ATTACHMENT 3

Public Comments and State Responses

UTAH DEPARTMENT OF HEALTH MEDICAID

Summary of Public Comments and State Responses

1115 Waiver Amendment
Medicaid Expansion

The State received comments from 99 individuals, advocacy groups and other community partners. The State appreciates all comments and feedback submitted regarding this waiver application. A summary of the comments submitted related to the waiver amendment and the State's responses to those comments are detailed below. Some comments were outside the scope of the waiver application and are not addressed in the State's responses.

General Comments

1. Many commenters stated they believe this proposal is contrary to the purpose of the Medicaid program and it would be illegal for the Secretary of Health and Human Services to approve the State's request. They also stated the State should expedite the implementation of full expansion by requesting it through a State Plan Amendment without any restrictions. They do not believe the State should wait for approval of the 1115 waiver amendment.

Response: In November 2018, Utah voters approved Proposition 3. The proposition expanded Medicaid to 133 percent of the federal poverty level (FPL) for adults ages 19-64, mandated an annual inflationary increase for all Medicaid providers across the entire Medicaid program (both in and out of expansion), and raised the State's sales tax. In February 2019, the Utah Legislature passed and Governor Herbert signed Senate Bill 96 citing concerns that Proposition 3's sales tax was insufficient to cover both the expansion and the mandatory provider rate increases and that growth in the Medicaid program might not be sustainable for the State in the long term. Senate Bill 96 directed the Utah Department of Health (UDOH) to seek a series of waivers that, if approved, would expand Medicaid up to 133 percent FPL, obtain enhanced match (90 percent federal/10 percent state), and implement other provisions designed to create an expansion program that closed the coverage gap while putting in place program integrity requirements and fiscal circuit breakers. Senate Bill 96 outlines a Medicaid expansion proposal that the Utah Legislature and Governor Herbert believe is feasible for Utah.

Section 1901 of Title XIX of the Social Security Act defines the purpose of the Medicaid program as follows:

> *For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of*

necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title.

Many commenters stated that the purpose of the Medicaid program was to furnish medical assistance; however, they did not acknowledge the phrase that immediately preceded it. The Act states that the purpose of the Medicaid program is to furnish medical assistance as far as practicable in each State. In Utah, the State Constitution requires that income taxes be spent on education and that the State must have a balanced budget. As a result, the sales tax is the primary source of funding for the State's General Fund. Medicaid, transportation and other infrastructure, public health and other social services, law enforcement and public safety, along with general government operations, all vie for funding from the State's General Fund. Over the last 19 years (1998 to 2017), Medicaid's General Fund expenditures as a share of General Fund revenues has grown from 12.7 percent to 26.1 percent. These growing costs occurred while Utah served the original populations targeted by Title XIX - families with dependent children and individuals that are aged, blind, or disabled. With the waiver approved in March 2019 and with this waiver request, the State included additional adults with dependent children and adults without dependent children who historically have not been served by Medicaid. While the State has been able to allocate existing resources to accommodate current Medicaid needs and has authorized an increase in sales tax to fund this waiver request, it may not be practicable in the State of Utah for Medicaid expenditures to continue to grow as a share of the available General Fund revenue nor to expect that higher sales tax rates on a narrowing tax base will serve as a reliable long term funding source for the program absent additional budgetary flexibilities. This waiver proposal requests that the Secretary of Health and Human Services approve this waiver to furnish medical assistance to Utahns ages 19-64 in a way deemed practicable by the Utah Legislature and Governor Herbert as defined through Senate Bill 96.

Section 1115 of the Social Security Act gives the Secretary broad authority to waive certain provisions of the Act:

(a) In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of title I, X, XIV, XVI, or XIX, or part A or D of title IV, in a State or States—

(1) the Secretary may waive compliance with any of the requirements of section 2, 402, 454, 1002, 1402, 1602, or 1902, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

(2)(A) costs of such project which would not otherwise be included as expenditures under section 3, 455, 1003, 1403, 1603, or 1903, as the case may be, and which are not included as part of the costs of projects under section 1110, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans, as may be appropriate,

Both under this administration and under President Obama's administration, the Centers for Medicare and Medicaid Services (CMS), has encouraged the State to bring proposals to CMS without trying to determine ahead of time all of the authorities needed for obtaining approval for the proposal. CMS has offered to use the flexibility available to it under statute to determine if there is a legal pathway forward to allow the State to pursue the flexibility it was seeking. It is not uncommon for CMS's interpretation of its authorities to evolve. As CMS Administrator Seema Verma said to state Medicaid directors in November 2017, "So now it is up to you, the states, to put your innovative ideas into practice. We very much look forward to your proposals and helping you implement successful initiatives that improve the health and lives of the diverse set of beneficiaries you serve." The State believes that the combination of the Secretary's authority to waive compliance with certain sections of Title XIX and to approve expenditures not otherwise matchable is sufficient to approve this waiver proposal, which will improve the health and lives of an estimated 120,000 to 140,000 Utahns.

On July 27, 2019, CMS released a statement saying, "...a number of states have asked CMS for permission to cover only a portion of the adult expansion group and still access the enhanced federal funding available through Obamacare. Unfortunately, this would invite continued reliance on a broken and unsustainable Obamacare system. While we have carefully considered these requests, CMS will continue to only approve demonstrations that comply with the current policy." While this statement indicates it is unlikely the Secretary will use his authority at this time to allow enhanced funding for an expansion that includes an enrollment cap, the State believes there are several important reasons for submitting this waiver request as originally envisioned by Senate Bill 96.

