

**Representative James A. Dunnigan** proposes the following substitute bill:

1 **MEDICAID AMENDMENTS**

2 2022 GENERAL SESSION

3 STATE OF UTAH

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

5 Senate Sponsor: Michael S. Kennedy

6 **LONG TITLE**

7 **General Description:**

8 This bill modifies provisions related to the Medicaid program.

9 **Highlighted Provisions:**

10 This bill:

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

17 **Money Appropriated in this Bill:**

18 This bill appropriates in fiscal year 2023:

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

22 **Other Special Clauses:**

23 None

24 **Utah Code Sections Affected:**



26 AMENDS:

27       **26-18-411**, as last amended by Laws of Utah 2020, Chapter 225

28       **26-18-415**, as last amended by Laws of Utah 2019, Chapters 1 and 393

29 ENACTS:

30       **26-18-427**, Utah Code Annotated 1953

31       **26-18-428**, Utah Code Annotated 1953

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

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

35       **26-18-411. Health coverage improvement program -- Eligibility -- Annual report**

36       **-- Expansion of eligibility for adults with dependent children.**

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

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

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

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

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

44       (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).

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

48       (e) "Homeless":

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

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

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

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

56           (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);

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

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

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

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

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

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

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

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

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

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

150        **26-18-415. Medicaid waiver expansion.**

151        (1) As used in this section:

152        (a) "Federal poverty level" means the same as that term is defined in Section

153        **26-18-411.**154        (b) "Medicaid waiver expansion" means an expansion of the Medicaid program in  
155 accordance with this section.156        (2) (a) Before January 1, 2019, the department shall apply to CMS for approval of a  
157 waiver or state plan amendment to implement the Medicaid waiver expansion.

158        (b) The Medicaid waiver expansion shall:

159        (i) expand Medicaid coverage to eligible individuals whose income is below 95% of  
160 the federal poverty level;161        (ii) obtain maximum federal financial participation under 42 U.S.C. Sec. 1396d(y) for  
162 enrolling an individual in the Medicaid program;163        (iii) provide Medicaid benefits through the state's Medicaid accountable care  
164 organizations in areas where a Medicaid accountable care organization is implemented;165        (iv) integrate the delivery of behavioral health services and physical health services  
166 with Medicaid accountable care organizations in select geographic areas of the state that  
167 choose an integrated model;168        (v) include a path to self-sufficiency, including work activities as defined in 42 U.S.C.  
169 Sec. 607(d), for qualified adults;170        (vi) require an individual who is offered a private health benefit plan by an employer to  
171 enroll in the employer's health plan;

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

173        (viii) permit the state to close enrollment in the Medicaid waiver expansion if the  
174 department has insufficient funding to provide services to additional eligible individuals.175        (3) If the Medicaid waiver described in Subsection (2)(a) is approved, the department  
176 may only pay the state portion of costs for the Medicaid waiver expansion with appropriations  
177 from:178        (a) the Medicaid Expansion Fund, created in Section **26-36b-208**;

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

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

181 expenditures.

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

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

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

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

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

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

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

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

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

204 (b) The department shall close the program to new enrollment if the cost of the  
205 Medicaid waiver expansion is projected to exceed the appropriations for the fiscal year that are  
206 authorized by the Legislature through an appropriations act adopted in accordance with Title  
207 63J, Chapter 1, Budgetary Procedures Act.

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

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

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

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

216 **26-18-427. Behavioral health delivery working group.**

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

219 (a) establishing specific and measurable metrics based on the outcomes described in  
220 Subsections 26-18-428(5)(a) through (e) that must be met before the department may  
221 implement the delivery system adjustments under Section 26-18-426;  
222 (b) improving the delivery of behavioral health services in the Medicaid program;  
223 (c) proposals to implement the delivery of services under Section 26-18-428; and  
224 (d) issues that are identified by accountable care organizations and behavioral health  
225 service providers.

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

227 (a) meet quarterly; and  
228 (b) consist of at least the following individuals:  
229 (i) the executive director or the executive director's designee;  
230 (ii) for each Medicaid accountable care organization, an individual selected by the  
231 accountable care organization;  
232 (iii) five individuals selected by the department to represent various types of behavioral  
233 health services providers, including, at a minimum, individuals who represent providers who  
234 provide the following types of services:

235 (A) acute inpatient behavioral health treatment;  
236 (B) residential treatment;  
237 (C) intensive outpatient or partial hospitalization treatment; and  
238 (D) general outpatient treatment;  
239 (iv) a representative of an association that represents behavioral health treatment  
240 providers in the state, designated by the Utah Behavioral Healthcare Council convened by the  
241 Utah Association of Counties;  
242 (v) a representative of an organization representing behavioral health organizations;

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

245        (vii) a representative of an association that represents local authorities who provide  
246        public behavioral health care, designated by the department;  
247        (viii) one member of the Senate, appointed by the president of the Senate; and  
248        (ix) one member of the House of Representatives, appointed by the speaker of the  
249        House of Representatives.

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

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

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

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

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

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

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

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

266        **26-18-428. Delivery system adjustments for the targeted adult Medicaid program.**

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

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

270        (a) July 1, 2023; and

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

273        (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.