H.B. 413
2nd Sub. (Gray)

Senator Michael S. Kennedy 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

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 This bill appropriates in fiscal year 2023:

20 ▸ to Department of Health and Human Services -- Integrated Health Care Services --

21 Medicaid Behavioral Health Services, as an ongoing appropriation:

22 • from the General Fund, $436,000.

23 **Other Special Clauses:**

24 None

25 **Utah Code Sections Affected:**

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26 AMENDS:
27 **26-18-411**, as last amended by Laws of Utah 2020, Chapter 225
28 ENACTS:
29 **26-18-427**, Utah Code Annotated 1953
30 **26-18-428**, Utah Code Annotated 1953
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32 *Be it enacted by the Legislature of the state of Utah:*
33 Section 1. Section **26-18-411** is amended to read:
34 **26-18-411. Health coverage improvement program -- Eligibility -- Annual report**
35 **-- Expansion of eligibility for adults with dependent children.**
36 (1) [~~For purposes of~~] As used in this section:
37 (a) "Adult in the expansion population" means an individual who:
38 (i) is described in 42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII); and
39 (ii) is not otherwise eligible for Medicaid as a mandatory categorically needy
40 individual.
41 (b) "Enhancement waiver program" means the Primary Care Network enhancement
42 waiver program described in Section 26-18-416.
43 (c) "Federal poverty level" means the poverty guidelines established by the Secretary of
44 the United States Department of Health and Human Services under 42 U.S.C. Sec. 9909(2).
45 (d) "Health coverage improvement program" means the health coverage improvement
46 program described in Subsections (3) through (10).
47 (e) "Homeless":
48 (i) means an individual who is chronically homeless, as determined by the department;
49 and
50 (ii) includes someone who was chronically homeless and is currently living in
51 supported housing for the chronically homeless.
52 (f) "Income eligibility ceiling" means the percent of federal poverty level:
53 (i) established by the state in an appropriations act adopted pursuant to Title 63J,
54 Chapter 1, Budgetary Procedures Act; and
55 (ii) under which an individual may qualify for Medicaid coverage in accordance with
56 this section.

57 (g) "Targeted adult Medicaid program" means the program implemented by the
58 department under Subsections (5) through (7).
59 (2) Beginning July 1, 2016, the department shall amend the state Medicaid plan to
60 allow temporary residential treatment for substance abuse, for the traditional Medicaid
61 population, in a short term, non-institutional, 24-hour facility, without a bed capacity limit that
62 provides rehabilitation services that are medically necessary and in accordance with an
63 individualized treatment plan, as approved by CMS and as long as the county makes the
64 required match under Section 17-43-201.
65 (3) Beginning July 1, 2016, the department shall amend the state Medicaid plan to
66 increase the income eligibility ceiling to a percentage of the federal poverty level designated by
67 the department, based on appropriations for the program, for an individual with a dependent
68 child.
69 (4) Before July 1, 2016, the division shall submit to CMS a request for waivers, or an
70 amendment of existing waivers, from federal statutory and regulatory law necessary for the
71 state to implement the health coverage improvement program in the Medicaid program in
72 accordance with this section.
73 (5) (a) An adult in the expansion population is eligible for Medicaid if the adult meets
74 the income eligibility and other criteria established under Subsection (6).
75 (b) An adult who qualifies under Subsection (6) shall receive Medicaid coverage:
76 (i) through the traditional fee for service Medicaid model in counties without Medicaid
77 accountable care organizations or the state's Medicaid accountable care organization delivery
78 system, where implemented and subject to Section 26-18-428;
79 (ii) except as provided in Subsection (5)(b)(iii), for behavioral health, through the
80 counties in accordance with Sections 17-43-201 and 17-43-301;
81 (iii) that, subject to Section 26-18-428, integrates behavioral health services and
82 physical health services with Medicaid accountable care organizations in select geographic
83 areas of the state that choose an integrated model; and
84 (iv) that permits temporary residential treatment for substance abuse in a short term,
85 non-institutional, 24-hour facility, without a bed capacity limit, as approved by CMS, that
86 provides rehabilitation services that are medically necessary and in accordance with an
87 individualized treatment plan.

