DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

Mr. Michael Hales
Director, Utah Medicaid and Health Financing
P.O. Box 143101
Salt Lake City, UT 84114-3101

SEP 2 8 2012

Dear Mr. Hales:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving your request to amend Utah's section 1115 demonstration project, entitled Primary Care Network (11-W-00145/8 and 21-W-00054/8). This amendment increases the income eligibility level for demonstration populations III and V from 150 percent of the Federal Poverty Level (FPL) to 200 percent of the FPL. This amendment is effective as of the date of this letter.

CMS approval of this section 1115 demonstration amendment is subject to the limitations specified in the approved waiver and expenditure authorities and not applicables list. The State may deviate from the Medicaid State plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to the expenditure authorities. All requirements of the Medicaid program as expressed in law, regulation, and policy statement not expressly waived or identified as not applicable shall apply to Utah's Primary Care Network Demonstration. This approval is also conditioned upon continued compliance with the enclosed special terms and conditions (STCs) defining the nature, character, and extent of Federal involvement in this project.

These approvals are conditioned upon written acceptance from the State that it agrees with the amendments, expenditure authorities, and STCs. This written acceptance is needed for our records within 30 days of the date of this letter.

Your project officer is Mr. Robert Nelb. He is available to answer any questions concerning your section 1115 demonstration. Mr. Nelb's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Division of State Demonstrations and Waivers
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-1055
Facsimile: (410) 786-8534
E-mail: robert.nelb@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Nelb and to Mr. Richard Allen, Associate Regional Administrator in our Denver Regional Office. Mr. Allen's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health
Colorado State Bank Building
1600 Broadway, Suite 700
Denver, Colorado 80202-4367

If you have questions regarding this approval, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP Services, at (410) 786-5647.

Sincerely,

Cindy Mann
Director

Enclosures

cc: Victoria Wachino, CMCS
Richard Allen, Associate Regional Administrator, Region VIII

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBERS: 11-W-00145/8 Title XIX
21-W-00054/8 Title XXI

TITLE: Primary Care Network (PCN)

AWARDEE: Utah Department of Health

Title XIX Waivers

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as *not applicable* in this list, shall apply to the demonstration project under title XIX of the Social Security Act (the Act) beginning July 1, 2010, through June 30, 2013. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

1. **Statewideness/Uniformity** **Section 1902(a)(1)**

To enable the State to provide differing types of managed care plans in certain geographical areas of the State for title XIX populations affected by this demonstration.

2. **Amount, Duration, and Scope of Services and Comparability** **Section 1902(a)(10)(B)**

To enable the State to provide benefits to Title XIX State plan populations affected by this demonstration (defined as "Current Eligibles") that are less than those available to other individuals under the State plan. In addition, this waiver enables the State to include additional benefits for Demonstration Eligibles and Current Eligibles, who are enrolled in a managed care delivery system, such as case management and health education, compared to the benefits available to individuals eligible under the State plan who are not affected by the demonstration.

3. **Freedom of Choice Section 1902(a)(23)**
To enable the State to restrict freedom of choice of providers for title XIX populations affected by this demonstration.

4. **EPSDT Section 1902(a)(43)**
To enable the State not to cover certain services required to treat a condition identified during an EPSDT screening.

This waiver applies to 19 and 20 year olds for all title XIX populations affected by this demonstration.

Title XXI Waivers

All requirements of the SCHIP program expressed in law, regulation, and policy statement, not expressly waived or identified as *not applicable* in this list, shall apply to demonstration project under title XXI of the Act beginning July 1, 2010, through June 30, 2013. In addition, these waivers may only be implemented consistent with the approved STCs.

1. Cost Sharing Exemption for American Indian/Alaskan Native (AI/AN) Children **Section 2102**

To the extent necessary to permit AI/AN children who are in all CHIP populations affected by this demonstration, and whose benefits are limited to premium assistance, to be charged premiums and/or cost sharing by the plans in which they are enrolled.

2. Benefit Package Requirements **Section 2103**

To permit the State to offer a benefit package for all CHIP populations affected by this demonstration that is limited to premium assistance.

3. Cost Sharing **Section 2103(e)**

To the extent necessary to permit all CHIP populations affected by this demonstration, whose benefits are limited to premium assistance, to have cost sharing imposed by employer-sponsored insurance plans.

4. **Qualified Employer Sponsored Coverage Section** **2105(c)(10).**

To permit the State to continue to offer a premium assistance subsidy to all CHIP populations affected by this demonstration that does not meet the requirements of section 2105(c).

CENTERS FOR MEDICARE & MEDICAID SERVICES
COSTS NOT OTHERWISE MATCHABLE AUTHORITIES

NUMBERS: 11-W-00145/8 (Title XIX)
21-W-00054/8 (Title XXI)

TITLE: Primary Care Network (PCN)

AWARDEE: Utah Department of Health

Medicaid Costs Not Otherwise Matchable Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of this demonstration, be regarded as matchable expenditures under the State's Medicaid title XIX State plan:

1. (Current Eligibles). Expenditures for optional services not covered under Utah's State plan or beyond the State plan's service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the Federal managed care regulations at 42 CFR 438 *et seq.*

2. (Demonstration Population I). Expenditures to provide PCN coverage to non-disabled and non-elderly individuals age 19 through 64 with incomes above the Medicaid standard but at or below 150 percent of the Federal poverty level (FPL) who are eligible for Medicaid but only through this section 1115 Medicaid demonstration project.

3. (Demonstration Population II). Expenditures to provide full Medicaid coverage to high-risk pregnant women with assets in excess of the limit established by the State plan.

4. (Demonstration Population III). Expenditures for premium assistance related to providing 12 months of guaranteed eligibility to subsidize the employee's share of the costs of the insurance premium for employer sponsored health insurance to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above the Medicaid standard but at or below 200 percent of the FPL, as well as their spouses, who are eligible for Medicaid but only through this section 1115 Medicaid demonstration.

5. (Demonstration Population V). Expenditures for premium assistance related to providing up to a maximum of 18 months of eligibility to subsidize the employee's share of the costs of the COBRA premium for COBRA continuation of coverage to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above the Medicaid standard but at or below 200 percent of the FPL, as well as their spouses, who are eligible for Medicaid but only through this section 1115 Medicaid demonstration.

Medicaid Requirements Not Applicable to the Demonstration Eligible Populations:

All requirements of the Medicaid statute will be applicable to those individuals who are made eligible for services solely by virtue of the demonstration project, for whom, under the expenditure authority listed above, the State will receive Federal financial participation in its expenditures, except those requirements specified below:

1. **Cost Sharing Requirements** — **Section 1902(a)(14) insofar as it Incorporates Section 1916 and 1916A**

To permit cost sharing that is more than nominal to be imposed upon the PCN's beneficiaries.

2. **Amount, Duration, and Scope of Services and Comparability** — **Section 1902(a)(10)(B)**

To enable the State to vary the amount, duration, and scope of services offered to individuals by Demonstration group, with the exception of Demonstration Group II to whom State plan services will be provided. In addition, this waiver enables the State to include additional benefits such as case management and health education not available to Medicaid beneficiaries enrolled in a managed care delivery system.

3. **Federally Qualified Health Centers Payments** — **Section 1902(a)(15) and Section 1902 (bb)**

To permit the State to pay for Federally Qualified Health Center services provided to Demonstration Population I beneficiaries on a basis other than a prospective payment system.

4. **Retroactive Eligibility** — **Section 1902(a)(34)**

To permit the State to eliminate retroactive eligibility for individuals in Demonstration Populations I and III.

CHIP Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A), State expenditures described below, shall, for the period beginning (December 15, 2009 through June 30, 2013), and to the extent of the State's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the State's title XXI plan. All requirements of title XXI will be applicable to such expenditures for the demonstration population for Demonstration Population VI, described below, except those specified below as not applicable to these expenditure authorities.

1. COBRA Children (Demonstration Population VI). Expenditures to provide premium assistance and benefits specified in the special terms and conditions (to children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child except for continuation of coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985

(COBRA), Pub. L. 99-272, and who elect to receive such premium assistance within 60 days after the date of approval of this authority. Such expenditures are authorized without regard to the funding limitation under section 2105(c)(2) of the Act. Moreover, the title XXI requirements listed below do not apply to the benefits for this population.

CHIP Requirements Not Applicable to CHIP Expenditure Authorities for Demonstration Population VI

1. **General Requirements, and Eligibility Screening Requirements** — **Section 2102**

The State child health plan does not have to reflect the demonstration population. Eligibility screening is not required to exclude eligibility for individuals enrolled in continuation coverage pursuant to COBRA.

2. **Restrictions on Coverage and Eligibility to Targeted Low-Income Children** — **Section 2103 and 2110**

Coverage and eligibility is not restricted to targeted low-income children, to the extent that it includes individuals enrolled under continuation coverage pursuant to COBRA.

3. **Qualified Employer Sponsored Coverage** — **Section 2105(c)(10)**

To permit the State to offer a premium assistance subsidy that does not meet the requirements of section 2105(c).

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBERS: **11-W-00145/8 (Title XIX)**
21-W-00054/8 (Title XXI)

TITLE: **Primary Care Network**

AWARDEE: **Utah Department of Health**

DEMONSTRATION EXTENSION PERIOD: **July 1, 2010 through June 30, 2013**

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I. PREFACE

The following are the Special Terms and Conditions (STCs) for Utah's Primary Care Network (PCN) Medicaid section 1115 demonstration program (hereinafter referred to as "Demonstration") for the waiver renewal under section 1115(f) of the Social security Act (the Act) for the extension period of July 1, 2010 through June 30, 2013. The parties to this agreement are the Utah Department of Health, Division of Health Care Financing ("State") and the Centers for Medicare & Medicaid Services ("CMS"). All requirements of the Medicaid and CHIP programs expressed in law, regulation and policy statement, not expressly waived or made not applicable in the list of Waivers and Expenditure authorities, shall apply to the Demonstration project.

The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective as of the approval letter's date, unless otherwise specified. Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the CMS Central Office Project Officer and the Regional Office State Representative at the addresses shown on the award letter. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. This Demonstration extension is approved through June 30, 2013. The STCs have been arranged into the following subject areas: program description and objectives, general program requirements, eligibility, benefits, enrollment, cost sharing, delivery systems, general reporting requirements, general financial requirements under title XIX, general financial requirements, monitoring budget neutrality for the demonstration, evaluation of the demonstration, and schedule of state deliverables during the demonstration extension.