First, the landscape regarding Medicaid expansion may change. Most notably, the U.S. Court of Appeals for the 5th Circuit will be issuing a decision in the *Texas v. U.S.*, litigation challenging the Affordable Care Act (ACA). Comments attributed to administration officials in news articles regarding CMS's position on partial expansion seem to tie this administration's position to a hope that *Texas v. U.S.* will overturn the ACA. However, as shown by the Supreme Court decision in *National Federation of Independent Business v. Sebelius* (2012), court decisions are not entirely predictable. Therefore, in light of the possibility that the legal situation regarding the ACA may change (or may not) in the near future, the State is submitting its entire request for review by the Secretary.

Second, the State's waiver request contains many other program features beyond the request for enhanced match for expansion with an enrollment cap. The State believes the other components of its waiver request can be approved and are important to operating an efficient and effective Medicaid Expansion program.

Lock-Out from the Medicaid Expansion for Committing an Intentional Program Violation (IPV)

2. Many commenters stated that this request is not needed because fraud is already defined under state law and prosecuted accordingly. They would like to know how an IPV is different from a fraud

determination. In addition, they state the amendment already clearly indicates that individuals can be charged for overpayments while appealing an IPV.

Response: A determination of fraud is made through a judicial procedure. Section 76-8-1205 Utah Code Annotated, defines public assistance fraud.

76-8-1205 Public assistance fraud defined.

Each of the following persons, who intentionally, knowingly, or recklessly commits any of the following acts is guilty of public assistance fraud:
(1) a person who uses, transfers, acquires, traffics in, falsifies, or possesses SNAP benefits as defined in Section 35A-1-102, a SNAP identification card, a certificate of eligibility for medical services, a Medicaid identification card, a fund transfer instrument, a payment instrument, or a public assistance warrant in a manner not allowed by law;
(2) a person who fraudulently misappropriates funds exchanged for SNAP benefits as defined in Section 35A-1-102, or an identification card, certificate of eligibility for medical services, Medicaid identification card, or other public assistance with which the person has been entrusted or that has come into the person's possession in connection with the person's duties in administering a state or federally funded public assistance program;
(3) a person who receives an unauthorized payment as a result of acts described in this section;
(4) a provider who receives payment or a client who receives benefits after failing to comply with any applicable requirement in Sections 76-8-1203 and 76-8-1204;
(5) a provider who files a claim for payment under a state or federally funded public assistance program for goods or services not provided to or for a client of that program;
(6) a provider who files or falsifies a claim, report, or document required by state or federal law, rule, or provider agreement for goods or services not authorized under the state or federally funded public assistance program for which the goods or services were provided;
(7) a provider who fails to credit the state for payments received from other sources;
(8) a provider who bills a client or a client's family for goods or services not provided, or bills in an amount greater than allowed by law or rule;
(9) a client who, while receiving public assistance, acquires income or resources in excess of the amount the client previously reported to the state agency administering the public assistance, and fails to notify the state agency to which the client previously reported within 10 days after acquiring the excess income or resources;
(10) a person who fails to act as required under Section 76-8-1203 or 76-8-1204 with intent to obtain or help another obtain an "overpayment" as defined in Section 35A-3-102; and
(11) a person who obtains an overpayment by violation of Section 76-8-1203 or 76-8-1204.

The determination of an IPV has been part of policy for Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and Medicaid for many years. The determination of an IPV is made through an administrative adjudicative proceeding under the Utah Administrative Procedures Act. The burden of proof is with the State. The standard of evidence is clear and convincing in both an administrative or judicial proceeding. The determination of an IPV through an

administrative proceeding with the possibility of a lock out of the Medicaid program is less onerous than a conviction based on a judicial criminal proceeding that could result in a third or second degree felony.

3. Several commenters stated they believe beneficiaries will be confused by what they must report and will get caught up in “red tape” trying to provide information, therefore causing them to lose coverage.

Response: Members are informed of what is required to be reported and when they must report. Current policy requires Medicaid members to report changes that affect eligibility within 10 days from the date of the change. The waiver makes no change to current reporting requirements.

4. Several commenters stated that while they appreciate the attempt to prevent fraud and abuse, they believe that individuals who might lose coverage due to this proposal, should be allowed a swift and effective appeals process, so they do not lose coverage due to an administrative mistake.

Response: All federally mandated appeal rights will be in place, as they are today. After the State has investigated a case for an IPV, and the Administrative Law Judge has concurred with the decision, an individual may be locked out for 6 months of the Adult Expansion Medicaid Program. The individual will receive notice of the decision. The notice includes the right to appeal and would be reviewed through the current administrative hearing process at the Department of Workforce Services (DWS).

5. Several commenters stated they believe the lock-out provision will only divert money from providing care to administering this provision. They also believe it will increase the administrative burden on patients on the Medicaid program.

Response: The determination of an IPV is currently in Medicaid policy. This is not new nor is it a change. The DWS Investigation unit conducts the investigation. Therefore there is no significant change to the current administrative burden to the State or members.

6. Several commenters stated they believe this provision includes vague or broad descriptions of an IPV. They believe this will lead to subjective decisions which likely will be influenced by implicit biases, resulting in certain populations, likely people of color and other marginalized groups- being more apt to be found to commit an IPV.

Response: The determination of an IPV has been in place for at least two decades for the SNAP, TANF and Medicaid programs. The burden of proof rests with the State. The State complies with judicial standards of evidence. When fault is alleged, the State must prove by clear and convincing evidence that the overpayment was obtained intentionally, knowingly, recklessly as "intentionally, knowingly, and recklessly" are defined in Section 76-2-103, by false statement, misrepresentation, impersonation, or

other fraudulent means, including committing any of the acts or omissions described in Sections 76-8-1203, 76-8-1204, or 76-8-1205.

7. Several commenters stated the lock-out period is problematic when coupled with the enrollment limit. They stated if someone was subject to a lock-out and an enrollment limit was enacted, they would continue to be locked-out for a longer time frame.

