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H.B. 413

1 **MEDICAID AMENDMENTS**

2 2022 GENERAL SESSION

3 STATE OF UTAH

4 **Chief Sponsor: James A. Dunnigan**

5 Senate Sponsor: ____________

6

7 **LONG TITLE**

8 **General Description:**

9 This bill modifies provisions related to the Medicaid program.

10 **Highlighted Provisions:**

11 This bill:

12 ▸ amends provisions relating to the targeted adult Medicaid program;

13 ▸ requires the department to convene a working group to discuss the delivery of

14 behavioral health services in the Medicaid program; and

15 ▸ authorizes certain adjustments in the delivery of behavioral health services for

16 individuals who are in the targeted adult Medicaid program if the department

17 determines that certain requirements are met.

18 **Money Appropriated in this Bill:**

19 None

20 **Other Special Clauses:**

21 None

22 **Utah Code Sections Affected:**

23 AMENDS:

24 **26-18-411**, as last amended by Laws of Utah 2020, Chapter 225

25 ENACTS:

26 **26-18-427**, Utah Code Annotated 1953

27 **26-18-428**, Utah Code Annotated 1953

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29 *Be it enacted by the Legislature of the state of Utah:*

30 Section 1. Section **26-18-411** is amended to read:

31 **26-18-411. Health coverage improvement program -- Eligibility -- Annual report**
32 **-- Expansion of eligibility for adults with dependent children.**

33 (1) [~~For purposes of~~] As used in this section:

34 (a) "Adult in the expansion population" means an individual who:

35 (i) is described in 42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII); and

36 (ii) is not otherwise eligible for Medicaid as a mandatory categorically needy
37 individual.

38 (b) "Enhancement waiver program" means the Primary Care Network enhancement
39 waiver program described in Section 26-18-416.

40 (c) "Federal poverty level" means the poverty guidelines established by the Secretary of
41 the United States Department of Health and Human Services under 42 U.S.C. Sec. 9909(2).

42 (d) "Health coverage improvement program" means the health coverage improvement
43 program described in Subsections (3) through (10).

44 (e) "Homeless":

45 (i) means an individual who is chronically homeless, as determined by the department;
46 and

47 (ii) includes someone who was chronically homeless and is currently living in
48 supported housing for the chronically homeless.

49 (f) "Income eligibility ceiling" means the percent of federal poverty level:

50 (i) established by the state in an appropriations act adopted pursuant to Title 63J,
51 Chapter 1, Budgetary Procedures Act; and

52 (ii) under which an individual may qualify for Medicaid coverage in accordance with
53 this section.

54 (g) "Targeted adult Medicaid program" means the program implemented by the
55 department under Subsections (5) through (7).

56 (2) Beginning July 1, 2016, the department shall amend the state Medicaid plan to
57 allow temporary residential treatment for substance abuse, for the traditional Medicaid
58 population, in a short term, non-institutional, 24-hour facility, without a bed capacity limit that

59 provides rehabilitation services that are medically necessary and in accordance with an
60 individualized treatment plan, as approved by CMS and as long as the county makes the
61 required match under Section 17-43-201.
62 (3) Beginning July 1, 2016, the department shall amend the state Medicaid plan to
63 increase the income eligibility ceiling to a percentage of the federal poverty level designated by
64 the department, based on appropriations for the program, for an individual with a dependent
65 child.
66 (4) Before July 1, 2016, the division shall submit to CMS a request for waivers, or an
67 amendment of existing waivers, from federal statutory and regulatory law necessary for the
68 state to implement the health coverage improvement program in the Medicaid program in
69 accordance with this section.
70 (5) (a) An adult in the expansion population is eligible for Medicaid if the adult meets
71 the income eligibility and other criteria established under Subsection (6).
72 (b) An adult who qualifies under Subsection (6) shall receive Medicaid coverage:
73 (i) through the traditional fee for service Medicaid model in counties without Medicaid
74 accountable care organizations or the state's Medicaid accountable care organization delivery
75 system, where implemented and at the department's discretion;
76 (ii) except as provided in Subsection (5)(b)(iii) and at the department's discretion, for
77 behavioral health, through the counties in accordance with Sections 17-43-201 and 17-43-301;
78 (iii) that integrates behavioral health services and physical health services with
79 Medicaid accountable care organizations in select geographic areas of the state that choose an
80 integrated model; and
81 (iv) that permits temporary residential treatment for substance abuse in a short term,
82 non-institutional, 24-hour facility, without a bed capacity limit, as approved by CMS, that
83 provides rehabilitation services that are medically necessary and in accordance with an
84 individualized treatment plan.
85 (c) Medicaid accountable care organizations and counties that elect to integrate care
86 under Subsection (5)(b)(iii) shall collaborate on enrollment, engagement of patients, and
87 coordination of services.
88 (6) (a) An individual is eligible for the health coverage improvement program under
89 Subsection (5) if:

90 (i) at the time of enrollment, the individual's annual income is below the income
91 eligibility ceiling established by the state under Subsection (1)(f); and
92 (ii) the individual meets the eligibility criteria established by the department under
93 Subsection (6)(b).
94 (b) Based on available funding and approval from CMS, the department shall select the
95 criteria for an individual to qualify for the Medicaid program under Subsection (6)(a)(ii), based
96 on the following priority:
97 (i) a chronically homeless individual;
98 (ii) if funding is available, an individual:
99 (A) involved in the justice system through probation, parole, or court ordered
100 treatment; and
101 (B) in need of substance abuse treatment or mental health treatment, as determined by
102 the department; or
103 (iii) if funding is available, an individual in need of substance abuse treatment or
104 mental health treatment, as determined by the department.
105 (c) An individual who qualifies for Medicaid coverage under Subsections (6)(a) and (b)
106 may remain on the Medicaid program for a 12-month certification period as defined by the
107 department. Eligibility changes made by the department under Subsection (1)(f) or (6)(b) shall
108 not apply to an individual during the 12-month certification period.
109 (7) The state may request a modification of the income eligibility ceiling and other
110 eligibility criteria under Subsection (6) each fiscal year based on projected enrollment, costs to
111 the state, and the state budget.
112 (8) Before September 30 of each year, the department shall report to the Health and
113 Human Services Interim Committee and to the Executive Appropriations Committee:
114 (a) the number of individuals who enrolled in Medicaid under Subsection (6);
115 (b) the state cost of providing Medicaid to individuals enrolled under Subsection (6);
116 and
117 (c) recommendations for adjusting the income eligibility ceiling under Subsection (7),
118 and other eligibility criteria under Subsection (6), for the upcoming fiscal year.
119 (9) The current Medicaid program and the health coverage improvement program,
120 when implemented, shall coordinate with a state prison or county jail to expedite Medicaid

121 enrollment for an individual who is released from custody and was eligible for or enrolled in
122 Medicaid before incarceration.
123 (10) Notwithstanding Sections 17-43-201 and 17-43-301, a county does not have to
124 provide matching funds to the state for the cost of providing Medicaid services to newly
125 enrolled individuals who qualify for Medicaid coverage under the health coverage
126 improvement program under Subsection (6).
127 (11) If the enhancement waiver program is implemented, the department:
128 (a) may not accept any new enrollees into the health coverage improvement program
129 after the day on which the enhancement waiver program is implemented;
130 (b) shall transition all individuals who are enrolled in the health coverage improvement
131 program into the enhancement waiver program;
132 (c) shall suspend the health coverage improvement program within one year after the
133 day on which the enhancement waiver program is implemented;
134 (d) shall, within one year after the day on which the enhancement waiver program is
135 implemented, use all appropriations for the health coverage improvement program to
136 implement the enhancement waiver program; and
137 (e) shall work with CMS to maintain any waiver for the health coverage improvement
138 program while the health coverage improvement program is suspended under Subsection
139 (11)(c).
140 (12) If, after the enhancement waiver program takes effect, the enhancement waiver
141 program is repealed or suspended by either the state or federal government, the department
142 shall reinstate the health coverage improvement program and continue to accept new enrollees
143 into the health coverage improvement program in accordance with the provisions of this
144 section.
145 Section 2. Section **26-18-427** is enacted to read:
146 **26-18-427. Behavioral health delivery working group.**
147 (1) The department shall convene a working group to advise the department on:
148 (a) improving the delivery of behavioral health services in the Medicaid program;
149 (b) proposals to implement the delivery of services under Section 26-18-428; and
150 (c) issues that are identified by accountable care organizations and behavioral health
151 service providers.

