



Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

To Whom It May Concern:

The Disability Law Center (DLC) is grateful for the opportunity to offer feedback on Utah's proposal to amend its Medicaid state plan and 1115 Primary Care Network demonstration waiver to incorporate the provisions of HB 437: Health Care Revisions. Our comments consist of requests for clarification and suggestions for ways to provide quality and affordable healthcare coverage to more of the most vulnerable among us.

The DLC is the federally-mandated protection and advocacy agency for people with disabilities in Utah. We envision a society where persons with disabilities are full and equal citizens under the law, are free from discrimination, and have access to the same opportunities afforded others. Our mission is to enforce and strengthen laws that protect the opportunities, choices and legal rights of Utahns with disabilities. The organization's services are available statewide and free of charge, regardless of income, legal status, language, or place of residence.

General

The DLC continues to believe full Medicaid expansion offers the state the best bang for its buck when it comes to improved health outcomes and fiscal responsibility. Even though it was predictable, we're tremendously troubled by the decline from 16,000 to 10,000 in the estimated number of Utahns who will benefit from these much-needed services and supports. Additionally, we're deeply disappointed to learn the legislature may reduce the number of slots for parents in the Primary Care Network, especially considering healthcare costs are often cited as contributing to economic instability. In turn, economic instability may lead to an increased chance of contact with the criminal justice system or homelessness. Paradoxically, reducing the likelihood of these outcomes is the primary rationale for Utah's approach to expanding Medicaid.

Positives

As frustrated as the DLC is with the waiver amendment's shrinking scope and ambition, we're thankful for Rep. Dunnigan's acknowledgment of the need, and his effort to do something about it. Specifically, we're grateful that around 4,000 more parents with children will be covered. At the same time, we hope the Department of Health (DOH) will use the flexibility it's seeking to explore options for expanding the reach of the program further.

Even though we've expressed concern with the declining numbers, we're thankful for the recognition of the critical role Medicaid can play in keeping several thousand more extremely

low-income Utahns with mental health and/or substance use disorders off the street and out of the criminal justice system. We appreciate the focus on the diversionary potential of mental health/drug courts and other community-based programs. We're also pleased to know these vulnerable groups will have the opportunity to experience at least some stability as the result of the inclusion of 12-month continuous eligibility.

Finally, given the constraints placed on it, we feel it's important to acknowledge the commitment and dedication of the Department to making sure the program reaches, and is useful to, as many Utahns as possible.

Concerns

There are around 63,000 Utahns in the state's coverage gap. They earn too much to qualify for Medicaid, but not enough to qualify for a subsidy through the federal exchange. By focusing on the sickest and most expensive members of this population, the waiver amendment barely makes a dent in this unacceptably high number. If it's based on them, we're worried the higher costs usually associated with these groups could negatively impact any future evaluation of the feasibility of expanding the program further.

Also, the prospect of stability offered by 12-month continuous eligibility is undercut by the fact that childless adults with the most significant needs can only remain eligible if they earn less than \$600 per year. The same issue arises for a parent with two children earning just over \$12,000 a year. The only way to reliably reduce homelessness and/or contact with the criminal justice system is to ensure an individual or family has meaningful employment paying a living wage. This is not a realistic prospect if an individual is forced to choose between a job and healthcare.

Additionally, the amendment says the benefits for parents will be different than those offered to traditional Medicaid enrollees. It's our understanding that the difference is limited to the number of physical or occupational therapy visits. If, in fact, the difference is so minor, wouldn't offering traditional Medicaid across the board be easier? If not, the apparent contradiction ought to be clarified and explained.

Populations

Mental Health/Substance Use

An estimated 97,000 Utahns have a mental illness. Somewhere around 230,000 have a substance use disorder. An important component of quality care for these groups is parity. That's why we appreciate DOH's recognition of the importance of providing the same level of access to physical and mental health care. To that end, we strongly support the Department's proposal to remove the 30-day limit for inpatient mental health treatment and the 30-visit limit for outpatient care; the addition of targeted case management for substance use disorders; and removal of the 30-visit limit on targeted case management services for the chronically mentally ill. Even so, the legislature reduced the ongoing appropriation for mental health and substance use treatment based on the assumption that around 12,000 of these persons would receive services through Medicaid, with the additional federal match making up the difference. Given the numbers are

now more likely between 6-7,000 individuals, it's imperative to find a way to restore funding to ensure critical treatment and supports remain available to this vulnerable population.

