Table of Contents

State/Territory Name: Utah

State Plan Amendment (SPA) #: UT-25-0014 and UT-25-0033

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

September 12, 2025

Jennifer Strohecker
Medicaid Director
Director, Division of Integrated Healthcare
P.O. Box 143101
Salt Lake City, UT 84114-3101

Dear Director Strohecker:

Your Title XXI Children's Health Insurance Program (CHIP) State Plan Amendments (SPAs), UT-25-0033 and UT-25-0014, submitted on June 19, 2025, and June 27, 2025, respectively, have been approved. The effective date for these SPAs is July 1, 2024.

Through SPA UT-25-0033, Utah updates the CHIP State Plan to indicate that the State permanently eliminates premiums and adds a new managed care vendor, Healthy U. SPA UT-25-0014 updates the CS21 to reflect the removal of the CHIP premiums.

Your Project Officer is Joyce Jordan. She is available to answer your questions concerning this amendment and other CHIP-related matters and can be reached at Joyce.Jordan@cms.hhs.gov.

If you have additional questions, please contact Mary Beth Hance, Acting Director, Division of State Coverage Programs, at (410) 786-4299. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Alice Weiss/

Acting Director
on Behalf of Sarah deLone, Director

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: The State of Utah

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Jennifer Strohecker	Position/Title: Medicaid Director, Director of Integrated Healthcare
Name: Jennifer Wiser	Position/Title: CHIP Director
Name:	Position/Title:

***Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 09380707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at

42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State

plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)

5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42CFR, 457.90)
6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))
7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess

the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)

11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration

including the budget)
- 10 (Annual Reports and Evaluations).

Medicaid Expansion- Medicaid SPA Requirements
States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the descriptions of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections) indicating State

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under “Option to Expand Medicaid” would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in “Option to Create a Separate Program” would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Amy Lutzky
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid, CHIP and Survey & Certification
Mail Stop - S2-01-16

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1 ☒ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1. and 1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. ☐ A combination of both of the above. (Section 2101(a)(2))

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2 ☐ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3 ☒ Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan

Effective Date: July 10, 1998

Implementation Date: August 1, 1998

SPA #_10_, Purpose of SPA: Rebenchmark CHIP benefits

Proposed effective date: November 19, 2011

Proposed implementation date: November 19, 2011

SPA #_11_, Purpose of SPA:_ Express Lane Eligibility and Presumptive Eligibility -pending

Proposed effective date: ELE- September 1, 2011; Presumptive Eligibility- April 1, 2012

Proposed implementation date: ELE- September 1, 2011; PE- April 1, 2012

SPA #_12_, Purpose of SPA: Rebenchmark CHIP benefits

Proposed effective date: July 1, 2012

Proposed implementation date: July 1, 2012
Withdrawn

SPA #_13_, Purpose of SPA: Rebenchmark CHIP benefits

Proposed effective date: July 1, 2012

Proposed implementation date: July 1, 2012

SPA #_14_, Purpose of SPA: Eliminate Presumptive Eligibility for children that meet the requirements of section 1920A of the Act. (Section 2107 (e)(1)(L)); (42 CFR 457.355)
Removing references to Plan A.

Proposed effective date: November 1, 2014

Proposed implementation date: November 1, 2014

SPA# 15, Purpose of SPA: Ex Parte Reviews

Proposed effective date: February 1, 2015

Proposed implementation date: February 1, 2015

SPA# 16, Purpose of SPA: Change Reports

Proposed effective date: November 1, 2015

Proposed implementation date: November 1, 2015

SPA# 17, Purpose of SPA: Rebenchmark CHIP dental benefits

Proposed effective date: July 1, 2016

Proposed implementation date: July 1, 2016

Proposed implementation date: July 1, 2016
SPA# 18, Purpose of SPA: FQHC Payment Methodology

Proposed effective date: July 1, 2016

Proposed implementation date: July 1, 2016

SPA #20 Purpose of SPA: CHIP Mental Health Parity and Addiction Equity Act Analysis, Removal of Co-Payment Requirements for Residential Treatment and the Removal of Co-payment Requirements for Mental Health and Substance Use Disorder Services in an Urgent Care

