

Representative James A. Dunnigan proposes the following substitute bill:

MEDICAID AMENDMENTS

2022 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Michael S. Kennedy

LONG TITLE

General Description:

This bill modifies provisions related to the Medicaid program.

Highlighted Provisions:

This bill:

- ▶ amends provisions relating to the targeted adult Medicaid program;
- ▶ requires the department to convene a working group to discuss the delivery of behavioral health services in the Medicaid program; and
- ▶ authorizes certain adjustments in the delivery of behavioral health services for individuals who are in the targeted adult Medicaid program if the department determines that certain requirements are met.

Money Appropriated in this Bill:

This bill appropriates in fiscal year 2023:

- ▶ to Department of Health and Human Services -- Integrated Health Care Services -- Medicaid Behavioral Health Services, as an ongoing appropriation:
 - from the General Fund, \$436,000.

Other Special Clauses:

None

Utah Code Sections Affected:



AMENDS:

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

26-18-415, as last amended by Laws of Utah 2019, Chapters 1 and 393

ENACTS:

26-18-427, Utah Code Annotated 1953

26-18-428, Utah Code Annotated 1953

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

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

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

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

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

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

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

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

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

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

(e) "Homeless":

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

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

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

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

(ii) under which an individual may qualify for Medicaid coverage in accordance with

57 this section.

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

60 (2) Beginning July 1, 2016, the department shall amend the state Medicaid plan to
61 allow temporary residential treatment for substance abuse, for the traditional Medicaid
62 population, in a short term, non-institutional, 24-hour facility, without a bed capacity limit that
63 provides rehabilitation services that are medically necessary and in accordance with an
64 individualized treatment plan, as approved by CMS and as long as the county makes the
65 required match under Section 17-43-201.

66 (3) Beginning July 1, 2016, the department shall amend the state Medicaid plan to
67 increase the income eligibility ceiling to a percentage of the federal poverty level designated by
68 the department, based on appropriations for the program, for an individual with a dependent
69 child.

70 (4) Before July 1, 2016, the division shall submit to CMS a request for waivers, or an
71 amendment of existing waivers, from federal statutory and regulatory law necessary for the
72 state to implement the health coverage improvement program in the Medicaid program in
73 accordance with this section.

74 (5) (a) An adult in the expansion population is eligible for Medicaid if the adult meets
75 the income eligibility and other criteria established under Subsection (6).

76 (b) An adult who qualifies under Subsection (6) shall receive Medicaid coverage:

77 (i) through the traditional fee for service Medicaid model in counties without Medicaid
78 accountable care organizations or the state's Medicaid accountable care organization delivery
79 system, where implemented and at the department's discretion;

80 (ii) except as provided in Subsection (5)(b)(iii) and at the department's discretion, for
81 behavioral health, through the counties in accordance with Sections 17-43-201 and 17-43-301;

82 (iii) that integrates behavioral health services and physical health services with
83 Medicaid accountable care organizations in select geographic areas of the state that choose an
84 integrated model; and

85 (iv) that permits temporary residential treatment for substance abuse in a short term,
86 non-institutional, 24-hour facility, without a bed capacity limit, as approved by CMS, that
87 provides rehabilitation services that are medically necessary and in accordance with an

88 individualized treatment plan.

89 ~~[(c) Medicaid accountable care organizations and counties that elect to integrate care~~
90 ~~under Subsection (5)(b)(iii) shall collaborate on enrollment, engagement of patients, and~~
91 ~~coordination of services.]~~

92 (6) (a) An individual is eligible for the health coverage improvement program under
93 Subsection (5) if:

94 (i) at the time of enrollment, the individual's annual income is below the income
95 eligibility ceiling established by the state under Subsection (1)(f); and

96 (ii) the individual meets the eligibility criteria established by the department under
97 Subsection (6)(b).