Response: The lock-out period continues to run regardless of enrollment being open or closed. While possible that the enrollment closes during someone's lock-out period, the lock-out period only applies to the Adult Expansion Medicaid Program, and other programs may still be available. If other programs are not available, these adults can reapply when enrollment opens again.

8. Several commenters express concern for the IPV definition including "failure to report a required change within 10 days". They would like this specific piece of the IPV definition removed.

Response: An IPV is different from an inadvertent error. In order to be considered an IPV, an individual would have to knowingly not report a required change within 10 days after the change occurs, and the individual knew the reporting requirements, and the intent was to obtain benefits they were not entitled to receive. The burden of proof is on the State to prove this occurred. The "failure to report in 10 days" provision is currently included in the definition of an IPV. This is not a change to policy.

9. Several commenters stated an individual's socioeconomic status can influence an individual's ability to adhere to program rules. They believe this is a difficult requirement for any income level. They also stated that individuals could be confused as to what they need to report, which would result in losing coverage over bureaucracy.

Response: Medicaid policy currently includes specific reporting requirements, as well as the IPV definition included in the lock-out proposal. The State is not proposing to change current reporting requirements or the definition of an IPV. The State is only proposing to apply a lock-out period if an IPV determination is made.

10. One commenter stated they will have to provide sliding fee scale services to individual's locked out and that this seems to be too harsh for what seems to be less serious offenses.

Response: An IPV is different from an inadvertent error. To be considered an IPV, the individual has to knowingly and intentionally make statements or withhold information to obtain benefits they are not or were entitled to receive. The State would not consider this as a "less serious offense", given the intent of the violation.

11. Several commenters stated that disenrollment policies reduce access to care, disrupt the continuity of care, and cause increased utilization of emergency departments. They believe this proposal will lead to these issues. They also believe locking individuals out of coverage does not achieve Medicaid objectives, and is not allowable under Section 1115 authority.

Response: The State currently has IPV policy in place. Medicaid policy currently includes specific reporting requirements, as well as the IPV definition included in the lock-out proposal. As stated in the response to Comment 1, the State must operate within the limits of its budget and therefore it is practical that only those individuals truly eligible for Medicaid should receive benefits. CMS will determine whether or not this and any other provision is allowable under this waiver authority.

12. One commenter stated the purported justification for Utah's Medicaid 1115 waiver is fiscal responsibility. However, implementation of the lock-out process would require Utah Medicaid to divert already thin administrative resources to oversee and conduct the program. They also state the potential dollar amount of savings that Utah Medicaid would achieve from locking low-income individuals out of Medicaid for 6-months is not provided, and input cannot be given without this.

Response: The State already has an IPV policy and process in place. IPV's are currently determined. The only change to the State's current process is the lock-out period. In response to the information regarding potential dollar savings, the State has met the transparency requirements found at 42 CFR 431.408. The waiver application and budget neutrality attachment reflect the required information.

13. One commenter stated the lock-out provision could have huge financial implications to individuals. They believe it is also not clear what overpayments a patient could be responsible for if the state determines an IPV occurred. For example, would an individual be forced to repay a capitation payment amount made to a managed care plan, even when they received no services?

Response: Under current Medicaid policy, if it is determined that an individual was not eligible to receive Medicaid, an overpayment is assessed for the months they were not eligible. The amount of the overpayment is based on claims paid on behalf of the individual as well as any capitation payments paid on behalf of the individual (if the individual was with a managed care plan). This will not change under the IPV lock-out policy. The only change under this proposal, is that if an individual has committed an IPV, they will have a 6-month lock-out period.

14. One commenter stated that charging individuals with overpayments for coverage received while awaiting an appeal decision could discourage individuals from appealing the decision, leading to unnecessary coverage losses and additional financial burdens.

Response: This proposed provision is consistent with current Medicaid regulation found in 42 CFR 230 which reads:

§431.230 Maintaining services.

(a) If the agency sends the 10-day or 5-day notice as required under §431.211 or §431.214 of this subpart, and the beneficiary requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless—

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.

(b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or beneficiary to recoup the cost of any services furnished the beneficiary, to the extent they were furnished solely by reason of this section.

Housing Related Services and Supports (HRSS)

15. Many commenters stated they are very supportive of the proposal to provide housing related services and supports. However, they believe it should be extended to all Adult Expansion members, not just the Targeted Adult Population. They believe providing to just a sub-group of the population contradicts the intent of Senate Bill 96.

Response: Based on the estimated cost to provide housing related services and the amount of funding designated for these services within overall Medicaid Expansion funding, the State determined to initially limit coverage to the Targeted Adult Population. Based on program flexibility the State is seeking to modify covered populations through administrative rule. After gaining additional cost and utilization experience, if funding is available, the State will consider covering housing related services for additional populations.

16. One commenter noted they strongly oppose the proposal to allow the State to make changes to this component through state administrative rulemaking, rather than the 1115 review and approval process. They believe this is contrary to transparency requirements.

Response: The intent of this proposal is to allow more flexibility and expedience to change approved waiver criteria in response to budget issues. Through this waiver request, the State is seeking CMS approval of defined options for operating the State's Medicaid Expansion program. The State would

then use its administrative rulemaking process to activate the options approved in the waiver. The State believes the rulemaking process is transparent and would follow the process outlined under the Utah Administrative Rulemaking Act , Title 63G Chapter 3 Utah Code Annotated which provides for public input.

After passing through an internal review and approval process, UDOH files all proposed rules with the Division of Administrative Rules. The proposed rules are then published in the Utah State Bulletin, which the public can access at https://rules.utah.gov/ to review the proposed changes. Upon publication, the public has 30 days to review and comment on the proposed changes, and may send their written comments to the contact person listed. UDOH reviews all comments provided during the public comment period, and has seven days after the comment period to determine whether it will go forward to make the rule effective, change the proposed rule, or simply let the rule lapse. UDOH also presents all rules to its Medical Care Advisory Committee and the Utah Indian Health Advisory Board.