II. PROGRAM DESCRIPTION AND OBJECTIVES

Utah's Primary Care Network (PCN) is a statewide section 1115 Demonstration to expand Medicaid coverage to certain able-bodied adults who are not eligible for State plan services and to offer these adults and children on the Children's Health Insurance Program (CHIP) an alternative to traditional direct coverage public programs. For State plan eligibles (referred to as Current Eligibles), who are categorically or medically needy parents or other caretaker relatives, the Demonstration provides a reduced benefit package and requires increased cost-sharing. Savings from this State plan population fund a Medicaid expansion for up to 25,000 uninsured adults age 19 to 65 with family incomes up to 150 percent of the Federal Poverty Level (FPL). This expansion population of parents, caretaker relatives, and childless adults is covered for a limited package of preventive and primary care services. Also high-risk pregnant women, whose resources made them ineligible under the State plan, are covered under the Demonstration for the full Medicaid benefits package. The PCN Demonstration was amended in October 2006 to also use Demonstration savings to offer assistance with payment of premiums for employer-sponsored health insurance (ESI) through Utah's Premium Partnership for Health Insurance (UPP). The UPP program uses Title XIX funds to provide up to $150 per month in ESI premium assistance to each uninsured working adult in families with income up to 200 percent FPL. UPP also uses Title XXI funds to provide premium assistance up to $120 per month per child for CHIP eligible children with family income up 200 percent FPL. UPP children receive dental coverage through direct CHIP coverage or they receive an additional $20 per month if they receive dental coverage through the ESI.

Section 1115(f) Extension – On March 1, 2010, the State of Utah formally requested an extension of the PCN Demonstration under the authority of Section 1115(f) of the Social Security Act. The demonstration, which would have expired on June 30, 2010, is approved for a 3-year extension from July 1, 2010, through June 30, 2013.

Previous Demonstration Waivers and Amendments:

- The Utah PCN 1115 demonstration waiver was submitted on December 11, 2001, approved on February 8, 2002, implemented on July 1, 2002, and was originally scheduled to expire on June 30, 2007.

- **Amendment #1** - This amendment made a technical correction needed to ensure that certain current Medicaid eligibles (i.e., those age 19 and above who are eligible through sections 1925 and 1931) in the demonstration who become pregnant get the full Medicaid State plan benefit package. It eliminated or reduced the benefit package for Current Eligibles to conform with changes to the benefits available under the State plan. Finally, it increased the co-payment for hospital admissions from $100 to $220, again to conform with changes to the State plan. (Approved on August 20, 2002, effective on July 1, 2002.)

- **Amendment #2** - This amendment provided a premium assistance option called Covered at Work (CAW) for up to 6,000 of the 25,000 potential expansion enrollees. Specifically, the State subsidizes the employee's portion of the premium for up to 5 years. The employer-sponsored insurance must provide coverage equal to or greater than the limited Medicaid package. The subsidy is phased down over 5 years, to provide a span of time over which employees' wages can increase to the point of unsubsidized participation in the employer-

sponsored plan. With this amendment, the State was also granted authority to reduce the enrollment fee for approximately 1,500 General Assistance beneficiaries, who are either transitioning back to work or are awaiting a disability determination. These individuals were required to enroll in PCN, but the $50 fee was prohibitive as they earn less than $260 per month. For this population, the State reduced the enrollment fee to $15. (Approved on May 30, 2003, effective on May 30, 2003.)

- **Amendment #3** - This amendment reduced the enrollment fee for a second subset of the expansion population. Specifically, approximately 5,200 individuals with incomes under 50 percent of the FPL had their enrollment fee reduced from $50 to $25. (Approved on July 6, 2004, effective on July 6, 2004.)

- **Amendment #4** - This changed the way that the maximum visits per year for Physical Therapy/Occupational Therapy/Chiropractic Services are broken out for the "Current Eligibles" ("non-traditional" Medicaid) population. Instead of limiting these visits to a maximum of 16 visits per policy year in any combination, the State provides 10 visits per policy year for Physical Therapy/Occupational Therapy and 6 visits per policy year for Chiropractic Services. (Approved on March 31, 2005, effective on March 31, 2005.)

- **Amendment #5** - This amendment implemented the adult dental benefit for the "Current Eligibles" population (section 1925/1931 and medically needy non-aged/blind/disabled adults). (Approved on August 31, 2005, effective on October 1, 2005.)

- **Amendment #6** - This amendment suspended the adult dental benefit coverage for Current Eligibles of Amendment #5 above. (Approved on October 25, 2006, effective on November 1, 2006.)

- **Amendment #7** - This amendment implemented an increase in the prescription co-payments for the Current Eligible population from $2.00 per prescription to $3.00 per prescription. (Approved on October 25, 2006, effective on November 1, 2006.)

- **Amendment #8** - This amendment implemented a Preferred Drug List (PDL) for Demonstration Population I adults in the PCN. (Approved on October 25, 2006, effective on November 1, 2006.)

- **Amendment #9** - This amendment implemented the State's Health Insurance Flexibility and Accountability (HIFA) application request, entitled State Expansion of Employer Sponsored Health Insurance (ESI) (dated June 23, 2006, and change #1 dated September 5, 2006). Also, this amendment suspended Amendment #2 - for the CAW program, which was absorbed by the new HIFA-ESI program. (Approved on October 25, 2006, effective on November 1, 2006.)

  This amendment provides the option of ESI premium assistance to adults with countable household income up to and including 150 percent of the FPL, if the employee's cost to participate in the plan is at least 5 percent of the household's countable income. The State subsidizes premium assistance through a monthly subsidy of up to $150 per adult. The

employer must pay at least half (50 percent) of the employee's health insurance premium, but no employer share of the premium is required for the spouse or children. Likewise, an ESI component for children provides CHIP-eligible children with family incomes up to and including 200 percent of the FPL with the option of ESI premium assistance through their parent's employer or direct CHIP coverage. The per-child monthly premium subsidy depends on whether dental benefits are provided in the ESI plan. If provided, the premium subsidy is $140 per month; otherwise, it is $120 per month. If dental benefits are not provided by a child's ESI plan, the State offers dental coverage through direct CHIP coverage. Families and children are subject to the cost sharing of the employee's health plan, and the amounts are not limited to the title XXI out-of-pocket cost sharing limit of 5 percent. Benefits vary by the commercial health care plan product provided by each employer. However, Utah ensures that all participating plans cover, at a minimum, well-baby/well child care services, age appropriate immunizations, physician visits, hospital inpatient, and pharmacy. Families are provided with written information explaining the differences in benefits and cost sharing between direct coverage and the ESI plan so that they can make an informed choice. All children have the choice to opt back into direct CHIP coverage at any time.

- **Amendment #10** – This amendment enables the State to provide premium assistance to children and adults for coverage obtained under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of employer-based group health coverage at group rates. COBRA coverage becomes available following the loss of employer sponsored insurance (ESI) due to specified qualifying events, such as an end of employment (voluntary or involuntary); divorce or legal separation; death of employee; entitlement to Medicare; reduction in hours of employment; and loss of dependent-child status. Through this amendment, Utah will provide premium assistance to programmatically-eligible adults and children (as differentiated from individuals who are COBRA-eligible but not otherwise eligible for the Utah COBRA premium assistance program) toward the purchase of COBRA coverage, in a manner similar to the provision of premium assistance for the purchase ESI coverage. (Medicare-eligible individuals who are also COBRA-eligible would be ineligible for the Utah COBRA Premium Assistance Program (CPAP) based on age or the State's standard processes of cross-matching with SSI/SSDI eligibility files).

  During its initial period of operation, Utah's COBRA Premium Assistance Program (CPAP) will work in tandem with the subsidy provided under ARRA for the purchase of COBRA coverage. Specifically, ARRA provides a Federal subsidy of 65 percent of the cost of COBRA coverage, to individuals and families affected by involuntary job loss occurring September 1, 2008, through December 31, 2009, and as extended by Congress. As long as the individual receives the ARRA subsidy, the State would provide the family with premium assistance based on the number of programmatically-eligible individuals, but limited to the lower of 35 percent of the cost of COBRA that remains the individual's responsibility or the maximum amounts allowable by the State under these STCs.

  The ARRA COBRA subsidy can last for up to 9 months, whereby individuals qualifying on December 31, 2009 could receive a subsidy through September 30, 2010. Once the ARRA

subsidy ends, or for those not eligible for the ARRA COBRA subsidy, the Utah CPAP will continue to provide a monthly payment for up to 18 months to offset the cost of COBRA coverage. Under the Utah program, the amount of premium assistance available to a family will be based on the number of programmatically-eligible individuals in the household. However, as with the existing ESI program, the State will use various administrative databases to ensure that it does not exceed the individual/family's share of the cost of the COBRA premium.

The Utah CPAP program will provide premium assistance to programmatically-eligible individuals and families with existing COBRA coverage, whether or not the individual qualifies for the ARRA COBRA subsidy. Individuals and families who are COBRA-eligible but uninsured may also apply for enrollment in the Utah CPAP. CPAP assistance will be limited to the maximums set in the ESI program, will last for the period of COBRA coverage, and will not exceed the family's share of the cost of the premium or the maximum amounts allowable as set by the State under these STCs. The amendment was approved by CMS on December 18, 2009.

Amendment #11 - This amendment raised the income eligibility for premium assistance for adults between the ages of 19 and 64 [Demonstration populations III (ESI) and V (COBRA)] from 150% of the FPL to 200% of the FPL. This amendment was approved by CMS on XXX.

- **Section 1115(e) Extension** - On June 23, 2006, the State of Utah formally requested an extension of their PCN 1115 demonstration waiver under the authority of Section 1115(e) of the Social Security Act. The demonstration, which would have expired on June 30, 2007, was approved for a 3-year extension from July 1, 2007, through June 30, 2010.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the Demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

    b. If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid or CHIP State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not

been approved through the amendment process set forth in paragraph 7 below *(Amendment Process)*.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved.

   a. Amendment requests must include, but are not limited to, the following:

      i. An explanation of the public process used by the State, consistent with the requirements of paragraph 15 *(Public Notice and Consultation with Interested Parties)*, to reach a decision regarding the requested amendment;

      ii. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

      iii. An up-to-date CHIP allotment neutrality worksheet, if necessary;

      iv. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

      v. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

   b. Changes to benefits described in the State plan shall be made by State plan amendment. Changes to benefits not described in the State plan shall be made by amendment to the Demonstration. Changes in benefits shall be implemented in accordance with the process set forth in Section V of these STCs.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

   As part of the Demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

a. Demonstration Summary and Objectives: The State must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

b. Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

c. Waiver and Expenditure Authorities: The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

d. Quality: The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.

e. Compliance with the Budget Neutrality Limit: The State must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the State must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

f. Draft report with Evaluation Status and Findings: The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The State may only suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has

ended, the State must provide a summary of each public comment received the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan.