The majority of individuals with serious mental illness/substance use disorders likely already qualify for disability Medicaid, and can enroll now. Instead of taking up slots which could be utilized by others, would targeted outreach and enrollment assistance to those not already categorically eligible be a better approach? Also, while a small number of individuals are civilly committed to the Utah State Hospital (USH), a larger number are committed to local mental health authorities. Both groups need access to quality and comprehensive care to maintain continuity and continue their recovery once released. Perhaps allocating separate slots for those served at USH and in the community makes sense? Additionally, residential treatment length-of-stay should be determined by medical necessity. Along the same lines, what's the rationale for the different adult and youth length-of-stay maximums? Finally, has the Department thought through what options exist for individuals requiring a stay longer than 90 days?

Chronically Homeless

According to the state's 2015 point-in-time count, there are approximately 3,025 homeless Utahns; about 223 of them are considered chronically homeless. Consequently, the success of the program in reaching this population will depend on how chronic homelessness is defined and which subgroups it includes. For example, how is an episode of chronic homelessness defined, measured, and verified? How do we account for individuals served by agencies not connected to the homeless management information system? Additionally, while we appreciate the inclusion of permanent supportive housing, will it encompass those residing in transitional housing or engaged in rapid rehousing as well? If not, we're potentially leaving more than a quarter of this population without access to quality coverage or care.

While we're pleased a stay of less than 90 days will not constitute a break in homelessness for eligibility purposes, we're concerned that requiring a disabling condition in addition to homelessness will further narrow the applicability and usefulness of the program for this very vulnerable subgroup. Furthermore, how would such a condition be defined? We're aware the Department is considering a definition encompassing developmental disability, PTSD, TBI-related cognitive impairments, and chronic illness, or disability, as well. While we certainly support the broader scope, we again note that many of these individuals may already be eligible for Medicaid through other entry points. If DOH decides to go this route, we may be missing an opportunity to cover more individuals, or those with different, but no less serious, needs.

Criminal Justice-Involved

Medicaid expansion was originally packaged as part of the solution to funding criminal justice reform. However, this group is part of the nonparent population and may now only include 3-5,000 individuals. The continued lack of adequate funding may ultimately undermine the shared goal of reducing recidivism. Similarly, by requiring court-ordered treatment, the program is foreclosed to those on pretrial release or whose time has expired. While we also understand the rationale for preferring rapid re-enrollment for recently released individuals (unpredictable release dates and living situations), we would like to see DOH and DWS revisit the possibilities around suspension, given CMS' recent guidance. Additionally, we strongly encourage exploring

the possibility of partnering with probation/parole officers, navigators, and application counselors to help bridge the gap between release and enrollment.

While it's certainly not sufficient, there's some structure and a few resources available to paroled state inmates. However, because local mental health authorities only have the vaguest of mandates to serve county jail inmates with mental illness, and severely limited resources once they're out, we strongly recommend that any safety net offered through the waiver amendment be designed to keep this subgroup from falling through the cracks.

Even though the waiver states that qualifying mental health and substance use disorder treatment programs will be articulated in administrative rule, outside of the Utah State Prison and Salt Lake County jail it's unclear whether qualifying programs exist, particularly in rural jails.

Additionally, because mental health treatment is frequently highly individualized, there appear to be fewer structured programs to choose from. Especially on the mental health side, where recovery is even more of an ongoing process, this raises the question of how "successful completion" is defined, measured, and verified?

What happens to individuals who are unable to complete successfully prior to their release for whatever reason? Are they eligible for the program? How long after successful completion is an ex-offender eligible? Perhaps it's possible to make an ex-offender who's actively engaged in treatment eligible for the program, similar to the mental health or drug court participation criteria?

General Assistance

The GA population is already extremely small. Requiring a mental health or substance use disorder makes this already narrow program even less beneficial to this extraordinarily vulnerable population. On the other hand, most individuals in this category with a mental health or substance use diagnosis are already likely eligible for Medicaid. Once again, perhaps emphasizing outreach and enrollment efforts, while targeting individuals with other needs who are less likely to categorically qualify, would be a more fruitful strategy?

Outcome Measures

While we appreciate the Department's replacement of a reduction in the length of homelessness and the number of hospital admissions with a year-two reduction in nonemergent use of the ER, we still suggest tracking and reporting mental health and/or drug court completion and recidivism rates over time for enrollees.

Physical/Behavioral Health Integration

Even though the waiver contemplates the integration of physical and mental health care as a future amendment, we don't want this important piece of the puzzle to be forgotten or lost. Therefore, we suggest convening a working group to design the integration pilot while the waiver is being finalized. This way, important components of the expansion and pilot can be coordinated to avoid future confusion and frustration.

Thank you for your time and consideration of our input and feedback. We look forward to serving as a resource in any way we can as the implementation process moves forward. In the meantime, if you have questions or would like more information, please don't hesitate to contact us.