In accordance with the provisions of the rulemaking act, individuals may also petition UDOH for a public hearing to discuss the proposed rule. UDOH would then grant the request, appoint a hearing officer, and make appropriate arrangements to accommodate a public gathering.

UDOH may also initiate a public hearing to discuss the proposed changes if it feels the need is warranted and that the changes require further outreach. In this case, UDOH may arrange to publish notice of the hearing in the State Bulletin when it files the proposed rule, or may arrange to publish this notice in the bulletin or newspaper after the rule filing.

UDOH also has the option of sending proposed changes to Medicaid providers, advocacy groups, shareholders, or others in the healthcare industry during the rulemaking process. This action is usually based on certain issues surrounding the rulemaking, or where UDOH just wants further input and consultation with the aforementioned groups.

In regards to the waiver process, CMS is under no statutory obligation to review 1115 waiver amendments in a timely fashion. The State has had many experiences where waiver amendments have sat with CMS for months and even years before final action was taken. In full compliance with federal transparency requirements, the State is seeking for a limited, defined scope of authority from CMS where the State could modify certain rules related to the approved waiver criteria definitions using a more timely and locally responsive administrative rules process.

17. One commenter stated while they support any initiative designed to help Utah's extremely low-income populations, they believe Medicaid is medical insurance, not a housing program, and therefore they do not support this proposal. They believe precious resources should not be directed away from core functions of the Medicaid program.

Response: Language in Senate Bill 96 requires UDOH to seek CMS authority to provide housing supports for eligible Medicaid expansion enrollees. In addition to the statutory mandate, the State acknowledged that a growing body of empirical evidence shows that addressing social determinants of health such as housing supports, has the potential to reduce medical utilization and cost. For example, a health care utilization study conducted in Seattle by Mackelprang and colleagues (2014) examined EMS utilization before and after entering a single-site Housing First program. The 91 program participants had substance use disorders. The study did not monitor health outcomes, but examined and categorized the reasons for EMS calls through examination of administrative data, both for two years prior to enrollment in supported housing and two years following enrollment. The study found a 54 percent reduction in EMS calls for those who entered supportive housing.

Not Allowing Hospitals to Make Presumptive Eligibility Determinations for the Adult Expansion Demonstration Population

18. Many commenters stated they are opposed to this provision. They believe hospital presumptive eligibility is an important entry point for individuals to receive Medicaid. They believe approval of this proposal will lead to individuals facing significant out of pocket costs, and increased uncompensated care costs for providers. They also stated while they believe retroactive eligibility is an important safeguard they do not believe it is sufficient.

Response: Senate Bill 96 directs the state not to implement hospital presumptive eligibility for adults on the Adult Expansion Medicaid program. Most Medicaid programs (including Adult Expansion Medicaid program) offer retroactive eligibility for the three months prior to the month the application is received. Three months retroactive coverage is not a benefit available in the commercial, marketplace, or Medicare plans. Due to the availability of retroactive coverage, uncompensated care costs and individual out-of-pocket expenses will only occur when an individual was never eligible for Medicaid.

19. One commenter stated that because the State has already waived retroactive eligibility, this proposal will lead to hospitals not being reimbursed for low income uninsured patients. They also believe this will lead to crippling financial liabilities for patients.

Response: The State has not had retroactive eligibility waived for the Adult Medicaid Expansion. These adults can continue to request retroactive eligibility when applying for Medicaid.

If the State obtains authority to waive retroactive eligibility at a later date through an administrative rule process, then the public and the State will be able to discuss at that time how to balance the need of the State to reduce expenditures and the impact on members and hospitals.

20. One commenter stated the waiver does not address the gap between those who have qualified under presumptive eligibility and those who successfully complete the Medicaid application process. They believe this does not address the actual impact.

Response: The State believes it has addressed this in the waiver amendment. The amendment states that approximately 54 percent of individuals approved for hospital presumptive eligibility are ultimately approved for ongoing Medicaid.

21. One commenter stated that Senate Bill 96 does not require the State to eliminate presumptive eligibility, only to "limit". They also indicate this only applied to the per capita cap waiver, not the fallback plan.

Response: While Senate Bill 96 uses the term "limit" in conjunction with the Hospital Presumptive Eligibility (HPE) Program, UDOH has consistently stated that this means to eliminate this group from the larger HPE program which includes several eligibility groups There have not been any discussions about "limiting" which hospitals or providers may determine eligibility under the HPE program or allowing a limited quota of individuals to qualify at any one HPE approved site. The Senate Bill 96 provisions limiting HPE are included under both the 'Per Capita Cap' waiver request as well as the 'Fallback' waiver amendment.

Managed Care Flexibilities

22. One commenter stated they are extremely concerned that these changes would limit oversight over patient care provided through managed care. They believe these issues require significant oversight to ensure taxpayer funds are being spent appropriately.

Response: This change does not limit CMS oversight. This change only allows the State to implement new rates and contracts in a timely manner while minimizing risk of federal funds disallowance. CMS still retains all oversight authority they have by federal law and regulation.

23. One commenter stated they are concerned that the previous Per Capita Cap waiver application indicated the State intended to submit plan contracts and rates to CMS by October 1, 2019, which is almost four weeks after the closure of the waiver comment period. It is unknown whether the State has already provided this information to CMS. They request additional clarification.

Response: Federal regulations encourage states to submit proposed rates and contracts at least 90 days before the contract/rate period. Rates for the Medicaid expansion group have been submitted to CMS for their review. Contracts for the expansion group are still in draft but will be sent to CMS soon. Both rates and contracts are subject to the current CMS review process.