The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b. Phase-out Plan Requirements: The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. Phase-out Procedures: The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

d. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

e. Post Award Forum: Within six months of the Demonstration's implementation, and annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the Demonstration. At least 30 days prior to the date of the planned public forum, the State must publish the date, time and location of the forum in a prominent location on its website. The State can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the Demonstration to meet the requirements of this STC. The State must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph IX.4 associated with the quarter in which the forum was held. The State must also include the summary in its annual report as required in paragraph IX.5.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the State's approved State plan, when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the State.

    In States with Federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal, and/or renewal of this Demonstration (42 C.F.R. §431.408(b)(3)). The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY

1. **Eligibility Criteria.** Mandatory and optional Medicaid State Plan populations derive their eligibility through the Medicaid State Plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived and as described in these STCs. Current Eligibles, as defined below, are included in the Demonstration to generate savings for covering the Expansion populations, to mandate enrollment in managed care by waiving the freedom of choice requirement, and to waive other specific programmatic requirements.

   Demonstration eligible populations are not otherwise eligible for Medicaid through the State Plan, and are only covered under Medicaid through the section 1115 demonstration.

2. **Eligibility Groups.** The Utah section 1115 Demonstration is comprised of the following Eligibility Groups:

   a. Current Eligibles are the following individuals, whose eligibility is derived from the State Plan, but whose coverage is affected by the demonstration: 1) adults age 19 and above who are eligible through section 1925 and 1931 of the Act, including those eligible through any liberalized section 1931 criteria already in the State plan; 2) adults age 19 through 64 who are medically needy and not aged, blind, or disabled. Individuals who are pregnant are excluded, through the 60th day post partum. Expenditures on current eligibles are considered demonstration expenditures for purposes of calculation of demonstration budget neutrality. There is no enrollment limit for this group. This population is a part of the original PCN demonstration and is not participating in the ESI program.

   b. Demonstration Population I is comprised of individuals age 19 through 64 with countable gross family income above the FPL levels for eligibility for Current Eligibles and at or below 150 percent of the FPL, who are U.S. citizens/legal residents, are residents of Utah, are not otherwise eligible for Medicaid through the State plan, do not qualify for Medicare or Veterans benefits, do not have other health insurance, and who are only covered under Medicaid through the section 1115 demonstration. There is no resource limit for Demonstration Population I.

      The State may exclude from Demonstration Population I individuals that have access to ESI such that the cost to the employee does not exceed a specified percentage of household countable income; the specified percentage may not exceed 15 percent.

      Demonstration Population I is subdivided into two groups:

      i. Custodial Parents/Caretaker Relatives: A population consisting of adults with children with family income levels that exceed the levels for eligibility under the State plan provisions implementing section 1931 of the Act. There is an annual average enrollment limit of 16,000 for this group.

ii. Childless Adults/Non-Custodial Parents: A Demonstration eligible population. There is an annual average enrollment limit of 9,000 for this group.

c. Demonstration Population II consists of pregnant women deemed by the State to be high risk, and who meet all Medicaid eligibility criteria under SOBRA, except that they have resources in excess of the limit established by the State plan. There is no enrollment limit for this group.

d. Demonstration Population III is comprised of working adults and their spouses age 19 through 64, with countable gross family incomes up to and including 200 percent of the FPL, who are U.S. citizens/legal residents, are residents of Utah, are not otherwise eligible for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and participate in an UPP-approved ESI plan where the employee's cost to participate in the plan is at least 5 percent of the household's countable income. Adults with incomes up to and including 150 percent of the FPL who would be eligible to participate in PCN as a member of Demonstration Population I, are only eligible for Demonstration Population III if they elect to receive premium assistance instead of PCN. These individuals are only covered under Medicaid through the section 1115 demonstration. Demonstration Population III is subdivided into two groups:

i. Custodial Parents/Caretaker Relatives: Adults with children with family income that exceeds the levels under the State plan provisions implementing section 1931 of the Act. There is no enrollment limit for this group.

i. Childless Adults/Non-Custodial Parents: A Demonstration eligible population. There is no enrollment limit for this group.

e. As of the 2010 renewal there is no Demonstration Population IV. This group is now referred to as the Current Eligible CHIP Children.

f. Demonstration Population V consists of adults age 19 through 64 with countable gross family income up to and including 200 percent of FPL, are U.S. citizens or legal residents, are resident(s) of Utah, do not qualify for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and would otherwise be eligible as a member of Demonstration Population III (except that the eligible individual or custodial parent/caretaker is able to enroll in COBRA continuation coverage based on any qualifying event rather than a qualifying ESI plan, and that COBRA-eligibles are not subject to the requirement that an employer subsidize at least 50 percent of the premium cost for the employee's health coverage).

Demonstration Population V is subdivided into two groups:

i. Custodial Parents/Caretaker Relatives: Adults with children with family income that exceeds the levels under the State plan provisions implementing section 1931 of the Act. .

ii. Childless Adults/Non-Custodial Parents: A Demonstration eligible population.

g. Current Eligible CHIP Children is comprised of children up to age 19 with family income up to and including 200 percent of the Federal poverty level (FPL) who would meet the definition of a targeted low-income child. These children are eligible for the CHIP, but the children's parents have elected to receive premium assistance for the employee's share of the cost of ESI instead of receiving CHIP direct coverage. There is no enrollment cap applied to this population. These children can opt back into direct coverage at any time.

h. Demonstration Population VI is comprised of children up to age 19 with family income up to and including 200 percent of the Federal poverty level (FPL) who would meet the definition of a targeted low-income child. These children can opt into direct coverage at any time. There is no enrollment cap applied to this population. Demonstration Population VI is subdivided into two groups:

   i. COBRA-Eligible Children: A child that meets the definition of a targeted low income child eligible under title XXI who is eligible and able to enroll in COBRA continuation coverage based on any qualifying event. These children are eligible for CHIP, but the child's parents have elected to receive premium assistance for the employee's share of the cost of COBRA continuation of coverage instead of receiving CHIP direct coverage.

   ii. COBRA Continuation Children: A child that meets the definition of a targeted low income children except for receipt of continuation coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272, and who elect to receive such premium assistance.

Table 1: Eligibility Groups

Note: This Table is presented for information purposes and does not change the State Plan requirements or otherwise establish policy.

Mandatory Medicaid State Plan Groups	FPL and/or Other Qualifying Criteria	Waiver Summary (see Waiver List) Costs Not Otherwise Matchable (see CNOM List)	Expenditure Reporting Form (see paragraph X.1(c), Medicaid, unless otherwise indicated)	Member-Month Reporting Category in section X.5, if applicable)
Section 1925 and 1931 TANF related adult family members	Income according to State Standard of Need	State wideness, Comparability, Freedom of Choice, EPSDT	PCN Current Eligibles	Current eligible
Optional Medicaid State Plan Groups				
Medically Needy adults who are not pregnant/post partum, aged, blind, or disabled	Individual must "spend down" to a Medically Needy Income Standard set by the State	State wideness, Comparability, Freedom of Choice, EPSDT	PCN Current Eligibles	Current eligible
PCN Demonstration Eligible Groups				
Adult custodial parents/caretaker relatives and childless adults/noncustodial parents Demonstration Population # 1	Up to and including 150% FPL	Comparability, Enrollment Fee, Freedom of Choice, EPSDT, Cost Sharing, FQHC, Retroactive Eligibility	PCN Adults w/Children(1) (parents/ caretaker relatives) PCN Childless Adults(1) (childless adults/noncustodial parents)	1902(r)(2)-PCN PCN Adults w/ Children (1) 1902(r)(2) - PCN Childless Adults(1) (childless adults/non-custodial parents)
High risk pregnant women Demonstration Population #2	SOBRA eligible except resources exceed State plan limit of $5,000	State wideness, Freedom of Choice,	PCN Demo Population 2	PCN Demo Population 2
ESI Demonstration Eligible Groups				
Adult custodial parents/caretaker relatives and childless adults/noncustodial parents Demonstration Population #3	Up to and including 200% FPL	Comparability, Freedom of Choice, EPSDT, Cost Sharing, Retroactive Eligibility	ESI Adults w/Children(3) (parents/ caretaker relatives) ESI Childless Adults(3) (childless adults/noncustodial parents)	1902(r)(2) - ESI Adults with Children ESI Childless Adults(3) (childless adults/non-custodial parents)

CHIP children of working adults - Current Eligible CHIP Children Population	Up to and including 200% FPL	Cost Sharing Exemption for AI/AN Children, Cost Sharing, Benefit Package Requirement	ESI Children (Title XXI)(4)	ESI Children
COBRA Premium Assistance Demonstration Eligible Groups				
Adult custodial parents/caretaker relatives and childless adults/noncustodial parents eligible for COBRA benefits Demonstration Population #5	Up to and including 200% FPL	Comparability, Freedom of Choice, EPSDT, Cost Sharing, Retroactive Eligibility	COBRA Adult w/ Children(5) (parents/ caretaker relatives) COBRA Childless Adult (5) (childless adults/non-custodial parents)	1902(r)(2) - COBRA Adults with children COBRA Childless Adult (5) (childless adults)
CHIP children of unemployed adults eligible for COBRA benefits Demonstration Population #6	Up to and including 200% FPL	Cost Sharing Exemption for AI/AN Children, Cost Sharing, Benefit Package Requirements	COBRA-Eligible Children COBRA-Continuation Children (Title XXI)	COBRA-Eligible Children COBRA-Continuation Children

V. BENEFITS

1. **Minimum for Current Eligibles.** Current Eligible adults enrolled in the Demonstration receive most of the services covered under Utah's State Plan according to the limitations specified in the State plan, except as modified below. This benefit package is reduced from that available under the State plan in accord with changes detailed in Table 2a. Any changes that would result in coverage limitations that are more restrictive than those listed in Table 2a, or less restrictive than both table 2a and the corresponding section of the Medicaid State plan, must be submitted as a demonstration amendment. If the State were to amend its Medicaid State plan to provide benefit limitations that are more restrictive than those listed in Table 2a (including elimination of any of the listed services), the revised State plan would determine the benefit. The State must notify the Project Officer of all planned changes to benefits for Current Eligibles, and provide an updated budget neutrality analysis with each such notification that shows the likely effect of the planned changes. CMS reserves the right to determine whether a change in benefits under the State plan that impacts this demonstration and effects budget neutrality for the demonstration would warrant an amendment. The State may not amend its Medicaid State plan to provide a Benchmark Benefit under section 1937 of the Act to Current Eligibles, or any subset of Current Eligibles, so long as this demonstration is in effect.