152 (2) The working group convened under Subsection (1) shall:
153 (a) meet quarterly; and
154 (b) consist of at least the following individuals:
155 (i) the executive director or the executive director's designee;
156 (ii) for each Medicaid accountable care organization, an individual selected by the
157 accountable care organization;
158 (iii) five individuals selected by the department to represent various types of behavioral
159 health services providers;
160 (iv) a representative of an association that represents behavioral health treatment
161 providers in the state, designated by the department;
162 (v) a representative of an association that represents local authorities who provide
163 public behavioral health care, designated by the department;
164 (vi) one member of the Senate, appointed by the president of the Senate; and
165 (vii) one member of the House of Representatives, appointed by the speaker of the
166 House of Representatives.
167 (3) The working group convened under this section shall:
168 (a) advise the department on whether the requirements described in Subsection
169 26-18-428(3)(a) are adequately met;
170 (b) coordinate the system of care for the targeted adult Medicaid program under
171 Section 26-18-411;
172 (c) address filing, authorization, reimbursement, and claims issues between providers,
173 accountable care organizations, and the department;
174 (d) share best practices for providing behavioral health services in the state;
175 (e) discuss wraparound service coverage for individuals in the Medicaid program who
176 need specific, nonclinical services to ensure a path to success; and
177 (f) develop recommendations for changes to statute or administrative rule that would
178 facilitate improved delivery of behavioral health services in the Medicaid program.
179 Section 3. Section **26-18-428** is enacted to read:
180 **26-18-428. Delivery system adjustments for the targeted adult Medicaid program.**
181 (1) As used in this section, "targeted adult Medicaid program" means the same as that
182 term is defined in Section 26-18-411.

183 (2) The department may implement the adjustments authorized in this section after:
184 (a) July 1, 2023; and
185 (b) the department determines that the requirements described in Subsection (3) can be
186 adequately met.
187 (3) The department may, for individuals who are enrolled in the targeted adult
188 Medicaid program:
189 (a) integrate the delivery of behavioral and physical health in certain counties; and
190 (b) deliver behavioral health services through an accountable care organization where
191 implemented.
192 (4) Before implementing the adjustments described in Subsection (3) in any county for
193 adults who qualify for the targeted adult Medicaid program, the department shall, at a
194 minimum, seek the input from:
195 (a) individuals who qualify for the targeted adult Medicaid program who reside in the
196 county;
197 (b) the county executive officer, members of the legislative body, and other county
198 officials;
199 (c) the local mental health authority and substance use authority;
200 (d) Medicaid accountable care organizations;
201 (e) providers of physical or behavioral health in the county who provide services to
202 enrollees in the targeted adult Medicaid program in the county; and
203 (f) other individuals that the department deems necessary.
204 (5) If the department provides Medicaid coverage through a managed care delivery
205 system, the department shall include language in the department's managed care contracts that
206 require the managed care plan to:
207 (a) be in compliance with federal Medicaid managed care requirements;
208 (b) timely and accurately process authorizations and claims in accordance with
209 Medicaid policy and contract requirements;
210 (c) adequately reimburse providers to maintain adequacy of access to care;
211 (d) provide care management services sufficient to meet the needs of Medicaid eligible
212 individuals enrolled in the managed care plan's plan; and
213 (e) timely resolve any disputes between a provider or enrollee with the managed care

214 organization's plan.

215 (6) The department may take corrective action if the accountable care organization fails

216 to comply with the terms of the accountable care organization's contract.