24. One commenter stated they are strongly opposed to the State's request to "implement contracts and rates prior to formal approval by CMCS and the Office of the Actuary" as this proposal leaves the State open to what could be significant financial losses should CMS not concur with the State's decisions. They believe this places the Medicaid program at increased financial risk, contrary to the waiver's global concern with making Medicaid a fiscally sustainable program.

Response: Under current regulations (42 CFR 438.806) a state must obtain prior approval of a managed care organization (MCO) (comprehensive risk) contract and rates. Prior approval by CMS is a condition for federal financial participation. All managed care rates are calculated under very specific rate setting guidance from CMS by the State's contracted actuarial firm, Milliman, Inc. The rates must be certified by the actuary as being actuarially sound. The current CMS process for rate approval takes months to complete. At the end of the process, CMS typically approves the rates originally submitted by the State.

The State waits until the rates are approved to reimburse the plan the current rate. This causes a delay in appropriate reimbursement and a significant administrative burden to the State and the plan when the State recoups and repays the plans the approved rates.

Under this waiver request, the State will still submit rates and contracts to CMS for final approval. The purpose of this waiver request is to allow the State to pay the current proposed rate and be assured federal financial participation pending CMS's review. This waiver will put the State at less risk by assuring federal match. If CMS requires any change to the rate or contract, the State will not be at risk of losing any federal match for the past period and will only be required to make changes prospectively resulting in far less administrative burden.

25. One commenter stated they are strongly opposed to the State's request for more flexibility in implementing contracts and rates prior to formal approval by CMS as this proposal leaves the State open to what could be significant financial losses or untenable contract situations should CMS not concur with the State's decisions.

Response: Please see the State's response to Comment 24.

26. One commenter stated they are strongly opposed to the State's request for more flexibility in implementing directed payments and rates prior to their formal approval by CMS as this proposal leaves the State open to what could be significant financial losses should CMS not concur with the State's decisions.

Response: Directed payments are part of the rate setting process. Please see the State's response to Comment 24.

27. One commenter stated they are strongly opposed to the State's proposal to "adopt an approach to network adequacy, access to care, and availability of services" without any firm definition of how those parameters would be established.

Response: Currently CMS does not provide any specific guidance or standards to states regarding network adequacy, access to care, and availability of services. The State is currently working to establish these standards and parameters in accordance with the requirements in federal regulation. The State intends to adopt these standards through administrative rule making allowing for full transparency and public comment.

Benefits

28. One commenter stated they are extremely disappointed that adults with dependent children receive fewer benefits than adults without children. They believe benefits should be the same.

Response: Currently, adults without dependent children (including Targeted Adult Medicaid members) receive traditional Medicaid benefits. Adults with dependent children receive non-traditional Medicaid benefits. This includes Parent Caretaker Relative Medicaid members. The State chose to keep benefits received by Adult Expansion Medicaid members consistent with the benefit packages offered today.

Demonstration Hypotheses and Evaluation

29. One commenter suggests there should be a comparison of how the people on ESI are doing health wise compared to those who receive regular Medicaid.

Response: As stated in the waiver amendment, the State will work with an independent evaluator to develop an evaluation plan. The suggested hypotheses may be refined and/or amended after consulting with the evaluator.

30. One commenter stated they do not agree with the hypotheses for community engagement, which proposes to compare health outcomes of Medicaid beneficiaries subject to the requirement with those who are not. They believe these are biased comparisons because people who are subject to the requirement are, by virtue of the fact they do not qualify for an exemption, almost certain to be more healthy than those not subject to the requirement.

Response: As stated above, the State will work with an independent evaluator to develop an evaluation plan. However, the State will follow CMS guidance specific to community engagement initiatives, in

developing an evaluation plan. The evaluation plan also requires CMS approval prior to conducting the evaluation. The State will consider this concern in consultation with the independent evaluator.

31. One commenter stated they are concerned with how the waiver will be evaluated. They stated they are left to wonder how the impact or effectiveness in terms of increasing coverage or access, and improving quality and efficiency will be monitored and safeguarded.

Response: As stated in the waiver amendment, the State will work with an independent evaluator to develop an evaluation plan. The evaluation plan requires CMS approval prior to conducting the evaluation.

Enrollment Limit

32. Several commenters referred to CMS's August 16, 2019, letter to Utah, which denies Utah's request to implement an enrollment limit for the expansion population, as this would be akin to partial expansion, and would make the State ineligible for the requested 90/10 FMAP.

Response: CMS has officially responded to the State's Per Capita Cap waiver indicating it will not approve this provision at this time; however, Senate Bill 96 requires that the State request this program feature again in the 'Fallback' waiver amendment.

33. Many commenters stated an enrollment limit would leave many people without access to critical care. They believe anyone who is eligible should receive Medicaid, as it is an entitlement program. They believe this provision does not meet the objectives of Medicaid. They are also concerned that there will be no waitlist, which they believe creates barriers to individuals needing care.

Response: As stated in the response to Comment 1, the Social Security Act states that the purpose of the Medicaid program is to furnish medical assistance as far as practicable in each State. While the State understands the commenters' concerns, enrollment in this adult expansion population will be limited by the amount of the state tax collected and other funds appropriated by the Legislature to fund the state share of the cost to operate this Medicaid program. Current estimates place funded enrollment at 120,000-140,000.

As was done previously with the Primary Care Network (PCN) and the Targeted Adult Medicaid program, the State is requesting the ability to open and close enrollment for this program in order to stay within the budget. Once the budget limit has been reached, enrollment will be closed. Enrollment numbers will be evaluated periodically to determine if additional individuals can be covered. If additional individuals can be covered, enrollment will be opened and applications will be accepted. All

individuals applying during the open enrollment period will be reviewed for eligibility and enrolled in the program if eligible.

