted from licensure in accordance with state law and under required supervision.

The providers identified above are the core providers of this level of service; however, in accordance with Chapter 1-5, B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure may also perform this service.

Procedure Code and Unit of Service:

H2016 – 1 unit per day

Record:

Documentation must include:

1. note each month documenting the dates supportive living was provided during the month; and

2. signature and licensure or credentials of the individual who prepared the documentation.

4 PROCEDURE CODES AND MODIFIERS

Procedure Code	Service and Units
90791	Psychiatric Diagnostic Evaluation - per 15 minutes
90792	Psychiatric Diagnostic Evaluation with Medical Services - per 15 minutes
H0031	Mental Health Assessment by Non-Mental Health Therapist - per 15 minutes
96101	Psychological Testing - per hour
96105	Assessment of Aphasia - per hour
96110	Developmental Screening - per hour
96111	Developmental Testing - per hour
96116	Neurobehavioral Status Exam - per hour (Per Chapter 2-1, requires manual review. Limited to 3 hours (3 units) per year unless additional time is approved based on manual review. More than 3 hours (3 units) per year require supportive documentation for the manual review.)
96118	Neuropsychological Testing - per hour (Per Chapter 2-1, requires manual review. Limited to 8 hours (8 units) per year unless additional time is approved based on manual review. More than 8 hours (8 units) per year require supportive documentation for the manual review.)
90832	Psychotherapy with patient and/or family member - 30 minutes
90834	Psychotherapy with patient and/or family member - 45 minutes
90837	Psychotherapy with patient and/or family member - 60 minutes
90846	Family Psychotherapy - without patient present - per 15 minutes
90847	Family Psychotherapy - with patient present - per 15 minutes
90849	Group Psychotherapy - Multiple-family group psychotherapy - per 15 minutes per Medicaid client
90853	Group Psychotherapy – per 15 minutes per Medicaid client
90839	Psychotherapy for Crisis, first 60 minutes* – per encounter
90840	Psychotherapy for Crisis, add-on to 90839, each additional 30 minutes
	*Note: Use 90832 for crisis contacts 30 minutes or less
90833	Psychotherapy add-on code, with patient and/or family member – 30 minutes (added to applicable evaluation and management (E/M) service code)
90836	Psychotherapy add-on code, with patient and/or family member – 45 minutes (added to applicable evaluation and management (E/M) service code)
90838	Psychotherapy add-on code, with patient and/or family member – 60 minutes (added to applicable evaluation and management (E/M) service code)
99211-99215*	Office or Other Outpatient Services Evaluation and Management (E/M) Services Codes- established patient

Procedure Code	Service and Units
99307-99310*	Subsequent Nursing Facility Care E/M Codes – established patient (should be used to report E/M services provided to a patient in a psychiatric residential center [a facility or a distinct part of a facility for psychiatric care, which provides 24-hour therapeutically planned and professionally staffed group living and learning environment])
99347-99350*	Home Services E/M Codes – established patient
99354	Prolonged Services, first hour (60 additional minutes with patient) - per encounter (Use with E/M codes 99211-99215 or 99347-99350; and with 90837 when psychotherapy place of service is where these E/M codes would be used.)
99355	Prolonged Services, each additional 30 minutes with patient (beyond the 60 additional minutes that are coded with 99354) – per encounter
99356	Prolonged Services, first hour (60 additional minutes with patient) - per encounter (Use with E/M codes 99307-99310 or inpatient-based E/M codes; and with 90837 when psychotherapy place of service is where these E/M codes would be used.)
99357	Prolonged Services, each additional 30 minutes with patient (beyond the 60 additional minutes that are coded with 99356) – per encounter
T1001	Nurse Evaluation and Assessment (Medication Management) - per encounter
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug) subcutaneous or intramuscular – per encounter
90785	Add-on code for interactive complexity (with procedure codes 90791, 90792, 90832, 90834, 90837, 90833, 90836, 90838; and E/M services codes)
H2019	Individual/Family Therapeutic Behavioral Services - per 15 minutes
H2019 with HQ modifier	Group Therapeutic Behavioral Services - per 15 minutes per Medicaid client
H2014	Individual Skills Training and Development (Psychosocial rehabilitative services with an individual) - per 15 minutes
H2017	Group Psychosocial Rehabilitative Services - per 15 minutes per Medicaid client
H2017 with U1 modifier	Group Psychosocial Rehabilitative Services - Intensive - per 15 minutes per Medicaid client
H0038	Peer Support Services, individual – per 15 minutes
H0038 with HQ modifier	Peer Support Services, group - per 15 minutes per Medicaid client
	Prepaid Mental Health Plans (PMHPs) Only - 1915(b)(3) Services
H0046	Personal Services - per 15 minutes
S5150	Respite Care - per 15 minutes
H2027	Psychoeducational Services – per 15 minutes
H2016	Supportive Living – per day

* To ensure correct adjudication of an E/M claim, always use the CG modifier with the E/M code. This modifier indicates the service provided was pharmacologic management covered under this program.