Table 2a - Benefits for Current Eligibles that are Different than State Plan Covered Services and Limitations

*The following Table is for illustrative purposes only and does not limit the State's ability to change the State Plan benefits through State Plan Amendments.

Service	Special Limitations for Current Eligibles
Hospital Services	Additional Surgical exclusions –See Utah Medicaid Provider Manual , Medical and Surgical Procedures Not Covered By The Non-Traditional Plan
Vision Care	One eye examination every 12 months, No eye glasses
Physical Therapy	Visits to a licensed PT professional (limited to a combination of 16 visits per policy year for PT and OT
Occupational Therapy	Visits to a licensed OT professional (limited to a combination of 16 visits per policy year for PT and OT
Speech and Hearing Services	Hearing evaluations or assessments for hearing aids are covered, Hearing aids covered only if hearing loss is congenital
Podiatry Services	Limited coverage for adults-(See Utah Medicaid Provider Manual, Non-Traditional Medicaid Plan)
Private Duty Nursing	Not covered
Abortions and	Same as traditional Medicaid with exclusions.

Service	Special Limitations for Current Eligibles
Sterilizations	(See Utah Medicaid Provider Manual, Non-Traditional Medicaid Plan)
Medical Supplies and Medical Equipment	Same as traditional Medicaid with exclusions. (See Utah Medicaid Provider Manual, Non-Traditional Medicaid Plan)
Organ Transplants	Kidney, liver, cornea, bone marrow, stem cell, heart and lung (includes organ donor)
Long Term Care	Not covered
Transportation Services	Ambulance (ground and air) for medical emergencies only (non-emergency transportation, including bus passes, is not covered)
Family Planning Services	Same as traditional Medicaid Services except for the following which are NOT covered: Norplant, infertility drugs, in-vitro fertilization, genetic counseling
Dental	Covered for pregnant women only. Remaining population limited to services to address relief of pain and infection.
Mental Health	30 inpatient days per year; 30 outpatient visits per year; also other exclusions. Can substitute OP visits for IP days.
Outpatient Substance Abuse	Services for substance abuse under FFS program and according to certain exclusions (See Utah Medicaid Provider Manual, Non-Traditional Medicaid Plan)
Targeted Case Management for the Chronically Mentally Ill	Targeted Case Management for the Chronically Mentally Ill sessions/visits count toward the 30 outpatient session/visit limit per enrollee per year (see Mental Health above)
Targeted Case Management for Substance Abuse	Not covered
Other Outside Medical Services	Services provided in freestanding ambulatory surgical centers

2. **Minimum for Demonstration Population I – PCN Eligibles.** The benefit package for Demonstration Population I is a limited benefit package of primary and preventative care services through the PCN program. These services include primary care physician, lab, radiology, durable medical equipment, emergency room services, pharmacy, dental, and vision. Covered services are often provided with different limitations than those covered in the State Plan. Inpatient hospital, specialty care, and mental health services are among the services that are not covered. The benefits are detailed in Table 2b. The benefit package for Demonstration Population I eligibles must be comprehensive enough to be consistent with

the goal of increasing the number of individuals in the State with health insurance, including at least a primary care benefit, which means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician. Medicaid State plan services other than those listed in Table 2b are not covered for Demonstration Population I. Should the State amend its Medicaid State plan to provide benefit limitations that are more restrictive for the services listed in Table 2b (including elimination of any of the listed services), the revised State plan would determine the benefit, and no demonstration amendment would be needed; all other changes to the benefit for Demonstration Population I must be made through a demonstration amendment. The State must notify the Project Officer of all planned changes to benefits for Demonstration Population I, and provide an updated budget neutrality analysis with each such notification that shows the likely effect of the planned changes.

Table 2b—Benefits for Demonstration Population I Eligibles that are Different than State Plan Covered Services and Limitations

*The following Table is for illustrative purposes only and does not limit the State's ability to change the State Plan benefits through State Plan Amendments.

Service	Special Limitations for Demonstration Population I
Hospital Services	Emergency Services in Emergency Room only
Physician Services	Services by licensed physicians and other health professionals for primary care services only
Vision Care	One eye examination every 12 months, no eyeglasses
Lab and Radiology Services	Lab and Radiology only as part of primary care services or as part of an approved emergency service as identified in the PCN Provider Manual
Occupational Therapy	Not covered
Chiropractic Services	Not covered
Speech and Hearing Services	Hearing evaluations for hearing loss or assessments for hearing aids are covered
Podiatry Services	Not covered
End Stage Renal Disease - Dialysis	Not covered
Home Health Services	Not covered
Hospice Services	Not covered
Private Duty Nursing	Not covered
Medical Supplies and Medical Equipment	Equipment only for recovery (see detail list in the PCN Provider Manual)
Abortions and Sterilizations	Not covered
'Inpatient Treatment for Substance Abuse and Dependency	Not covered
Organ Transplants	Not covered

Service	Special Limitations for Demonstration Population I
Long Term Care	Not Covered
Transportation Services	Ambulance (ground and air) for medical emergencies only (non-emergency transportation is not covered)
Family Planning Services	Consistent with physician and pharmacy scope of services. Not covered: Norplant, Infertility drugs, Invitro fertilization, Genetic counseling, Vasectomy, Tubal ligation.
High-Risk Prenatal Services	Not covered
Medical and Surgical Services of a Dentist	Not covered
Health Education including Diabetes and Asthma	Not covered
Pharmacy	Pharmacy services limited to 4 prescriptions per month; prior authorization required for non-PDL drugs when a PDL exists for a drug class; some injectables are covered in a pharmacy, and any other injectables identified in the PCN Provider Manual
Dental	Limited scope of services: Exams, Preventive services, Fillings, and Limited extractions.
Mental Health	Not covered
Outpatient Substance Abuse	Not covered
Targeted Case Management for the Chronically Mentally Ill	Not covered
Targeted Case Management for Substance Abuse	Not covered
Targeted Case Management for Homeless	Not covered
Targeted Case Management for HIV/AIDs	Not covered

3. **Minimum for Demonstration Population II – High Risk Pregnant Women Eligibles.** The benefit package for high risk pregnant women in Population II eligibles is that available under the Medicaid State Plan to pregnant women who are eligible to receive only services related to pregnancy, or to other conditions that may complicate pregnancy. No benefit

reductions implemented through demonstration authority apply to Demonstration Population II eligibles.

4. **Benefit Definition**

   a. **For Adults in Demonstration Populations III and V – Premium Assistance.** The sole benefit provided to persons eligible for premium assistance (through ESI or COBRA coverage) is assistance in paying the employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans.

   b. **For Children in Demonstration (Current Eligible CHIP Children and Demonstration Populations VI) – Premium Assistance.** The primary benefit provided to children eligible for premium assistance (through ESI or COBRA coverage) is assistance in paying the child's share of the employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans.

      Dental benefits for children will be offered through two paths. If the health benefit package that is available to a child through qualified premium assistance coverage includes dental benefits, the child's premium assistance will be approximately equivalent to the per-child-per-month cost under the title XXI State plan including dental costs. If a child does not receive dental benefits through the qualified premium assistance plan. The State's minimum dental coverage for children is set by legislation, and is benchmarked to the coverage of the largest private carrier. If dental coverage is not provided by the participating premium assistance plan, the coverage is the same as direct coverage.

   c. Utah will ensure that all participating premium assistance insurance plans cover well-baby/well-child care services, age-appropriate immunizations, and emergency care. The State will also ensure children receive physician visits, hospital inpatient, and pharmacy benefits, at a minimum. Utah may use State rules to establish a set of additional criteria that will be used to determine which insurance plans shall be "qualified plans."

   d. Benefits furnished by qualified premium assistance insurance plans are not benefits under this Demonstration; as indicated in paragraph V.4, the only benefit under this Demonstration is premium assistance. Qualified plans are not restricted from offering additional benefits, at the option of the plan, which may vary by the plan to which the individual or family has access.

5. **Choice of Benefit Plans.** An eligible individual or family may enroll in any qualified insurance plan that meets the requirements specified in State rules and is provided by their employer or to which they have access through COBRA.

6. **Premium Assistance Subsidy Determination.** Eligible individuals and families who enroll in a qualifying health benefit plan will receive premium assistance, under the following conditions:

a. In accord with the enrollment and implementation procedures as defined in section VI, the State will provide an eligible and enrolled individual or family with a premium assistance subsidy.

b. The premium assistance amount for participating plans:
   i. Must not exceed the maximum amount of the participant's share of the premium.
   ii. The maximum subsidy limit, which the State may adjust in accord with paragraph V.6(c), is:

- **For ESI plans –**

Adults = $150 per enrollee per month
Children = $120 per enrollee per month with State wrap around dental benefits.
Children = $140 per enrollee per month if the plan provides dental benefits comparable to those offered through direct State coverage.

- **For COBRA plans –**

Adults = $150 per enrollee per month
Children = $120 per enrollee per month with State wrap around dental benefits.
Children = $140 per enrollee per month if the plan provides dental benefits comparable to those offered through direct State coverage.

c. **Adjustments for Health Care Inflation.** For adults enrolled in the premium assistance programs, the State may increase the maximum amount per month as long as it does not exceed the without waiver ceiling amount established in the budget neutrality calculation of estimated service expenditures.