34. One commenter sought clarity on how the enrollment limit will work with retroactive eligibility.

Response: If an individual applies for Adult Expansion during an open enrollment period, and they request retroactive medical coverage, they will be allowed retroactive coverage (if otherwise eligible). This applies even if the retroactive months were during a closed enrollment period. However, if the individual applies when enrollment is closed (and is therefore not eligible), retroactive coverage will not be allowed, even if the retroactive months were during open enrollment. The individual must apply during an open enrollment period to receive retroactive coverage.

35. One commenter stated that enrollment limits would force health centers to supplement the Medicaid program in a way Congress did not intend to subsidize the care of those who are otherwise eligible.

Response: The State is operating its current "Bridge" expansion program with an enrollment limit. This waiver proposal is expected to continue coverage for an estimated 120,000 to 140,000 Utahns. Some of these are individuals who previously had no health care coverage, many of whom sought care through health centers. Continuation of this coverage for these adults helps relieve the financial burden of health centers for the care of the uninsured.

36. One commenter stated the State did not provide the required assessment to the impact on enrollment for this proposal.

Response: The State's estimates for impacts to enrollment are stated within the applicable waiver application sections. The budget neutrality documents require enrollment figures to be equivalent for "without waiver" and "with waiver." Budget neutrality is calculated at a per-member level and there are no calculated savings that result from reduced enrollment.

37. One commenter stated that the State cites "fiscal sustainability" as a reason for an enrollment limit. However, they add that it is hardly clear that Utah's Medicaid program faces a crisis of sustainability that necessitates a waiver of eligibility provision. They add that the waiver provides no evidence to suggest that the value of any potentially achievable sustainability would outweigh the potential negative effects of the waiver on coverage.

Response: As stated in the response to Comment 1, Medicaid's General Fund expenditures as a share of General Fund revenues has grown from 12.7 percent to 26.1 percent over the last 19 years. Senate Bill

96 directs the State to request approval of an enrollment limit to stay within the appropriations for this program.

Community Engagement Requirement

38. One commenter sought assurances that the State will follow fair hearing processes when applying the community engagement requirements.

Response: Individuals who become ineligible due to failure to comply with the work requirement will retain all federally mandated appeals rights. All decision notices sent to enrollees contain information on how to appeal decisions. The current process for appeals will be followed.

39. Many commenters stated they disapprove of the community engagement requirement, as it does not promote the objectives of Medicaid, as shown by recent court rulings.

Response: The State received approval to implement a community engagement requirement. As stated in the CMS approval letter dated March 29, 2019, "Utah and CMS will be able to evaluate the effectiveness of a policy that is designed to improve the health of Medicaid beneficiaries and promote their financial independence. Promoting beneficiary health and independence advances the objectives of the Medicaid program. Indeed, in 2012, HHS specifically encouraged states to develop demonstration projects "aimed at promoting healthy behaviors" and "individual ownership in health care decisions" as well as "accountability tied to improvement in health outcomes.""

40. Many commenters stated this requirement will increase the administrative burden on impacted individuals, likely decreasing the number of people with coverage. They cited Arkansas as an example of individuals losing coverage. They also believe the administrative cost to the State will be high.

Response: Utah's community engagement requirement is significantly less onerous than Arkansas's requirement. Utah is structuring its community engagement requirement to be similar to SNAP. Individuals who are meeting the SNAP requirement or who are already exempt under the SNAP requirement will meet the Medicaid community engagement requirement. In addition, due to similarity to SNAP, Utah already has the technology and the infrastructure to support a community engagement requirement for Medicaid. Therefore, the administrative cost to Utah will be minimal. Finally, due to the simplicity of Utah's community engagement requirement and the options for exemption or hardship, Utah's estimates on the impact on enrollment may differ from those estimated by other states.

41. Many commenters stated they believe the current exemptions will not capture all individuals who have, or at risk of serious and chronic health issues that prevent them from working.

Response: Many adults with chronic conditions are able to work and may want to do so. Any adult can access employment services or choose to participate. However, the State is developing a list of potential serious or chronic health conditions that would meet the definition of physically or mentally unable to work. The State is considering using these conditions to automatically exempt an adult with one of these conditions.

42. Several commenters stated concerns with the impact to children if their parents lose coverage due to the community engagement requirement and enrollment limit. They state that studies show that if parents do not have medical coverage, their children are less likely to have medical coverage.

Response: Children may be determined eligible for Medicaid independently from their parents. Many children receive Medicaid or CHIP even though their parents were not previously eligible for coverage or are currently not covered by Medicaid. Members will be provided with clear information on how to meet the community engagement requirement. In addition, the State has provided members with multiple pathways to meet an exemption or request a hardship waiver when one is warranted. The State intends to monitor and evaluate the implementation of the community engagement requirement to minimize any potential negative impact on children.

43. Several commenters requested exemptions for specific illnesses or diseases, such as cancer and HIV. They indicated Michigan and Arizona as states who have done so, by including these in the definition of medically frail.

Response: The State appreciates this feedback from commenters. The current exemptions proposed in the waiver are quite broad and are intended to cover any condition which prohibits an individual from participating in community engagement. In addition, the waiver also includes a request for a hardship exemption to address unique circumstances. The State is also considering creating a list of conditions that would automatically exempt an adult with one of these conditions.

44. One commenter stated the implementation and administrative costs will be high, as indicated by other states. They ask that the State include a projection of administrative costs associated with implementation be included in the waiver.

Response: Other states have designed their community engagement requirements very differently than what Utah has proposed. Some states designed entirely new systems to capture information for their community engagement program. Utah's program relies on existing resources at DWS that already provide job assessment, training, and search reporting for SNAP recipients. The State anticipates operating the community engagement requirement within its existing resources.

Waiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19 and 20 year old adults

45. Many commenters are strongly opposed to the request to waive EPSDT. They state EPSDT is the backbone of the Medicaid program for children and young adults and ensures that all medically necessary services they are found to need are provided. They also state that this benefit is much needed due to the mental health and SUD crisis within this population. In addition, they state that dental care would be cut at a time when young adults are entering the job market, and it has been proven that dental issues impact an individual's ability to get employment.

Response: Utah has had a waiver of EPSDT for 19 and 20 year old adults since the approval of Utah's current 1115 Primary Care Network Waiver in 2002. In addition, as of November 2017, all adults on Utah Medicaid, including 19 and 20 year olds, receive the full array of behavioral health services.

Full dental services have not been available for most adults between 19-64 with or without dependent children (only disabled 19 and 20 year old adults receive full dental benefits). Budget estimates for Senate Bill 96 did not include dental coverage for 19 and 20 year old adults. Expanding dental benefits to these adults would require an additional appropriation.

46. One commenter stated the Secretary does not have the authority to waive EPSDT, both because Congress' intent with respect to EPSDT coverage is abundantly clear, and because the requirement is located outside of § 1396a. They also stated that without EPSDT these individuals will not receive medically necessary services, as Utah limits coverage of certain mental health services for adults enrolled in its 1115 PCN waiver.

Response: Previous Secretaries have approved and reauthorized Utah's current waiver of EPSDT. Utah's 1115 Primary Care Network demonstration waiver includes a waiver of EPSDT for 19-20 year Current Eligible (Non-Traditional parents 0-40 percent FPL). In addition, effective November 1, 2017, full mental health benefits were restored for all adults as a result of a waiver amendment to the PCN Waiver. Therefore there are no differences in behavioral health benefits for adults.

47. One commenter stated the EPSDT waiver should be rescinded because it was not included in Senate Bill 96 and was not requested by the state legislature.

Response: Utah has had a waiver of EPSDT for 19 and 20 year old adults since the approval of Utah's current 1115 Primary Care Network Waiver in 2002. This waiver continues to exist for parents whose income is between 0 to 40 percent FPL. Although not required by Senate Bill 96, the State is requesting the same waiver of EPSDT requirements for 19-20 year old adults with higher incomes as a matter of

equity in the adults with dependent children group. Senate Bill 96 authorizes UDOH to include additional flexibilities and cost controls in this waiver request beyond those specifically identified in the bill.

Employer-Sponsored Insurance (ESI) Requirement

48. Several commenters stated they are concerned that this proposal will divert funds that could be used for patient care to cover the administrative costs of coordinating benefits between the ESI provider and Medicaid. They do not believe this an efficient use of funds for such a small portion of the population. They also believe ESI creates administrative complexity.

Response: The State already has established processes for purchasing ESI and coordinating benefits and payments for members. As such, this process does not require significant new administrative infrastructure and is not expected to divert funds for patient care. ESI presents an opportunity for members to be covered with a commercial plan as their primary benefit as well as Medicaid as a secondary benefit while maintaining cost effectiveness.

49. One commenter stated they are concerned about the beneficiary communications around the wraparound benefit offered. They believe this will create unnecessary complexity and barriers to care for beneficiaries. They state national research shows states have not sufficiently explained the availability of wraparound services.

Response: For those beneficiaries that have access to ESI we will notify them in advance of the requirement to enroll and allow time for them to enroll in their coverage. After the ESI coverage is added, all future claims are processed by the ESI coverage first and the Medicaid coverage second. This is a routine and regular process for health insurance companies and Medicaid has years of experience in processing these types of claims. Some individuals may receive additional services if their health plan covers beyond the scope of Medicaid's services.

50. One commenter referred to concerns that remain from the previous waiver request for ESI. These concerns include: timeframe that the individual will be "locked-out" if they fail to enroll in ESI; how ESI coverage and premium amount will be verified; what safeguards will be in place to ensure someone does not lose coverage due to an individual or state error; what occurs if someone accidentally misses an enrollment period.

Response: The State is proposing to lock-out individuals from Medicaid when they miss the opportunity to enroll, up until such time that the person enrolls in their employer sponsored plan, lose access to their employer sponsored plan, or 12-months, whichever comes first. The State will be clear in its

communication to beneficiaries so they will know when this requirement applies to them. The State will validate the premium using all available verification methods except "customer statement", meaning that health plan enrollment may be validated electronically, through a collateral contact with the employer or insurance company, or by other paperwork turned in by the beneficiary. In order to protect beneficiaries, they always have the right to request a fair hearing if they believe they have been closed or denied in error.

51. One commenter stated that the State did not include an estimate regarding the number of individuals that would lose eligibility due to failure to enroll in ESI coverage.

Response: The State estimates 100-200 members per year will lose eligibility due to failure to enroll in ESI coverage. This information has been added to the waiver application.

Changes through Administrative Rulemaking

52. Several commenters expressed concern that the request to allow the State to make certain changes through the administrative rule process would relinquish federal oversight of the areas where the State is allowed to make these changes. They also believe that bypassing the full notice and comment process could place the State at an undetermined financial risk should CMS come out later with a negative decision on something that had only been processed (and approved) at the state level.

Response: The intent of this proposal is to allow more flexibility and expedience to change approved waiver criteria in response to budget issues. Through this waiver request, the State is seeking CMS approval of defined options for operating the State's Medicaid Expansion program. The State would then use its administrative rulemaking process to activate the options approved in the waiver.

Administrative rulemaking is governed under the Utah Administrative Rulemaking Title 63G Chapter 3, Utah Code Annotated. State law requires an opportunity for public comment on proposed rulemaking similar to the federal process for waiver amendments. Proposed rules are published on a public website. The State must allow at least 30 days for public comment. In addition, UDOH reports on all rulemaking at its Medical Care Advisory Committee and the Utah Indian Health Advisory Board, which are open to the public. While the state administrative rule process and the federal 1115 waiver amendment process both require UDOH meet certain transparency requirements, the administrative rule making process is more timely which allows the State to implement necessary changes without significant delays.