ATTACHMENT 12

Public Comments and State Responses

Attachment 12

Summary of Public Comments and State Responses

1st Public Comment Period- May 9, 2016 through June 8, 2016

The State received a total of 142 comments from individuals, advocacy groups and other state agencies. Most commenters expressed support for full Medicaid expansion. Absent full expansion, many commenters supported keeping the existing Primary Care Network (PCN) program. Some comments were outside the scope of the waiver and are not addressed in the State responses here.

Comments Regarding the Waiver Renewal and Existing Programs

Primary Care Network Enrollment Limits

Comment: Several commenters stated that PCN enrollment limits should be changed to allow additional slots for adults without dependent children, when parents move off of PCN to another Medicaid program. They also stated that the PCN slots that become available by moving parents to Medicaid should not be reduced to help fund Medicaid expansion to the new adult without dependent children group.

Response: The State concurs with this recommendation. The waiver amendment has been modified to request that the Centers for Medicare and Medicaid Services (CMS) remove the enrollment limits for adults with children and adults without children within the PCN program. The overall PCN enrollment cap of 25,000 would remain in place. The issue regarding a potential reduction in PCN slots to fund this adult expansion will need to be addressed through the legislative appropriations process.

Benefits for Parents

Comment: One commenter asked that all parents eligible for Medicaid be able to receive traditional Medicaid benefits, rather than the current non-traditional benefit package "current eligibles" receive.

Response: The State appreciates this comment, however budget neutrality savings from the slightly reduced non-traditional benefit package fund the PCN program.

Comment: One commenter asked for a clarification as to why the amendment states the new adult group will be offered traditional Medicaid benefits, but the expenditure authority notes

that part of the reason for requesting the waiver is to offer benefits that are less than those available to other individuals under the state plan.

Response: The new adult without children group will receive the traditional Medicaid benefits that are authorized under the state plan. The budget neutrality document the commenter is referring to is specific to the "current eligibles" group, which is the parent/caretaker-relative group. This group receives non-traditional Medicaid benefits.

EPSDT Waiver Concern

Comment: One commenter asked for clarification regarding the termination of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) waiver. They are concerned about any anticipated consequences of this.

Response: Termination of the EPSDT waiver for the non-traditional benefit allows the State to cover certain services required to treat a condition identified through an EPSDT screening for 19 and 20 year olds. This change is actually an increase in the benefits currently provided to this age group. We only anticipate positive consequences.

Comments Regarding the Adult Expansion

General Comments

Comment: Many commenters (107 total) responded that they do not support the proposed plan to provide coverage to the new groups of adults without dependent children, because they want full Medicaid expansion. In addition, many stated they supported the Healthy Utah proposal, but want full Medicaid expansion to be implemented. Several commenters stated they support the waiver to implement the new program to cover the new adult without dependent children group, but they only see this as a start and would like to see full Medicaid expansion implemented in the near future.

Response: This waiver amendment is designed to implement House Bill 437. The bill specifically outlines the groups to be covered: the chronically homeless; those involved in the justice system through probation, parole or court ordered treatment, and having a need for mental health treatment or substance abuse treatment; and those in need of mental health treatment or substance abuse treatment but who are not involved in the justice system. The Utah Department of Health (UDOH) was tasked with further refining the definition of the groups that will be covered by the health improvement coverage program authorized by the bill. The UDOH received input from many stakeholder groups to help define who would be eligible.

House Bill 437 does not authorize full Medicaid expansion. The State must develop coverage groups within the statutory provisions of House Bill 437. If the Legislature chooses to further

expand Medicaid coverage in the future, appropriate state plan amendments and/or waivers will be developed at that time.

Definition of Chronically Homeless

Comment: Two commenters suggested the "disabling condition" component of the chronically homeless definition be re-considered. They believe having to meet this criteria will increase the difficulty of becoming eligible for Medicaid, and that this group of people could already be eligible for Medicaid due to their disability.

Response: We appreciate the comment, however, the State intends to retain disabling condition in the definition of chronic homelessness. This will keep the definition of chronic homeless aligned with the one used by the United States Department of Housing and Urban Development (HUD). It is hoped this alignment will allow for easier identification and verification by the Department of Workforce Services (DWS), as they have access to the Homeless Management Information System (HMIS) used by most shelter providers. DWS will determine eligibility for the new program.

