HB0413S02 compared with HB0413S01

~~{deleted text}~~ shows text that was in HB0413S01 but was deleted in HB0413S02.

inserted text shows text that was not in HB0413S01 but was inserted into HB0413S02.

DISCLAIMER: This document is provided to assist you in your comparison of the two bills. Sometimes this automated comparison will NOT be completely accurate. Therefore, you need to read the actual bills. This automatically generated document could contain inaccuracies caused by: limitations of the compare program; bad input data; or other causes.

~~{Representative James A}~~Senator Michael S. ~~{Dunnigan}~~Kennedy 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 this section.

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

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

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

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

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

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

(i) through the traditional fee for service Medicaid model in counties without Medicaid accountable care organizations or the state's Medicaid accountable care organization delivery system, where implemented and ~~{at the department's discretion}~~subject to Section 26-18-428;

(ii) except as provided in Subsection (5)(b)(iii)~~{ and at the department's discretion}~~, for

behavioral health, through the counties in accordance with Sections 17-43-201 and 17-43-301;

(iii) that, subject to Section 26-18-428, integrates behavioral health services and physical health services with Medicaid accountable care organizations in select geographic areas of the state that choose an integrated model; and

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

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

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

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

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

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

(i) a chronically homeless individual;

(ii) if funding is available, an individual:

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

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

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

(c) An individual who qualifies for Medicaid coverage under Subsections (6)(a) and (b) may remain on the Medicaid program for a 12-month certification period as defined by the department. Eligibility changes made by the department under Subsection (1)(f) or (6)(b) shall

not apply to an individual during the 12-month certification period.

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

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

(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**}~~**26-18-427** 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:~~

~~}~~enacted to read:

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

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

(2) On or before May 31, 2022, the department shall convene a working group to ~~{advise}~~collaborate with 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}~~regarding:

(i) compliance of managed care organizations in the state with federal Medicaid managed care requirements;

(ii) timeliness and accuracy of authorization and claims processing in accordance with Medicaid policy and contract requirements;

(iii) reimbursement by managed care organizations in the state to providers to maintain adequacy of access to care;

(iv) availability of care management services to meet the needs of Medicaid-eligible individuals enrolled in the plans of managed care organizations in the state; and

(v) timeliness of resolution for disputes between a managed care organization and the managed care organization's providers and enrollees;

(b) improving the delivery of behavioral health services in the Medicaid program;

(c) proposals to implement the delivery ~~{of services}~~system adjustments authorized under ~~{Section}~~Subsection 26-18-428(3); and

(d) issues that are identified by ~~{accountable}~~managed care organizations~~{ and}~~, behavioral health service providers, and the department.

(~~{2}~~3) The working group convened under Subsection (~~{1}~~2) 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 with which the department contracts, 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}~~4) The working group convened under this section shall recommend to the department:

(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{~~under Subsection (2)(a);

(b) how physical and behavioral health services may be integrated for the targeted adult Medicaid program~~{ under Section 26-18-411;~~

~~(c) address filing,}~~, including ways the department may address issues regarding:

(i) filing of claims;

(ii) authorization and reauthorization for treatment services~~{,}~~;

(iii) reimbursement~~{, and claims issues between providers, accountable}~~ rates; and

(iv) other issues identified by the department, behavioral health services providers, or Medicaid managed care organizations~~{, and the department}~~;

(~~{~~d~~}~~c) ~~{ advise the department on}~~ ways to improve delivery of behavioral health services to enrollees~~{ in the Medicaid program}~~, including changes to statute or administrative rule; and

(~~{~~e~~}~~d) ~~{ discuss}~~ wraparound service coverage for ~~{individuals in the Medicaid program}~~enrollees 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}~~3. 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 delivery system adjustments authorized ~~{in this section after}~~under Subsection (3) only on the later of:

(a) July 1, 2023; and

(b) the department ~~{determines that}~~determining that the Medicaid program, including providers and managed care organizations, are satisfying the metrics established ~~{by}~~in collaboration with the~~{ behavioral health delivery}~~ working group convened under ~~{Section}~~Subsection 26-18-427~~{ are met}~~(2).

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

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

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

(4) Before implementing the delivery system adjustments described in Subsection (3) in ~~{any}~~a county~~{ for adults who qualify for the targeted adult Medicaid program}~~, the department shall, at a minimum, seek the input from:

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

(b) the ~~{county}~~county's executive officer,~~{ members of the}~~ legislative body, and other county officials who are involved in the delivery of behavioral health services;

(c) the local mental health authority and substance use authority that serves the county;

(d) Medicaid managed care organizations operating in the state, including Medicaid accountable care organizations;

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

(f) other individuals that the department deems necessary.

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

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

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

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

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

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

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

Section ~~{5}~~4. **Appropriation.**

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

ITEM 1

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

From General Fund $436,000

Schedule of Programs:

Medicaid Behavioral Health Services $436,000

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

~~}~~the request for appropriation in the 2022 General Session entitled Alignment of Behavioral Health Service Codes for Medicaid Reimbursement.