Finally, the State anticipates that the federal government will include language in the State's Standard Terms and Conditions that requires the State to notify CMS of any proposed and final rulemaking so

CMS can maintain its oversight of the State's waiver. Therefore, the State does not believe this process creates any additional or undetermined financial risk.

53. One commenter stated that if the State would like to make specific changes identified in this section of the waiver at this time, it should explicitly ask CMS to waive these provisions in its current application and include a more complete analysis of their impact on beneficiaries.

Response: Through this waiver request, the State is seeking CMS approval of defined options for operating the State's Medicaid Expansion program. The State would then use its administrative rulemaking process to activate the options approved in the waiver. The process the State is proposing will allow the State to make changes within the parameters established by the waiver in a transparent but more timely manner.

$25 Copay for Non-Emergent use of the Emergency Department

54. Many commenters are opposed to a $25 copay for non-emergent use of the emergency department. They believe this could deter individuals from seeking necessary care during emergency situations, and they should not be forced to self-diagnose. They believe patients should be educated regarding what is emergent vs. non-emergent, if this is approved and implemented. They also state a graduated cost structure combined with education efforts would promote the state's goal of reducing non-emergent use of the emergency room and could be of benefit to Medicaid beneficiaries.

Response: The State appreciates this feedback. The State is modifying its proposal to include additional education. The State anticipates providing education after the first non-emergent use of the emergency room and quarterly thereafter. If a beneficiary does not modify his/her behavior and continues to inappropriately use emergency departments for non-emergent reasons, a nominal surcharge will be added to their premium.

55. One commenter stated the proposal does not meet key criteria of the Section 1916(f) of the Social Security Act for when a Medicaid beneficiary can be charged a copay.

Response: The State appreciates this feedback. Because the State has changed its proposal regarding the $25 copay, Section 1916(f) will no longer apply.

Expansion of Targeted Adult Medicaid Subgroups

56. Several commenters stated they support new subgroups but do not support closing enrollment for individual subgroups under administrative rule. They believe the State's request to make changes to this

program without going through CMS' required notice and comment procedure is contrary to Medicaid's emphasis on transparency in the 1115 waiver review and approval process.

Response: The State currently has approval to suspend enrollment for Targeted Adult Medicaid. The State is requesting to continue this authority, and to apply this authority to the individual subgroups. If an individual is ineligible for the Targeted Adult Medicaid program due to enrollment being suspended, eligibility for Adult Expansion Medicaid will be determined. Through this waiver request, the State is seeking CMS approval of defined options for operating the State's Medicaid Expansion program. The State would then use its administrative rulemaking process to activate the options approved in the waiver.

Premiums

57. One commenter stated the Medicaid Act prohibits states from charging premiums to individuals with household income below 150 percent of FPL. These limits exist outside of § 1396a, and as a result, cannot be waived under § 1115. Time and again, Congress has made clear its intent to insulate the substantive limits on premiums and cost-sharing from waiver under § 1115.

Response: CMS has approved premiums in other States (e.g., Iowa and Michigan). As stated in Comment 1, Section 1115 of the Social Security Act gives the Secretary broad authority to waive certain provisions of the Act. CMS has encouraged the State to bring proposals to CMS without trying to determine ahead of time all of the authorities needed for obtaining approval for the proposal. CMS has offered to use the flexibility available to it under statute to determine if there is a legal pathway forward to allow the State to pursue the flexibility it was seeking.

58. Many commenters stated that premiums serve as a barrier to obtaining and maintaining Medicaid for those with low incomes. They also state premiums result in increases in disenrollment, shorter lengths of enrollment, and serve as a deterrent to those eligible from enrolling.

Response: Medicaid beneficiaries who will pay premiums are those who have been eligible for coverage in the federal marketplace and have likely paid premiums before. When members financially participate in their healthcare they are more engaged in their healthcare decisions and better prepared for future health coverage in the private sector.

59. One commenter stated the proposed waiver does not indicate whether services received during the suspended period would be retroactively covered.

Response: Individuals can request coverage for months in which they failed to pay premiums (up to 3 months). However, they must pay past due premiums to regain eligibility. If it has been more than six months from when the coverage ended, they will not be required to pay past due premiums.

60. One commenter stated they are concerned there is no grace period in which to pay the premium before they lose eligibility.

Response: The State is proposing to follow the process used for the Children's Health Insurance Program (CHIP), which is consistent with private health insurance. Individuals must pay their premium by the end of the month it is due or they will lose eligibility. Individuals may also need to pay past due premiums to regain eligibility. If it has been more than six months from when the coverage ended, they will not be required to pay past due premiums.

61. Several commenters stated there will be a high administrative cost to implementing and collecting premiums. They believe the State has not included any consideration of the administrative costs of a premium.

Response: The State intends to build upon existing infrastructure for collecting premiums from CHIP members. This is expected to mitigate the increased administrative cost of collecting premiums for Medicaid Expansion adults with incomes from 101-133 percent FPL. The State is still developing its estimates for the cost of implementing and collecting these new premiums.

62. One commenter stated the State is offering an overly optimistic percentage of people who would fail to pay a premium.

Response: The State is estimating that disenrollment due to non-payment of premiums will be similar to experience with Marketplace plan enrollees. The State used information from Washington State's Annual Grace Period Report (2017)[1] in which 5,077 enrollees out of 149,628 were terminated for non-payment of premiums. This equates to 3.4 percent and the State has assumed the same percentage.

[1] https://www.wahbexchange.org/wp-content/uploads/2018/01/HBE_EB_180112_Annual-Grace-Period-Report.pdf