Comment: One commenter suggested that UDOH coordinate with additional partners to identify and verify eligibility for the chronically homeless criteria, particularly for those who do not use the HMIS system.

Response: We appreciate the comment. The State intends to work with community partners to develop ways to identify the chronically homeless who are not captured in HMIS.

Comment: One commenter asked if the inclusion of people in permanent supportive housing will encompass those residing in transitional housing or engaged in rapid rehousing.

Response: We appreciate the comment. This question has not been raised previously and we will investigate as to whether transitional housing and rapid rehousing should be included in the definition. Clarification on this issue would be provided through administrative rule.

Justice System Involvement

Comment: One commenter stated that House Bill 437 gained stakeholder support by stating this bill would satisfy the unmet need for treatment related to Utah's Justice Reinvestment Initiative, and that as written, the bill eliminates individuals released on pretrial that lack a court order into treatment. They believe the bill falls short of meeting the unmet Justice Reinvestment Initiative treatment needs.

Response: We understand the commenter's concerns, however, the proposal was drafted within the limitations of the appropriations associated with House Bill 437.

Comment: One commenter stated that prioritizing those "involved in the justice system" over those who have similar treatment needs, but are not "involved in the justice system", could promote criminal activity.

Response: We appreciate the commenter's concerns. However, at this time the concern is speculative since the program is not yet implemented.

Coverage for People who are released from the State Hospital

Comment: One commenter stated that limiting coverage for those who are civilly committed to the State Hospital and then discharged seems counter-productive. They believe the goal is to keep and treat individuals in the community and only access more intensive levels of care when absolutely necessary.

Response: The intent of this criteria is to assure individuals leaving the State Hospital continue to get the treatment they need once they return to the community. It is assumed these individuals will have high needs and have an elevated risk of subsequent incidents if they do not receive additional care.

Comment: One commenter stated that a larger number of people are committed to local mental health authorities than to the State Hospital. They suggested that separate slots be allocated for both.

Response: We understand the commenter's concerns, however, the proposal was drafted within the limitations of the appropriations associated with House Bill 437.

Comment: One commenter stated they are concerned that the eligibility criteria of being released from the State Hospital will encourage additional use of the State Hospital when this is already a limited resource with long waiting lists.

Response: We appreciate the commenter's concerns, however, at this time the concern is speculative since the program is not yet implemented.

Definition of "Behavioral Health Treatment Program"

Comment: Several commenters asked for clarification of the definition of a "behavioral health treatment program" and how long after successfully completing a program they would be eligible. In addition, they asked how people who are released prior to successful completion of a program will be handled.

Response: The waiver application is being modified to change the definition from "behavioral health treatment program" to "substance use disorder treatment program". The State intends through rulemaking to define how long after completion of a program someone would be

eligible and define circumstances where an individually released while successfully participating in a treatment program could be eligible.

Comment: While commenters were supportive of including people who are involved in the justice system who have a mental health or substance use disorder, several commenters stated they are concerned with the criteria of "completing a behavioral health treatment program" due to the fact that not all areas of the state have such programs. They believe not all inmates will have access to a program in order to qualify under this criteria.

Response: We appreciate the commenters' concerns, however, the proposal was drafted within the limitations of the appropriations associated with House Bill 437.

Comment: Several commenters were concerned that incarceration would be a prerequisite to be eligible for Medicaid and that it would impact sentencing decisions by judges. They are concerned that judges may sentence offenders to jail time to become eligible for Medicaid when they would otherwise have been given probation. They believe that eligibility should be based on the need for services as determined by a validated assessment instrument.

Response: We appreciate the commenters' concerns. However, at this time the concern that judges may sentence to meet this criteria is speculative since the program is not yet implemented. In addition, the proposal was drafted within the limitations of the appropriations associated with House Bill 437.

Suggestion for Changes to Adult Expansion Groups

Comment: One commenter submitted a request to a have a specific population included in the covered groups. They would like inmates paroling to the community with significant mental illness to be covered, specifically those with schizophrenia, major depressive disorder and bipolar disorder. They believe they are in significant need of continued care in the community, both with treatment and medication services.

Response: We appreciate the commenter's concerns, however, the proposal was drafted within the limitations of the appropriations associated with House Bill 437.

Concern with the Cost and Number of People to Be Covered by the New Adults without Dependent Children Group

Comment: Several commenters asked why the Legislature and UDOH were not aware that the program would cover less people than the originally estimated amount of 16,000. They are concerned that this number has decreased since House Bill 437 was originally passed.

Response: Original estimates for coverage were developed on a broader mix of individuals, which would have included many healthy, lower-cost individuals. As the covered populations became further defined, our consultant, Milliman, determined the populations defined in the

proposal had much higher medical needs. Because of this, the cost per individual is higher than expected, and the number of people the State can cover within the appropriated amount is less.