98 (b) Based on available funding and approval from CMS, the department shall select the
99 criteria for an individual to qualify for the Medicaid program under Subsection (6)(a)(ii), based
100 on the following priority:

101 (i) a chronically homeless individual;

102 (ii) if funding is available, an individual:

103 (A) involved in the justice system through probation, parole, or court ordered
104 treatment; and

105 (B) in need of substance abuse treatment or mental health treatment, as determined by
106 the department; or

107 (iii) if funding is available, an individual in need of substance abuse treatment or
108 mental health treatment, as determined by the department.

109 (c) An individual who qualifies for Medicaid coverage under Subsections (6)(a) and (b)
110 may remain on the Medicaid program for a 12-month certification period as defined by the
111 department. Eligibility changes made by the department under Subsection (1)(f) or (6)(b) shall
112 not apply to an individual during the 12-month certification period.

113 (7) The state may request a modification of the income eligibility ceiling and other
114 eligibility criteria under Subsection (6) each fiscal year based on projected enrollment, costs to
115 the state, and the state budget.

116 (8) Before September 30 of each year, the department shall report to the Health and
117 Human Services Interim Committee and to the Executive Appropriations Committee:

118 (a) the number of individuals who enrolled in Medicaid under Subsection (6);

(b) the state cost of providing Medicaid to individuals enrolled under Subsection (6);
and

(c) recommendations for adjusting the income eligibility ceiling under Subsection (7),
and other eligibility criteria under Subsection (6), for the upcoming fiscal year.

(9) The current Medicaid program and the health coverage improvement program,
when implemented, shall coordinate with a state prison or county jail to expedite Medicaid
enrollment for an individual who is released from custody and was eligible for or enrolled in
Medicaid before incarceration.

(10) Notwithstanding Sections 17-43-201 and 17-43-301, a county does not have to
provide matching funds to the state for the cost of providing Medicaid services to newly
enrolled individuals who qualify for Medicaid coverage under the health coverage
improvement program under Subsection (6).

(11) If the enhancement waiver program is implemented, the department:

(a) may not accept any new enrollees into the health coverage improvement program
after the day on which the enhancement waiver program is implemented;

(b) shall transition all individuals who are enrolled in the health coverage improvement
program into the enhancement waiver program;

(c) shall suspend the health coverage improvement program within one year after the
day on which the enhancement waiver program is implemented;

(d) shall, within one year after the day on which the enhancement waiver program is
implemented, use all appropriations for the health coverage improvement program to
implement the enhancement waiver program; and

(e) shall work with CMS to maintain any waiver for the health coverage improvement
program while the health coverage improvement program is suspended under Subsection
(11)(c).

(12) If, after the enhancement waiver program takes effect, the enhancement waiver
program is repealed or suspended by either the state or federal government, the department
shall reinstate the health coverage improvement program and continue to accept new enrollees
into the health coverage improvement program in accordance with the provisions of this
section.

Section 2. Section 26-18-415 is amended to read:

26-18-415. Medicaid waiver expansion.

(1) As used in this section:

(a) "Federal poverty level" means the same as that term is defined in Section 26-18-411.

(b) "Medicaid waiver expansion" means an expansion of the Medicaid program in accordance with this section.

(2) (a) Before January 1, 2019, the department shall apply to CMS for approval of a waiver or state plan amendment to implement the Medicaid waiver expansion.

(b) The Medicaid waiver expansion shall:

(i) expand Medicaid coverage to eligible individuals whose income is below 95% of the federal poverty level;

(ii) obtain maximum federal financial participation under 42 U.S.C. Sec. 1396d(y) for enrolling an individual in the Medicaid program;

(iii) provide Medicaid benefits through the state's Medicaid accountable care organizations in areas where a Medicaid accountable care organization is implemented;

(iv) integrate the delivery of behavioral health services and physical health services with Medicaid accountable care organizations in select geographic areas of the state that choose an integrated model;

(v) include a path to self-sufficiency, including work activities as defined in 42 U.S.C. Sec. 607(d), for qualified adults;

(vi) require an individual who is offered a private health benefit plan by an employer to enroll in the employer's health plan;

(vii) sunset in accordance with Subsection (5)(a); and

(viii) permit the state to close enrollment in the Medicaid waiver expansion if the department has insufficient funding to provide services to additional eligible individuals.