For children enrolled in the premium assistance programs, the per child monthly premium assistance payment will be approximately equivalent to the per-child-per-month cost under the title XXI State plan (excluding dental costs – currently $120 per month; or including dental costs – currently $140 per month).

d. The premium assistance subsidy will be paid directly to the individual / family up to the maximum amount specified in paragraph V.6(b-c).

e. The COBRA subsidy -

   i. For a qualified individual, who is determined to be an assistance-eligible individual under section 3001 of the American Recovery and Reinvestment Act of 2009 (ARRA) and can receive the nine-month ARRA COBRA subsidy, the UPP-Like COBRA program will provide additional premium assistance to subsidize the payment of the former employee's 35 percent share of the monthly premium for COBRA continuation coverage (up to the limits set below).

   ii. After the expiration of the ARRA COBRA subsidy, the Utah COBRA premium assistance program will subsidize the former employee's share in accord with paragraph V.6(b)

VI. ENROLLMENT AND IMPLEMENTATION

1. General Requirements

a. Unless otherwise specified in these STCs, all processes for eligibility, enrollment, redeterminations, terminations, appeals, etc. must comply with Federal law and regulations governing Medicaid and CHIP.

b. Any individual who is denied eligibility in any health coverage program authorized under this demonstration must receive a notice from the State that gives the reason for denial, and includes information about the individual's right to appeal.

c. The State will adhere to the demonstration population enrollment limits presented in Section IV *Eligibility*.

2. Enrollment in the PCN Program (Demonstration Population I).

a. Individuals applying for the PCN program must be screened for eligibility in Medicaid and CHIP, and enrolled in Medicaid or CHIP if determined eligible. Applicants who are determined not to be eligible for Medicaid or CHIP must then be screened for eligibility for Demonstration Population II (High Risk Pregnant Women), and if eligible enrolled as a High Risk Pregnant Women.

b. If an applicant is determined not to be eligible for other coverage (as specified in (a) above) and meets all of the eligibility criteria for PCN, and if PCN is open to new enrollment at the time of the determination, the applicant may be enrolled in PCN.

c. PCN may be closed to new enrollment either at the State's election, or because the enrollment limit specified in these STCs has been reached. If PCN is closed to new enrollment, the State will stop taking applications. Applications will not be held over for a new enrollment period. The State will notify CMS in writing at least thirty (30) days prior to the opening of enrollment and include the estimated date when enrollment will be closed. The State may separately open or close enrollment for the two PCN groups described in Section IV.2b.

d. The State will provide for a redetermination of eligibility at least once every 12 months.

3. Enrollment for High Risk Pregnant Women (Demonstration Population II)

a. Individuals applying for medical assistance as High Risk Pregnant Women must be screened for eligibility in Medicaid and CHIP, and enrolled in Medicaid or CHIP if determined eligible.

b. Any applicant that is determined not to be eligible for Medicaid or CHIP and meets all of the eligibility criteria for Demonstration Population II must be enrolled and become

eligible for services as a member of Demonstration Population II. The State may not close enrollment in Demonstration Population II.

c. Post-partum eligibility, redeterminations, notifications, and appeals will be handled in accord with procedures established in the State plan for Medicaid eligible pregnant women.

4. Enrollment in UPP for ESI Premium Assistance (Demonstration Populations III and Current Eligible CHIP Children).

a. Adults with incomes up to and including 150% of the FPL who have been determined eligible for the PCN (Demonstration Population I) may be given an opportunity to receive premium assistance for ESI through UPP, instead of the PCN benefit.

b. Adults with incomes up to and including 200% of the FPL who meet all other requirements for demonstration population III will be given the option to receive premium assistance for ESI through UPP.

c. Families with dependent children that are eligible for CHIP may elect to have their children receive premium assistance for ESI through UPP, instead of receiving CHIP coverage. However, children may opt back into direct coverage at any time.

d. The State must establish and maintain procedures (which may be done through rulemaking) that will:

i. Ensure that at least one adult family member is employed, that the employer offers health insurance as a benefit, that the benefit qualifies for the premium assistance subsidy, and that the employee elects to participate and maintains participation in the ESI plan for all individuals receiving UPP subsidies from the State;

ii. Provide written information prior to enrollment in UPP explaining the differences in benefits and cost sharing between direct PCN and/or CHIP coverage and ESI coverage, so that they can make an informed choice (if the individual is eligible for direct PCN and/or CHIP);

iii. Ensure the consent of the responsible adult family member to receiving premium assistance under UPP instead of coverage through PCN or CHIP (if the individual is eligible for direct PCN and/or CHIP);

iv. Allow children to opt out of ESI and begin receiving CHIP coverage at any time, with an immediate effective date upon request;

v. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled in ESI coverage and the individual's/family's share of the premium;

vi. Require clients to notify the Utah Department of Health within 10 days if they change their ESI plan, there is a change in the amount of their premium, or their ESI coverage is terminated;

vii. Ensure that the total amount of UPP subsidies provided to an individual or family does not exceed the amount of the employee's financial obligation toward their ESI coverage;

viii. Provide for recovery of payments made for months in which the individual or family did not receive ESI coverage. The Federal share must be returned within the timeframes established in statute and regulations; and

ix. Provide for a redetermination of eligibility at least once every 12 months.

5. Enrollment in Utah COBRA Premium Assistance Program

a. Adults with incomes up to and including 150% of the FPL who have been determined eligible for the PCN (Demonstration Population I) and who are eligible for COBRA continuation of coverage may be given an opportunity to receive premium assistance for COBRA coverage through UPP, instead of the PCN benefit.

b. Adults with incomes up to and including of 200% of the FPL who meet all other requirements for demonstration population V will be given the option to receive premium assistance for COBRA through UPP.

c. Families with dependent children that are eligible for CHIP, and whose children have lost COBRA-eligible ESI coverage, may elect to have their children receive premium assistance for COBRA coverage through UPP, instead of receiving CHIP coverage.

d. The State may offer premium assistance for COBRA coverage to all adults and children who are receiving COBRA coverage and who are receiving a subsidy of 65 percent of its cost under ARRA. COBRA premium assistance may be offered to adults and children who would be eligible for PCN or CHIP, respectively, if uninsured. Families must submit applications within the 60 day period referenced above to qualify for this assistance.

e. The State must establish and maintain procedures (which may be done through rulemaking) that will:

i. Ensure that at least one adult family member is eligible for COBRA continuation coverage, that the COBRA benefit qualifies for the COBRA premium assistance subsidy, and that the eligible individual elects to participate and maintains participation in the COBRA plan for all individuals receiving UPP COBRA subsidies from the State;

ii. Provide written information prior to enrollment explaining the differences in benefits and cost sharing between direct PCN and/or CHIP coverage and COBRA coverage, so that they can make an informed choice (if the individual is eligible for direct PCN and/or CHIP);

iii. Ensure the consent of the responsible adult family member to receiving COBRA premium assistance instead of coverage through PCN or CHIP (if the individual is eligible for direct PCN and/or CHIP);

iv. Allow children to opt out of the Utah COBRA Premium Assistance Program and begin receiving CHIP coverage at any time; with an immediate effective date upon request.

v. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled in COBRA coverage and the individual's/family's share of the premium. Verification may include the use of the Coverage Election Notice, forms developed by the State, and use of inter-agency administrative databases such as eFILE;

vi. Require clients to notify the Utah Department of Health within 10 days if there is a change in the amount of their premium or their COBRA coverage is terminated;

vii. Ensure that the total amount of the Utah COBRA Premium Assistance Program subsidy(ies) provided to an individual or family does not exceed the amount of the former employee's financial obligation toward their COBRA coverage, which must be net of any ARRA subsidy amount received;

viii. Provide for recovery of payments made for months in which the individual or family did not receive COBRA coverage. The Federal share must be returned within the timeframes established in statute and regulations; and

ix. Provide for a review of benefits on a timeframe consistent with anticipated changes in COBRA coverage or premiums and a redetermination of eligibility at least once every 12 months.

6. **Disenrollment from the Premium Assistance Programs.** If an individual / family is involuntarily disenrolled from a Demonstration premium assistance program, such as when a participating plan no longer meets the established State criteria or the individual meets the eligibility criteria for direct Medicaid coverage:

a. There is no sanction period before the adult, who has been involuntarily disenrolled from a premium assistance program, could be enrolled in the PCN program.

b. Adults involuntarily disenrolled from premium assistance will be seamlessly enrolled in the PCN program if they have an FPL less than 150%. PCN must immediately

enroll these individuals regardless if enrollment is closed to the general public to ensure that there is no break in coverage.

c. There is no sanction period before a child, who has been involuntarily disenrolled from a premium assistance program, could be enrolled in CHIP.

d. Children involuntarily disenrolled from premium assistance will be seamlessly enrolled in the CHIP program. Utah CHIP will ensure that there is no break in coverage.

7. **Interaction with Medicaid.** For individuals eligible for Demonstration Populations III (ESI adults) and V (COBRA adults) who are not eligible for Demonstration Population I (PCN), the State will offer opportunities for these individuals to enroll in Demonstration Population I or other direct Medicaid coverage if they are later determined to be eligible for such coverage.

a. Individuals may at any time apply for Medicaid, and if determined eligible, be enrolled in direct coverage.

b. At least every 12 months, the State must remind each individual by mail, an eligibility redetermination, or other comparable means that he or she is entitled to apply for Medicaid and provide directions on how to initiate an application. In particular, the reminder must point out that the participant is likely to qualify for Medicaid if pregnant.

c. Within 60 days of the award of these special terms and conditions, the State will submit a plan, for CMS approval, that addresses the State's process for transitioning Demonstration Population III and V eligible individuals who become eligible for Medicaid into direct coverage, if the individual elects such coverage.

g. COST SHARING

1. **Cost Sharing.** Cost sharing for Current Eligibles and Demonstration Populations I and II are described below.

   a. Current Eligibles. Cost sharing amounts for Current Eligibles may differ from those specified in the Medicaid State Plan, but may not exceed the amounts in the following table:

   b. Cost sharing amounts for Demonstration Population I may not exceed those approved in the Medicaid State plan for Current Eligibles, or the amounts shown in the table below, whichever are higher.

   c. Cost sharing amounts for Demonstration Population II may not exceed the highest amounts (by service) applicable to pregnant women, as specified in the Medicaid State plan.