Comment: Two commenters are concerned that the "risk pool" created by the proposed waiver consists entirely of individuals with acute and intensive medical needs, and there is no "low risk" population to balance against, as you find in the typical Medicaid eligible population.

Response: We concur with the commenters' concerns.

Concern with the Zero Percent Income Limit for Adults without Dependent Children Group

Comment: Several commenters stated that the income limit of 0 percent FPL for this group may serve as a disincentive for otherwise eligible individuals to seek and maintain employment.

Response: We appreciate the commenters' concerns, however, at this time the concern is speculative since the program is not yet implemented.

Comment: Commenters were supportive of the provision to allow 12-months of continuous eligibility after a person becomes ineligible. However, they were concerned that the low income limit would incentivize people to quit their job once the 12-months ends in order to remain eligible.

Response: We appreciate the commenters' concerns, however, at this time the concern is speculative since the program is not yet implemented.

Concerns with the General Assistance Criteria

Comment: One commenter stated that requiring a mental health or substance use disorder makes the General Assistance criteria even less beneficial to this population, given the small number already served by the General Assistance program. They commented that this population is already likely to be eligible for Medicaid. They suggested we emphasize outreach and enrollment efforts, while targeting individuals with other needs who are are less likely to qualify.

Response: We appreciate the commenter's concerns, however, the proposal was drafted within the limitations of the appropriations associated with House Bill 437. Individuals who may otherwise qualify for Medicaid are actively identified by the Department of Workforce Services and assisted through the process. If eligible, they are enrolled in the appropriate Medicaid program.

Equal Access Concern with Adult Expansion

Comment: One commenter stated he believes there is an equal access issue under the 14th amendment with only covering specific groups of people. He stated he believes that by paying into the tax system, everyone should have equal access to Medicaid in Utah.

Response: We appreciate the commenter's concerns, however, we have consulted with the Attorney General's Office on this issue and do not believe this program creates an equal access issue under the 14th amendment.

Outcome Measures

Comment: One commenter stated that using the reduction in the length of homelessness as an outcome measure could be problematic due to a factor outside of the program's control: the availability of affordable housing. They also stated determining the success or failure on the number of hospital admissions could be troublesome as pent up need may drive a significant increase in demand. Instead, they suggest we track mental health and/or drug court completion and recidivism rates over time for enrollees.

Response: We appreciate the comment. However, it would be difficult to determine if Medicaid eligibility or the threat of jail time for failure to comply with the court's requirement is causing a reduction in recidivism. The State will remove the two measures highlighted by the commenter and will instead measure the reduction in non-emergent use of the Emergency Room for the chronically homeless population beginning in year-two of the demonstration.

Substance Use Disorder Residential Treatment Services

Comment: Several commenters stated they believe the length of residential treatment should be determined by medical necessity and not given a specific length of stay limit.

Response: We appreciate the commenters' concern. We believe the proposal being made strikes a balance between CMS concerns regarding the length of stay and the needs of individuals who can benefit from this important service.

Comment: Commenters asked for clarification regarding the maximum of two 90-day stays, and if the stays have to be different episodes of care. In addition, they also asked why the length of stays are different for adults and adolescents.

Response: The proposal is modeled after the state of California's waiver, which is the only state that has been granted this type of waiver.

Comment: Two commenters asked what the expectation is for treatment centers who have clients that need more than the 90-days of treatment per medical necessity guideline.

Response: The intent is to limit the treatment as stated in the proposed draft amendment.

Comment: One commenter asked if there will be any maximum length of time given for perinatal members.

Response: After further feedback from CMS, the language regarding perinatal members is being deleted from the amendment. They will fall under the proposal for other adults.

Summary of Public Comments and State Responses

2nd Public Comment Period- July 16, 2016 through August 15, 2016

The State received a total of six comments during the 2nd public comment period. The State specifically requested comments related to the budget neutrality section of the waiver. No comments related to budget neutrality were received. All six comments received requested or supported adoption of full Medicaid expansion.

Comment: Six commenters responded that they do not support the proposed plan to provide coverage to the new groups of adults without dependent children, because they want full Medicaid expansion.

Response: This waiver amendment is designed to implement House Bill 437. The bill specifically outlines the groups to be covered: the chronically homeless; those involved in the justice system through probation, parole or court ordered treatment, and having a need for mental health treatment or substance abuse treatment; and those in need of mental health treatment or substance abuse treatment but who are not involved in the justice system. The Utah Department of Health (UDOH) was tasked with further refining the definition of the groups that will be covered by the health improvement coverage program authorized by the bill. The UDOH received input from many stakeholder groups to help define who would be eligible.

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