(3) If the Medicaid waiver described in Subsection (2)(a) is approved, the department may only pay the state portion of costs for the Medicaid waiver expansion with appropriations from:

(a) the Medicaid Expansion Fund, created in Section 26-36b-208;

(b) county contributions to the non-federal share of Medicaid expenditures; and

(c) any other contributions, funds, or transfers from a non-state agency for Medicaid

expenditures.

~~[(4)(a) In consultation with the department, Medicaid accountable care organizations and counties that elect to integrate care under Subsection (2)(b)(iv) shall collaborate on enrollment, engagement of patients, and coordination of services.]~~

~~[(b)]~~ (4) As part of the provision described in Subsection (2)(b)(iv), the department shall apply for a waiver to permit the creation of an integrated delivery system:

~~[(i) for any geographic area that expresses interest in integrating the delivery of services under Subsection (2)(b)(iv); and]~~

(a) only if the requirements established in Section [26-18-428](#) are satisfied; and

~~[(ii)]~~ (b) in which the department:

~~[(A)]~~ (i) may permit a local mental health authority to integrate the delivery of behavioral health services and physical health services;

~~[(B)]~~ (ii) may permit a county, local mental health authority, or Medicaid accountable care organization to integrate the delivery of behavioral health services and physical health services to select groups within the population that are newly eligible under the Medicaid waiver expansion; and

~~[(C)]~~ (iii) may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to integrate payments for behavioral health services and physical health services to plans or providers.

(5) (a) If federal financial participation for the Medicaid waiver expansion is reduced below 90%, the authority of the department to implement the Medicaid waiver expansion shall sunset no later than the next July 1 after the date on which the federal financial participation is reduced.

(b) The department shall close the program to new enrollment if the cost of the Medicaid waiver expansion is projected to exceed the appropriations for the fiscal year that are authorized by the Legislature through an appropriations act adopted in accordance with Title 63J, Chapter 1, Budgetary Procedures Act.

(6) If the Medicaid waiver expansion is approved by CMS, the department shall report to the Social Services Appropriations Subcommittee on or before November 1 of each year that the Medicaid waiver expansion is operational:

(a) the number of individuals who enrolled in the Medicaid waiver program;

- (b) costs to the state for the Medicaid waiver program;
- (c) estimated costs for the current and following state fiscal year; and
- (d) recommendations to control costs of the Medicaid waiver expansion.

Section 3. Section **26-18-427** is enacted to read:

26-18-427. Behavioral health delivery working group.

(1) On or before May 31, 2022, the department shall convene a working group to advise the department on:

(a) establishing specific and measurable metrics based on the outcomes described in Subsections [26-18-428\(5\)\(a\)](#) through (e) that must be met before the department may implement the delivery system adjustments under Section [26-18-426](#);

(b) improving the delivery of behavioral health services in the Medicaid program;
(c) proposals to implement the delivery of services under Section [26-18-428](#); and
(d) issues that are identified by accountable care organizations and behavioral health service providers.

(2) The working group convened under Subsection (1) shall:

(a) meet quarterly; and

(b) consist of at least the following individuals:

- (i) the executive director or the executive director's designee;
- (ii) for each Medicaid accountable care organization, an individual selected by the accountable care organization;
- (iii) five individuals selected by the department to represent various types of behavioral health services providers, including, at a minimum, individuals who represent providers who provide the following types of services:

(A) acute inpatient behavioral health treatment;

(B) residential treatment;

(C) intensive outpatient or partial hospitalization treatment; and

(D) general outpatient treatment;

(iv) a representative of an association that represents behavioral health treatment providers in the state, designated by the Utah Behavioral Healthcare Council convened by the Utah Association of Counties;

(v) a representative of an organization representing behavioral health organizations;

(vi) the chair of the Utah Substance Use and Mental Health Advisory Council created in Section [63M-7-301](#);

(vii) a representative of an association that represents local authorities who provide public behavioral health care, designated by the department;

(viii) one member of the Senate, appointed by the president of the Senate; and

(ix) one member of the House of Representatives, appointed by the speaker of the House of Representatives.