Table 3: Comparison of Adult Medicaid Programs – July 2009

Benefit	Traditional Medicaid - usually 18 years or older	Non-Traditional Medicaid - usually 19 years or older	PCN- Fee for Service - 19 years or older
Out of Pocket Maximum	* **Pharmacy** $15 per month **Inpatient** $220 per year **Physician & Outpatient** $100 per year	$500 per calendar year per person	$1000 per calendar year per person (up to $50 enrollment fee not included)
Dental	*Not covered*	*Not covered*	10% co-pay - limited benefits
Emergency Room	* no co-pay. $6 co-pay for non-emergency use of the ER.	*no co-pay. $6 co-pay for non-emergency use of the ER.	$30 co-pay per visit - See PCN Member Guide for limitations
Family Planning	**Office visit** - no co-pay **Pharmacy** - no co-pay *See current OTC list*	**Office visit** - no co-pay **Pharmacy** - no co-pay *See current OTC list* *Implants and patches are not covered*	**Office visit** - $5 co-pay per visit **Pharmacy** - refer to pharmacy benefit , *See current OTC list* *Implants and sterilization not covered*
Inpatient Hospital	*$220 co-pay yearly for non-emergency stays	$220 co-pay each non-emergency stay	Not a covered service
Lab	no co-pay	no co-pay	Lab - 5% co-pay if Medicaid allowed amount over $50
Medical Equipment & Supplies	no co-pay	no co-pay	10% co-pay for covered services
Mental Health	no co-pay at prepaid Mental Health Center	no co-pay - limited benefit *30 annual inpatient, 30 annual outpatient visits*	Not a covered service
Occupational and Physical Therapy	no co-pay	$3 co-pay - *limited to a combined 10 visits per year*	Not a covered service

Office Visit & Outpatient	***Outpatient** - $3 co-pay per visit **Office visit** - $3 co-pay per visit	**Outpatient** - $3 co-pay **Office visit** - $3 co-pay per visit - *no co-pay for preventative care or immunizations*	**Outpatient** - not covered **Office visit** - $5 co-pay per visit - *Pregnancy related services not covered*
Pharmacy	*$3 co-pay per prescription limited to $15 monthly *Review process for more than 7 prescriptions per month* *Limited over-the-counter drug coverage*	$3 co-pay per prescription *Review process for more than 7 prescriptions per month* *Limited over-the-counter drug coverage*	*Limited to 4 prescriptions per month* **Generic** - $5 co-pay **Brand Name** - co-pay is 25%
Transportation	no co-pay	no co-pay - *limited to emergency transportation*	no co-pay - *limited to emergency transportation*
Vision Services	Optometrist – no co-pay for annual eye exam. Ophthalmologist - $3.00 co-pay for annual eye exam. Glasses not covered	Annual coverage limited to $30.00 for a medically necessary eye exam *Glasses not covered*	$5.00 co-pay for annual exam *Glasses not covered*
X-Ray	no co-pay	no co-pay	X-ray - 5% co-pay if Medicaid allowed amount over $100

2. **Demonstration Populations III and Current Eligible CHIP Children in ESI and Demonstration Populations V and VI in COBRA.** Adults and children of families that choose premium assistance will have cost sharing requirements (including the out-of-pocket maximum) as set by their qualified plan. Children who choose to receive coverage through premium assistance will be charged cost sharing amounts set by their ESI or COBRA coverage and will not be limited to the title XXI five percent (5%) out-of-pocket family income maximum. All other cost sharing, including co-payments, and co-insurance, are set by the qualified plan and the responsibility of the participant.

3. **Cost Sharing for Certain American Indian/Alaskan Native Eligibles.** American Indian/Alaskan Native individuals enrolled in the PCN demonstration are subject to cost sharing exemptions of section 5006 or the American Recovery Reinvestment Act of 2009 (and are not required to pay premiums or cost sharing for services received through the Indian health care system) except that such charges may be imposed on populations whose benefits are limited to premium assistance for ESI or COBRA coverage by the plans in which they enroll.

4. **Enrollment Fee.** The State may impose an annual enrollment fee of up to $50.00 for Demonstration Population I PCN eligibles. Any increase in the enrollment fees to a level above $50 must be submitted as a demonstration amendment. The State will provide CMS with written notification of any changes to the amount of the enrollment fee or waivers of the enrollment fee and provide information on the current enrollment fee policy in each Quarterly Report. No enrollment fee may be imposed on Current Eligibles or Demonstration Populations II, III, V, VI and Current Eligible CHIP Children.

VIII. DELIVERY SYSTEMS

1. **Enrollment in Managed Care.** The State may require Current Eligibles and Demonstration Populations I and II to receive the health care benefits to which they are entitled through managed care delivery systems, consistent with regulations at 42 CFR 438 *et seq.*

2. **Compliance with Managed Care Reporting Requirements** A status update on managed care delivery systems, including a discussion of recent developments, problems encountered and steps taken to resolve them, must be included in each Annual Report.

3. **ESI and COBRA Delivery Systems.** Demonstration Populations III through VI will receive services through the delivery systems provided by their respective qualified plan for ESI or COBRA premium assistance.

IX. GENERAL REPORTING REQUIREMENTS

1. **General Financial Requirements.** The State must comply with all general financial requirements, including reporting requirements related to monitoring budget neutrality, set forth in Section X. The State must submit any corrected budget and/or allotment neutrality data upon request.

2. **Monthly Enrollment Report.** Within 20 days following the first day of each month, the State must report Demonstration enrollment figures for the month just completed to the CMS Project Officer and Regional Office contact via e-mail, using the table below. The data requested under this subparagraph is similar to the data requested for the Quarterly Report in Attachment A under Enrollment Count, except that they are compiled on a monthly basis.

Demonstration Populations (as hard coded in the CMS 64)	**Point In Time Enrollment** (last day of month)	**Newly Enrolled Last Month**	**Disenrolled Last Month**
Mandatory Medicaid State Plan Groups			
Section 1925 and 1931 TANF related adult family members			
Optional Medicaid State Plan Groups			
Medically Needy adults who are not pregnant/post partum, aged, blind, or disabled			
PCN Demonstration Eligible Groups			
Adult custodial parents/caretaker relatives and childless adults/noncustodial parents Demonstration Population # 1			
High risk pregnant women Demonstration Population #2			
ESI Demonstration Eligible Groups			
Adult custodial parents/caretaker relatives and childless adults/noncustodial parents Demonstration Population #3			
CHIP State Plan Group			
CHIP children of working adults (Current Eligible CHIP Children)			
COBRA Premium Assistance Demonstration Eligible Groups			
Adult custodial parents/caretaker relatives and childless adults/noncustodial parents eligible for COBRA benefits - Demonstration Population #5			
CHIP children of unemployed adults eligible for COBRA benefits - Demonstration Population #6			

3. **Monthly Calls.** CMS will schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery,

enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any demonstration amendments the State is considering submitting. CMS will provide updates on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS will jointly develop the agenda for the calls.

4. **Quarterly Progress Reports.** The State must submit progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include the following, but are not limited to:

   a. An updated budget neutrality monitoring spreadsheet;

   b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, grievances, quality of care, and access that is relevant to the Demonstration, pertinent legislative or litigation activity, and other operational issues;

   c. Action plans for addressing any policy, administrative, or budget issues identified;

   d. Quarterly enrollment reports for Demonstration eligibles, that include the member months and end of quarter, point-in-time enrollment for each Demonstration population, and other statistical reports listed in Attachment A; and

   e. Evaluation activities and interim findings.

5. **Annual Report.**

   a. The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the Demonstration.

   b. The State will continually monitor the costs of providing premium assistance and of direct coverage and report the comparative assessment in the Annual Report.

   c. The State must submit the draft annual report no later than 120 days after the close of the Demonstration year (DY).

   d. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

6. **Transition Plan.** The State is required to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration. On September 30, 2011, the state submitted a draft transition plan describing the State's plans to implement the provisions of the ACA for individuals enrolled in the demonstration."

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

1. **Reporting Expenditures under the Demonstration.** The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide Federal financial payment (FFP) for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs. FFP will be provided for expenditures net of collections in the form of pharmacy rebates, enrollment fees, or third party liability.

   a. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality limit will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or l0.c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in item 2. DY1 will be the year beginning July 1, 2002 and ending June 30, 2003, and subsequent DYs will be defined accordingly.

   b. Premium offsets and enrollment fees that are collected by the State for enrollees under this demonstration shall be reported to CMS on the CMS-64 summary sheet. Enrollment fees shall be reported as an Administrative offset on Line 9.d., columns c and d. Premium offsets shall be reported as a Services offset on Line 9.d., columns a. and b. In order to assure that the demonstration is properly credited with these collections, please provide the appropriate information on the CMS-64 narrative.

   c. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (section XII). Utah must complete separate waiver forms for the following eligibility groups/waiver names:
      i. Current Eligibles,
      ii. PCN Adults w/Children(1),
      iii. PCN Childless Adults(1),
      iv. High Risk Pregnant Women(2),
      v. ESI Adults w/Children(3), and
      vi. ESI Childless Adults(3).
      vii. COBRA Adults with Children(5)
      viii. COBRA Childless Adults (5)

ix. Current Eligible CHIP Children(4) and COBRA Children(6) are reported on the applicable CMS-21 form.

2. **Expenditures Subject to the Budget Agreement.** For the purpose of this section, the term "expenditures subject to the budget neutrality limit" will include all Medicaid expenditures on behalf of all demonstration participants (i.e., Current Eligibles, Demonstration Population I, Demonstration Population II, Demonstration Population III, and Demonstration Population V as defined in section X.1(c)(*i-viii*) of the STCs).

3. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration, using separate CMS-64.10 waiver and 64.10 waiver forms, with waiver name "ADM".