88 [~~(c) Medicaid accountable care organizations and counties that elect to integrate care~~
89 ~~under Subsection (5)(b)(iii) shall collaborate on enrollment, engagement of patients, and~~
90 ~~coordination of services.~~]
91 (6) (a) An individual is eligible for the health coverage improvement program under
92 Subsection (5) if:
93 (i) at the time of enrollment, the individual's annual income is below the income
94 eligibility ceiling established by the state under Subsection (1)(f); and
95 (ii) the individual meets the eligibility criteria established by the department under
96 Subsection (6)(b).
97 (b) Based on available funding and approval from CMS, the department shall select the
98 criteria for an individual to qualify for the Medicaid program under Subsection (6)(a)(ii), based
99 on the following priority:
100 (i) a chronically homeless individual;
101 (ii) if funding is available, an individual:
102 (A) involved in the justice system through probation, parole, or court ordered
103 treatment; and
104 (B) in need of substance abuse treatment or mental health treatment, as determined by
105 the department; or
106 (iii) if funding is available, an individual in need of substance abuse treatment or
107 mental health treatment, as determined by the department.
108 (c) An individual who qualifies for Medicaid coverage under Subsections (6)(a) and (b)
109 may remain on the Medicaid program for a 12-month certification period as defined by the
110 department. Eligibility changes made by the department under Subsection (1)(f) or (6)(b) shall
111 not apply to an individual during the 12-month certification period.
112 (7) The state may request a modification of the income eligibility ceiling and other
113 eligibility criteria under Subsection (6) each fiscal year based on projected enrollment, costs to
114 the state, and the state budget.
115 (8) Before September 30 of each year, the department shall report to the Health and
116 Human Services Interim Committee and to the Executive Appropriations Committee:
117 (a) the number of individuals who enrolled in Medicaid under Subsection (6);
118 (b) the state cost of providing Medicaid to individuals enrolled under Subsection (6);

119 and
120 (c) recommendations for adjusting the income eligibility ceiling under Subsection (7),
121 and other eligibility criteria under Subsection (6), for the upcoming fiscal year.
122 (9) The current Medicaid program and the health coverage improvement program,
123 when implemented, shall coordinate with a state prison or county jail to expedite Medicaid
124 enrollment for an individual who is released from custody and was eligible for or enrolled in
125 Medicaid before incarceration.
126 (10) Notwithstanding Sections 17-43-201 and 17-43-301, a county does not have to
127 provide matching funds to the state for the cost of providing Medicaid services to newly
128 enrolled individuals who qualify for Medicaid coverage under the health coverage
129 improvement program under Subsection (6).
130 (11) If the enhancement waiver program is implemented, the department:
131 (a) may not accept any new enrollees into the health coverage improvement program
132 after the day on which the enhancement waiver program is implemented;
133 (b) shall transition all individuals who are enrolled in the health coverage improvement
134 program into the enhancement waiver program;
135 (c) shall suspend the health coverage improvement program within one year after the
136 day on which the enhancement waiver program is implemented;
137 (d) shall, within one year after the day on which the enhancement waiver program is
138 implemented, use all appropriations for the health coverage improvement program to
139 implement the enhancement waiver program; and
140 (e) shall work with CMS to maintain any waiver for the health coverage improvement
141 program while the health coverage improvement program is suspended under Subsection
142 (11)(c).
143 (12) If, after the enhancement waiver program takes effect, the enhancement waiver
144 program is repealed or suspended by either the state or federal government, the department
145 shall reinstate the health coverage improvement program and continue to accept new enrollees
146 into the health coverage improvement program in accordance with the provisions of this
147 section.
148 Section 2. Section **26-18-427** is enacted to read:
149 **26-18-427. Behavioral health delivery working group.**

150 (1) As used in this section, "targeted adult Medicaid program" means the same as that
151 term is defined in Section 26-18-411.
152 (2) On or before May 31, 2022, the department shall convene a working group to
153 collaborate with the department on:
154 (a) establishing specific and measurable metrics regarding:
155 (i) compliance of managed care organizations in the state with federal Medicaid
156 managed care requirements;
157 (ii) timeliness and accuracy of authorization and claims processing in accordance with
158 Medicaid policy and contract requirements;
159 (iii) reimbursement by managed care organizations in the state to providers to maintain
160 adequacy of access to care;
161 (iv) availability of care management services to meet the needs of Medicaid-eligible
162 individuals enrolled in the plans of managed care organizations in the state; and
163 (v) timeliness of resolution for disputes between a managed care organization and the
164 managed care organization's providers and enrollees;
165 (b) improving the delivery of behavioral health services in the Medicaid program;
166 (c) proposals to implement the delivery system adjustments authorized under
167 Subsection 26-18-428(3); and
168 (d) issues that are identified by managed care organizations, behavioral health service
169 providers, and the department.
170 (3) The working group convened under Subsection (2) shall:
171 (a) meet quarterly; and
172 (b) consist of at least the following individuals:
173 (i) the executive director or the executive director's designee;
174 (ii) for each Medicaid accountable care organization with which the department
175 contracts, an individual selected by the accountable care organization;
176 (iii) five individuals selected by the department to represent various types of behavioral
177 health services providers, including, at a minimum, individuals who represent providers who
178 provide the following types of services:
179 (A) acute inpatient behavioral health treatment;
180 (B) residential treatment;