(3) The working group convened under this section shall:

(a) establish specific and measurable metrics based on the outcomes described in Subsections [26-18-428](#)(5)(a) through (e) that must be met before the department may implement the delivery system adjustments under Section [26-18-426](#);

(b) coordinate the system of care for the targeted adult Medicaid program under Section [26-18-411](#);

(c) address filing, authorization and reauthorization for treatment services, reimbursement, and claims issues between providers, accountable care organizations, and the department;

(d) advise the department on ways to improve delivery of behavioral health services to enrollees in the Medicaid program;

(e) discuss wraparound service coverage for individuals in the Medicaid program who need specific, nonclinical services to ensure a path to success; and

(f) develop recommendations for changes to statute or administrative rule that would facilitate improved delivery of behavioral health services in the Medicaid program.

Section 4. Section **26-18-428** is enacted to read:

26-18-428. Delivery system adjustments for the targeted adult Medicaid program.

(1) As used in this section, "targeted adult Medicaid program" means the same as that term is defined in Section [26-18-411](#).

(2) The department may implement the adjustments authorized in this section after:

(a) July 1, 2023; and

(b) the department determines that the metrics established by the behavioral health delivery working group convened under Section [26-18-427](#) are met.

(3) The department may, for individuals who are enrolled in the targeted adult

274 Medicaid program:

275 (a) integrate the delivery of behavioral and physical health in certain counties; and

276 (b) deliver behavioral health services through an accountable care organization where
277 implemented.

278 (4) Before implementing the adjustments described in Subsection (3) in any county for
279 adults who qualify for the targeted adult Medicaid program, the department shall, at a
280 minimum, seek the input from:

281 (a) individuals who qualify for the targeted adult Medicaid program who reside in the
282 county;

283 (b) the county executive officer, members of the legislative body, and other county
284 officials;

285 (c) the local mental health authority and substance use authority;

286 (d) Medicaid accountable care organizations;

287 (e) providers of physical or behavioral health in the county who provide services to
288 enrollees in the targeted adult Medicaid program in the county; and

289 (f) other individuals that the department deems necessary.

290 (5) If the department provides Medicaid coverage through a managed care delivery
291 system, the department shall include language in the department's managed care contracts that
292 require the managed care plan to:

293 (a) be in compliance with federal Medicaid managed care requirements;

294 (b) timely and accurately process authorizations and claims in accordance with
295 Medicaid policy and contract requirements;

296 (c) adequately reimburse providers to maintain adequacy of access to care;

297 (d) provide care management services sufficient to meet the needs of Medicaid eligible
298 individuals enrolled in the managed care plan's plan; and

299 (e) timely resolve any disputes between a provider or enrollee with the managed care
300 organization's plan.

301 (6) The department may take corrective action if the accountable care organization fails
302 to comply with the terms of the accountable care organization's contract.

303 **Section 5. Appropriation.**

304 The following sums of money are appropriated for the fiscal year beginning July 1,

305 2022, and ending June 30, 2023. These are additions to amounts previously appropriated for
306 fiscal year 2023. Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures
307 Act, the Legislature appropriates the following sums of money from the funds or accounts
308 indicated for the use and support of the government of the state of Utah.

309 ITEM 1

310 To the Department of Health and Human Services - Integrated Health Care Services

311 From General Fund \$436,000

312 Schedule of Programs:

313 Medicaid Behavioral Health Services \$436,000

314 The Legislature intends that appropriations provided under this section be used by the
315 Division of Integrated Healthcare within the Department of Health and Human Services to pass
316 through to local substance abuse and mental health authorities for any match requirement
317 associated with H.B. 413, Medicaid Amendments.