4. **Claiming Period.** All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

5. **Reporting Member Months.** For the purpose of calculating the budget neutrality expenditure limit and other purposes, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the Eligibility Groups (EGs) as defined in Section IV and X.1 above. Enrollment information should be provided to CMS in conjunction with the quarterly and monthly Enrollment Reports referred to in section IX. If a quarter overlaps the end of one DY and the beginning of another DY, member/months pertaining to the first DY must be distinguished from those pertaining to the second.

   a. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

   b. There will be four demonstration populations that will be reported for the purpose of calculating the without waiver baseline (budget neutrality expenditure limit) using the following waiver names. The four groups used for calculating the budget neutrality expenditure limit are described below:

      i. "PCN Current Eligibles," as defined in section IV (*Eligibility*) of these STCs.

      ii. "PCN Adults with Children(1)" is a hypothetical group under "1902(r)(2) – PCN Adults with Children" and members of the Demonstration Population I, as defined in

the Eligibility section of these STCs, who could be eligible for Medicaid under section 1931 of the Act if the State further liberalized its eligibility criteria in its State plan. PCN Adults w/Children(1)" does not include members of Demonstration Population I who are childless adults/noncustodial parents, or members of Demonstration Populations II or III.

iii. "ESI Adults with Children(3)"is a hypothetical group under "1902(r)(2) – ESI Adults with Children" and are members of the Demonstration Population III, as defined in the Eligibility section of these STCs, who could be eligible for Medicaid under section 1931 of the Act if the State further liberalized its eligibility criteria in its State plan. "1902(r)(2) - ESI Adults w/Children(3)" does not include members of Demonstration Population III who are childless adults/noncustodial parents, or members of Demonstration Populations I or II.

iv. "COBRA Adults with children(5)" is a hypothetical group under "1902(r)(2) – COBRA Adults with Children" and are members of the Demonstration Population V, as defined in the Eligibility section of these STCs, who could be eligible for Medicaid under section 1931 of the Act if the State further liberalized its eligibility criteria in its State plan. "1902(r)(2) – COBRA Adults w/Children(X)" does not include members of Demonstration Population III, or members of Demonstration Populations I or II.

c. Demonstration Population II of pregnant women (reported as "PCN Demo Population(2)"), "ESI Childless Adults(3)", "COBRA Childless Adults(5)", and Private, Non-Group Coverage Childless Adults (7) will be reported separately, but not included in the title XIX budget neutrality expenditure limit.

d. Current Eligible CHIP Children of title XXI CHIP ESI Children (reported as "ESI Children") and Demonstration Population VI of title XXI (CHIP COBRA Children reported as "COBRA Children") reported as Non-Group Children will be reported separately. Expenditures for title XXI ESI Children and COBRA Children are reported on the CMS-21.

6. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality limit. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

7. **Extent of FFP for the Demonstration.** The CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in the Budget Neutrality Monitoring For the Demonstration section:

    a. Administrative costs, including those associated with the administration of the demonstration.

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.

    c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

8. **Sources of Non-Federal Share.** The State certifies that the matching non-Federal share of funds for the Demonstration is State /local monies. The State further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a. CMS may review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b. Any amendments that impact the financial status of the program shall require The State to provide information to CMS regarding all sources of the non-Federal share of funding.

9. **State Certification of Funding Conditions.** Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

10. **Corrective Actions to Resolve Financial Reporting Problems.** On October 26, 2006, in conjunction with approval of amendments to the PCN Demonstration, CMS required the State to take corrective actions to resolve financial reporting problems in Utah's CMS-64 report. Consistent with the CMS-64 reports that have been submitted by the State, the budget neutrality spreadsheets presented by the State in support of its Amendment #10 proposal show approximately $21.2 million in Federal savings for DYs 1-5. However, the

problematic financial reporting has resulted in an unreliable determination of budget neutrality for the PCN Demonstration. Although the State has made improvements to its financial reporting processes, work on correcting past financial reports has not progressed to the point where corrections can be made to the CMS-64 reports for DYs 1-5. Consequently, the following rules will apply to the determination of budget neutrality for the PCN Demonstration.

a. By January 31, 2010, the State must submit a written report to CMS that contains the following:

   i. Documentation of how it has accomplished all of the steps required under Phase II of the Terms and Conditions for the 1915(b) Choice of Health Care Provider & Hemophiliac Disease Management Waiver, which were provided to the State by letter from CMS on December 23, 2008;

   ii. A corrective action plan with implementation dates for all actions recommended by the Phase II auditor; and

   iii. The results of the State's work to complete the non-risk contract payment limit for SFY 2003, SFY 2004, and SFY 2005. CMS may require further corrective actions after reviewing the contents of this report.

b. When CMS considers all future amendments and renewals to the PCN Demonstration, the State will not have available budget neutrality savings of title XIX funds for DYs 1-5, until such time as CMS and the Federal Review Team have assessed the evidence presented by the State and determined whether any savings can be acknowledged for these DYs.

c. Budget neutrality savings for DY 1-5 cannot be available until CMS and the Federal Review Team (FRT) determine that CMS-64 reports for those years can be used as part of calculating budget neutrality. In order for CMS to determine that the CMS-64 reports for these years can be used for purposes of determining budget neutrality in DYs 1-5 and for the State to access savings from DYs 1-5, the State will:

   i. Using the methodology (consistent with subparagraph 10.c(iv)) for the non-risk contract payment limit test, conduct a review of contract payments for State fiscal year (SFY) 2003, SFY 2004, and SFY 2005 in order to make an upper payment limit calculation for the 1115 demonstration waiver program.

   ii. Verify that all capitation payments made to the Utah Prepaid Mental Health Program for Current Eligibles for SFYs 2003, SFY 2004, and SFY 2005 were correctly reported on the CMS-64 Waiver forms for the 1115 demonstration, that capitation payments made for other populations were excluded from those forms, and that if errors are discovered, determine appropriate adjustments.

iii. Make final corrections to the CMS-64 Waiver forms and expenditure reports through prior period adjustments.

iv. Submit an evidence package to CMS and the FRT describing the methodology the State used to determine: 1) the non-risk contract payment limit for the 1115 demonstration, and 2) the changes made to the CMS-64 Waiver forms and expenditure reports. This evidence package must be approved by CMS before budget neutrality for DYs 1-5 can be determined.

d. Should any future audit, other investigation, or corrections to the CMS-64s show that the demonstration was not budget neutral in DYs 1-5, the State must return any excess funds it received to the Federal government.

11. **State Assurances.**

a. Status at Time of Approval of Amendment #10. The acceptance of these STCs is Utah's confirmation that its information technology systems and administrative processes (including internal controls) are able to report reliably and accurately expenditures related to the 1115 demonstration to the CMS-64 system.

b. Implementing Changes Based on the Independent Audit. The State assures to CMS and the Federal Review Team that the budget neutrality of contemporary DYs is measurable and verifiable. This assurance will be verified in part through the Phase II audit findings. Should the Phase II audit find that the State's current information technology systems and administrative processes (including internal controls) are not sufficient to report expenditures related to the 1115 demonstration to the CMS-64 report reliably and accurately, CMS will require further corrective action until such assurances can be made.

c. Moving Forward. The State must assure CMS at all times of the integrity and accuracy of its claims processing systems and for the administrative processes associated with claiming FFP. In order to support the continuation of this Demonstration, future amendments, or extension requests, Utah must maintain the State's information technology systems and administrative processes (including internal controls) so that expenditures related to the 1115 demonstration are reliably and accurately reported on the CMS-64.

XI. GENERAL FINANCIAL REQUIREMENTS

1. **Expenditures Subject to the Allotment Neutrality Limit.** The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved CHIP plan and those provided through the Utah HIFA-ESI demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP only for allowable Utah demonstration expenditures that do not exceed the State's available title XXI allotment. Expenditures for Current Eligible CHIP Children and demonstration population VI are subject to the allotment neutrality limit.

2. **Quarterly Expenditure Reporting through the MBES/CBES.** In order to track expenditures under this demonstration, the State will report demonstration expenditures through the MBES/CBES, as part of the routine quarterly CMS-21 reporting process. Title XXI demonstration expenditures will be reported on separate Forms CMS-21 Waiver/CMS-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the DY in which services were rendered or for which capitation payments were made).

3. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.

4. **Standard Medicaid Funding Process.** The standard CHIP funding process will be used during the demonstration. Utah must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the State shall provide updated estimates of expenditures for the demonstration populations. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

5. **State Certification of Funding Conditions.** The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

6. **Limitation on Title XXI Funding.** Utah will be subject to a limit on the amount of Federal title XXI funding that the State may receive on Current Eligible CHIP Children and demonstration population VI expenditures during the waiver period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment,

including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the separate child health program or demonstration until the next allotment becomes available. Total Federal title XXI funds for the State's CHIP program (i.e., the approved title XXI State plan and this demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.

7. **Administrative Costs.** Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total title XXI net expenditures.

8. **Exhaustion of title XXI Funds.** If the State exhausts the available title XXI Federal funds in a Federal fiscal year during the period of the demonstration, the State may continue to provide coverage to the approved title XXI State plan separate child health program population, the Current Eligible CHIP Children, and Demonstration Population VI with State funds.

9. **Exhaustion of Title XXI Funds Notification.** All Federal rules shall continue to apply during the period of the demonstration that title XXI Federal funds are not available. The State is not precluded from closing enrollment or instituting a waiting list with respect to the Current Eligible CHIP Children and Demonstration Population VI. Before closing enrollment or instituting a waiting list, the State will provide prior notice to CMS.

XII MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

1. **Limit on Title XIX Funding.** The State will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

2. **Risk.** The State will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of Medicaid eligibles. By providing FFP for all eligibles, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of Medicaid eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

3. **Calculation of the Budget Neutrality Limit: General.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in paragraph 6 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The Federal share of this limit will represent the maximum amount of FFP that the State may receive during the Demonstration period for the types of Medicaid expenditures described below. The Federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in paragraph 7 below.

4. **Impermissible DSH, Taxes, or Donations.** CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments (if necessary adjustments must be made). CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

5. **"Hypothetical" Eligibility Groups.** Budget neutrality agreements may include optional Medicaid populations that could be added under the State plan but were not included in current expenditures. For this demonstration, these are the "1902(r)(2)-PCN Adults with Children," "1902(r)(2)-ESI Adults with Children" and "1902(r)(2)-COBRA Adults with Children" groups. However, the agreement will not permit access to budget neutrality "savings" from the addition of the group. A prospective per capita cap on Federal financial

risk is established for these groups based on the costs that the population is expected to incur under the demonstration.

6. **Demonstration Populations Used to Calculate the Budget Neutrality Limit.** For each DY, separate annual budget limits of Medicaid service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in section X. The trend rates and per capita cost estimates for each EG for each year of the demonstration are listed in the table below. The base year per capita amounts for "1902(r)(2)-PCN," "1902(r)(2)-ESI," and "1902(r)(2)-COBRA" are designated by the initials "BY." The monthly per person costs for Current Eligibles are derived from the State fiscal year base year (SFY 2001) monthly per person cost of $333.55, trended forward to DY1 using two years of an 8.0 percent annual trend. The trend rate of 6.6 percent for DY 6 through 8 is based on the FY-2007 President's Budget for the adult category. The trend rate of 6.3 percent for DY 9 through 11 is based on the FY 2010 President's Budget for the adult category. The per capita amounts shown below reflect rounding to the nearest cent at each step of the calculation.