181 (C) intensive outpatient or partial hospitalization treatment; and
182 (D) general outpatient treatment;
183 (iv) a representative of an association that represents behavioral health treatment
184 providers in the state, designated by the Utah Behavioral Healthcare Council convened by the
185 Utah Association of Counties;
186 (v) a representative of an organization representing behavioral health organizations;
187 (vi) the chair of the Utah Substance Use and Mental Health Advisory Council created
188 in Section 63M-7-301;
189 (vii) a representative of an association that represents local authorities who provide
190 public behavioral health care, designated by the department;
191 (viii) one member of the Senate, appointed by the president of the Senate; and
192 (ix) one member of the House of Representatives, appointed by the speaker of the
193 House of Representatives.
194 (4) The working group convened under this section shall recommend to the
195 department:
196 (a) specific and measurable metrics under Subsection (2)(a);
197 (b) how physical and behavioral health services may be integrated for the targeted adult
198 Medicaid program, including ways the department may address issues regarding:
199 (i) filing of claims;
200 (ii) authorization and reauthorization for treatment services;
201 (iii) reimbursement rates; and
202 (iv) other issues identified by the department, behavioral health services providers, or
203 Medicaid managed care organizations;
204 (c) ways to improve delivery of behavioral health services to enrollees, including
205 changes to statute or administrative rule; and
206 (d) wraparound service coverage for enrollees who need specific, nonclinical services
207 to ensure a path to success.
208 Section 3. Section **26-18-428** is enacted to read:
209 **26-18-428. Delivery system adjustments for the targeted adult Medicaid program.**
210 (1) As used in this section, "targeted adult Medicaid program" means the same as that
211 term is defined in Section 26-18-411.

212 (2) The department may implement the delivery system adjustments authorized under
213 Subsection (3) only on the later of:
214 (a) July 1, 2023; and
215 (b) the department determining that the Medicaid program, including providers and
216 managed care organizations, are satisfying the metrics established in collaboration with the
217 working group convened under Subsection 26-18-427(2).
218 (3) The department may, for individuals who are enrolled in the targeted adult
219 Medicaid program:
220 (a) integrate the delivery of behavioral and physical health in certain counties; and
221 (b) deliver behavioral health services through an accountable care organization where
222 implemented.
223 (4) Before implementing the delivery system adjustments described in Subsection (3)
224 in a county, the department shall, at a minimum, seek the input from:
225 (a) individuals who qualify for the targeted adult Medicaid program who reside in the
226 county;
227 (b) the county's executive officer, legislative body, and other county officials who are
228 involved in the delivery of behavioral health services;
229 (c) the local mental health authority and substance use authority that serves the county;
230 (d) Medicaid managed care organizations operating in the state, including Medicaid
231 accountable care organizations;
232 (e) providers of physical or behavioral health services in the county who provide
233 services to enrollees in the targeted adult Medicaid program in the county; and
234 (f) other individuals that the department deems necessary.
235 (5) If the department provides Medicaid coverage through a managed care delivery
236 system under this section, the department shall include language in the department's managed
237 care contracts that require the managed care plan to:
238 (a) be in compliance with federal Medicaid managed care requirements;
239 (b) timely and accurately process authorizations and claims in accordance with
240 Medicaid policy and contract requirements;
241 (c) adequately reimburse providers to maintain adequacy of access to care;
242 (d) provide care management services sufficient to meet the needs of Medicaid eligible

243 individuals enrolled in the managed care plan's plan; and
244 (e) timely resolve any disputes between a provider or enrollee with the managed care
245 plan.
246 (6) The department may take corrective action if the managed care organization fails to
247 comply with the terms of the managed care organization's contract.
248 Section 4. **Appropriation.**
249 The following sums of money are appropriated for the fiscal year beginning July 1,
250 2022, and ending June 30, 2023. These are additions to amounts previously appropriated for
251 fiscal year 2023. Under the terms and conditions of Title 63J, Chapter 1, Budgetary Procedures
252 Act, the Legislature appropriates the following sums of money from the funds or accounts
253 indicated for the use and support of the government of the state of Utah.
254 ITEM 1
255 To the Department of Health and Human Services - Integrated Health Care Services
256 From General Fund $436,000
257 Schedule of Programs:
258 Medicaid Behavioral Health Services $436,000
259 The Legislature intends that appropriations provided under this section be used by the
260 Division of Integrated Healthcare within the Department of Health and Human Services to pass
261 through to local substance abuse and mental health authorities to pay for the local substance
262 abuse and mental health authorities' increased match requirement associated with the request
263 for appropriation in the 2022 General Session entitled Alignment of Behavioral Health Service
264 Codes for Medicaid Reimbursement.