DY	Current Eligibles Per Capita	Current Eligibles Trend	1902(r)(2)-PCN Adults with Children Per Capita	1902(r)(2) -ESI Adults with Children Per Capita	1902(r)(2) -COBRA Adults with Children Per Capita	1902(r)(2)-PCN-, ESI- and COBRA - Adults with Children Trends
1	$389.05	8.00%	$54.00 (BY)			8.00%
2	$420.17	8.00%	$58.32			8.00%
3	$453.79	8.00%	$62.99			8.00%
4	$490.08	8.00%	$68.02			8.00%
5	$529.29	8.00%	$73.47	$150.00 (BY)		8.00%
6	$564.22	6.60%	$78.32	$159.5		6.60%
7	$601.46	6.60%	$83.49	$170.45		6.60%
8	$641.16	6.60%	$89.00	$181.70	$181.70 (BY)	6.60%
9	$681.55	6.30%	$94.61	$193.15	$193.15	6.30%
10	$724.49	6.30%	$100.57	$205.32	$205.32	6.30%
11	$770.13	6.30%	$106.90	$218.25	$218.25	6.30%

7. **Composite Federal Share Ratio.** The Composite Federal Share is the ratio calculated by dividing the sum total of Federal financial participation (FFP) received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

8. **Exceeding Budget Neutrality.** The budget neutrality limit calculated above in Section XII paragraph 3will apply to actual expenditures for demonstration services as reported by the State under Section X. If at the end of the demonstration period the budget neutrality limit has been exceeded, the excess Federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

9. **New Funding.** If the State seeks to reallocate title XXI or Disproportionate Share Hospital funds to fund this demonstration, the State must request a demonstration amendment. These funds are only available on a prospective basis. In order to provide for a seamless continuation of 1115 waiver authority for the eligibles under title XIX, the State should provide CMS with adequate notification of the State's intent.

10. **Enforcement of Budget Neutrality.** The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. In addition, no later than 6 months after the end of each DY, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, it must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
DY 1	DY 1 budget neutrality cap	+8.0 percent
DY 2	DYs 1 and 2 combined budget neutrality limit	+3.0 percent
DY 3	DYs 1 through 3 combined budget neutrality limit	+1.0 percent
DY 4	DYs 1 through 4 combined budget neutrality limit	+0.5 percent
DY 5	DYs 1 through 5 combined budget neutrality limit	0 percent
DY 6	DYs 1 through 6 combined budget neutrality limit	+2.5 percent
DY 7	DYs 1 through 7 combined budget neutrality limit	+0.75 percent
DY 8	DYs 1 through 8 combined budget neutrality limit	0 percent
DY 9	DYs 1 through 9 combined budget neutrality limit	+2.5 percent
DY 10	DYs 1 through 10 combined budget neutrality limit	+.75 percent
DY 11	DYs 1 through 11 combined budget neutrality limit	0 percent

XIII EVALUATION OF THE DEMONSTRATION

a. **Submission of a Draft Evaluation Plan.** The State shall submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after CMS approval of the Demonstration extension. At a minimum, the draft design shall include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target population for the Demonstration. The draft design shall discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design shall include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

   As a component of the draft evaluation plan for the Demonstration, the State will conduct an outcomes analysis of the impact of the PCN program on individuals with chronic conditions.

b. **Inclusion of COBRA Special Study Components.** The State shall submit to CMS for approval an amendment to the Evaluation Plan referenced in section XIII.1 *(Submission of a Draft Evaluation Plan)* no later than 120 days after CMS's approval of the COBRA Premium Assistance Program. Suggested special study topics from which the State may choose for its amendment to the Evaluation Plan include, but are not limited to, the following:

   a. The impact of the COBRA subsidy on reducing the number of uninsured adults by 1,000 and the number of uninsured children by 500.

   b. The impact of the COBRA subsidy on reducing the number of uninsured when families purchase family or dependent coverage for individuals losing employer-sponsored health insurance.

   c. The impact of the COBRA subsidy on reducing the number of uninsured children not currently eligible for public health insurance who may be covered because of the family's choice to enroll in family coverage based on the premium assistance they receive through the Utah COBRA Premium Assistance Program.

   d. The impact of the COBRA subsidy on providing families with more options for obtaining health care and help them remain with their private coverage and by allowing parents and children to be enrolled in the same health insurance plan and helping families coordinate their health care.

   e. The impact of the COBRA subsidy on reaching families who are losing their health insurance but do not want to participate in direct coverage CHIP.

   f. A pre- and post-test impact of the ARRA COBRA subsidy on the uptake of the Utah COBRA Premium Assistance Program.

g. The source(s) of baseline and subsequent statewide and regional uninsured data.

3. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft evaluation plan within 60 days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State shall implement the evaluation plan and submit its progress in each of the quarterly and annual reports. The State shall submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration or with the State's application for renewal. CMS shall provide comments within 60 days after receipt of the report. The State shall submit the final evaluation report within 60 days after receipt of CMS comments.

4. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

5. **CMS Independent Evaluation.** Should CMS undertake an independent evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

6. **Evaluation Topics.** For the premium assistance programs, Utah will:

   a. monitor and report on progress toward understanding the barriers to health insurance participation by employers, health plans, and low-income working parents;

   b. address common administrative challenges or other obstacles for employers, health plans, and premium assistance recipients related to enrollment;

   c. evaluate key program outcomes to determine the program's effectiveness;

   d. include any limitations, challenges, or opportunities presented by the demonstration;

   e. include successes or best practices, interpretations or conclusions reached during the demonstration;

   f. examine and review the objectives and the hypotheses proposed as part of this demonstration; and

   g. inform CMS of the status of the State's evaluation in the quarterly and annual reports using the timeframes specified herein.

6. **Monitoring Premium Assistance.** The State will monitor the participating premium assistance plans and provide the following information in the State's demonstration annual report.

   a. For Demonstration Populations III, V, VI and Current Eligible CHIP Children enrolled in premium plans, the State will provide a summary of the benefits predominantly provided through the various participating plans across the State.

   b. The State must monitor the extent to which participating employers may decrease or cease to provide ESI. This monitoring can be accomplished by tracking changes in employer contribution levels toward ESI and/or by measuring the degree of substitution of ESI coverage.

   c. The State shall not only monitor such changes, but also shall be prepared to address substantial decreases in employer contribution levels and/or data delineating significant substitution of coverage.

XIV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	Deliverable	Paragraph
30 days after approval date	State acceptance of Demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
120 days after approval date	Submit Draft Design for Evaluation Report	XIII.1(a-g)
September 30, 2011	Submit a Transition Plan	IX.6
1 year before expiration of the demonstration	Submit a request for extension or a phase-out plan	III.8
120 days before expiration of the demonstration	Submit Draft Final Evaluation Report	XIII.2
	Submit Final Evaluation Report	XIII.2
Monthly Deliverables	Monitoring Call	IX.8
	Monthly Point-in-Time Enrollment Data	IX.2
Quarterly Deliverables Due 60 days after end of each quarter, except 4th quarter	Quarterly Progress Reports	IX.4
	Quarterly Expenditure Reports	Section X
	Enrollment Reports on all populations and on 21 Waiver Form in SEDS	IX.4 and Attachment A
Annual Deliverables Due 90 days after end of each 4th quarter	Annual Progress Reports	IX.5 and Attachment A
	Annual Expenditure Reports	IX.5
All Reports Required by Section 2500 of the State Medicaid Manual		

ATTACHMENT A

Under Section IX, paragraph 1 *(Quarterly Progress Report)* of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.
The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:
Title Line One – Utah Primary Care Network
Title Line Two - Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:
Example: Demonstration Year: 9 (7/1/2010 – 6/30/2013)
Federal Fiscal Quarter: 3/2010 (10/07 - 12/07)
Footer: Approval Period July 1, 2010 – June 30, 2013

I. Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any Demonstration amendments related to eligibility or benefits.

Please complete the following table that outlines all enrollment activity under the demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0".

III. EnrollmentCounts for Quarter
Note: Enrollment counts should be person counts, not member months

Demonstration Populations	Total No. Enrollees in current Quarter
Mandatory Medicaid State Plan Groups	
Section 1925 and 1931 TANF related adult family members	
Optional Medicaid State Plan Groups	
Medically Needy adults who are not pregnant/post partum, aged, blind, or disabled	
PCN Demonstration Eligible Groups	

Adult custodial parents/caretaker relatives and childless adults/noncustodial parents Demonstration Population # 1	
High risk pregnant women Demonstration Population #2	
ESI Demonstration Eligible Groups	
Adult custodial parents/caretaker relatives and childless adults/noncustodial parents Demonstration Population #3	
CHIP State Plan Eligible Children	
CHIP children of working adults (Current Eligible CHIP Children)	
COBRA Premium Assistance Demonstration Eligible Groups	
Adult custodial parents/caretaker relatives and childless adults/noncustodial parents eligible for COBRA benefits - Demonstration Population #5	
CHIP children of unemployed adults eligible for COBRA benefits - Demonstration Population #6	

IV. Outreach/Innovative Activities to Assure Access
Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for Demonstration enrollees or potential eligibles.

V. Collection and Verification of Encounter Data and Enrollment Data
Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

VI. Operational/Policy/Systems/Fiscal Developments/Issues
Identify all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the Demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

VII. Action Plans for Addressing Any Issues Identified
Summarize the development, implementation, and administration of any action plans for addressing issues related to the Demonstration.

VIII. Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the State's actions to address these issues.

IX. Member Month Reporting
Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Section 1925 and 1931 TANF related adult family members				
Medically Needy adults who are not pregnant/post partum, aged, blind, or disabled				
Adult custodial parents/caretaker relatives and childless adults/non-custodial parents Demonstration Population # 1				
High risk pregnant women Demonstration Population #2				
Adult custodial parents/caretaker relatives and childless adults/non-custodial parents Demonstration Population #3				
Adult custodial parents/caretaker relatives and childless adults/non-custodial parents eligible for COBRA benefits Demonstration Population #5				

B. Not Used in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
CHIP children of working adults (Current Eligible CHIP Children)				
CHIP children of unemployed adults eligible for COBRA benefits Demonstration Population #6				

X. Consumer Issues
A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

XI. Quality Assurance/Monitoring Activity
Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

XII. Demonstration Evaluation
Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XIII. Enclosures/Attachments
Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

XIV. State Contact(s)
Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

XV. Date Submitted to CMS