Clinic

Proposed effective date: July 1, 2021

Proposed implementation date: July 1, 2021

SPA# 21, Purpose of SPA: Update CHIP benefits

Proposed effective date: July 1, 2019

Proposed implementation date: July 1, 2019

SPA# 22, Purpose of SPA: Add CHIP Disaster Relief COVID-19 Plan. The Secretary of the Department of Health and Human Services declared a public health emergency (PHE) on January 31, 2020, under section 319 of the Public Health Service Act (42 U.S.C. 247d), in response to COVID-19, followed by a National Emergency declaration signed by the President on March 13, 2020. In response to this declaration, the State will implement changes related to tribal consultation, eligibility and redeterminations, premiums and cost sharing processes. The duration of the policy will be determined by the end of the federally declared PHE.

Proposed effective date: March 1, 2020

Proposed implementation date: March 1, 2020

SPA # 23, Purpose of SPA: Implement the requirements of section 5022 of the SUPPORT Act

Proposed effective date: July 1, 2020

Proposed implementation date: July 1, 2020

SPA# 24, Delay timeliness requirements on ex parte renewals.

Proposed effective date: February 1, 2021

Proposed implementation date: February 1, 2021

SPA# 25, Purpose of SPA: Update CHIP Benefits

Proposed effective date: July 1, 2021

Proposed Implementation date: July 1, 2021

SPA# 26, Purpose of SPA: The purpose of this SPA is to demonstrate compliance with the
American Rescue Plan Act provisions that require states to cover treatment (including treatment
of a condition that may seriously complicate COVID-19 treatment), testing and vaccinations for
COVID-19 without cost sharing in CHIP

Proposed effective date: March 11, 2021

Proposed implementation date: March 11, 2021

SPA# UT-22-0027, Purpose of SPA: To include provisions of reimbursement for single-day patient encounters in an FQHC and RHC and to update and clarify the prospective payment and alternative payment methodologies for ran FQHC and RHC

Proposed effective date: May 1, 2022

Proposed implementation date: May 1, 2022

SPA# UT-23-0028, Purpose of SPA: The purpose of this SPA is to update the CHIP out of pocket maximum member notification process.

Proposed effective date: April 1, 2023

Proposed implementation date: April 1, 2023

SPA# UT-23-0029, Purpose of SPA: To update the CHIP dental benchmark plan and benefits.

Proposed effective date: July 1, 2023

Proposed implementation date: July 1, 2023

SPA# UT-24-0031, Purpose of SPA: The State is assuring that it covers age-appropriate vaccines and their administration, without cost sharing.

Proposed effective date: July 1, 2024

Proposed implementation date: July 1, 2024

SPA# UT-25-0033, Purpose of SPA: The purpose of this SPA is to update the Premium requirements and to add a new CHIP vendor.

Proposed effective date: July 1, 2024

Proposed implementation date: July 1, 2024

Superseding Pages of MAGI CHIP State Plan Material

State: Utah

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
UT-13-0001 Approval Date: 12/19/13 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 CS15	Eligibility – Targeted Low Income Children MAGI-Based Income Methodologies	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Incorporate within a separate subsection under section 4.3
UT-13-0005 Approval Date: 10/08/14	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Effective/Implementation Date: January 1, 2014				
UT-13-0002 Approval Date: 11/01/13 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
UT-13-0003 Approval Date: 11/01/13 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
UT-13-0004 Approval Date: 12/19/13 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19	Non-Financial Eligibility – Residency Non-Financial Eligibility – Citizenship Non-Financial Eligibility – Social Security Number	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1-LR; 4.1.1-LR Supersedes the current section 4.1.9.1

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
		CS20 CS21 CS27	Non-Financial Eligibility - Substitution of Coverage Non-Financial Eligibility – Non-Payment of Premiums Continuous Eligibility	Supersedes the current section 4.4.4 Supersedes the current section 8.7 Supersedes the current section 4.1.8
UT-16-0001 Approval Date: 08/18/16 Effective Date: July 1, 2016	Non-Financial Eligibility	CS18	Non-Financial Eligibility – Citizenship (CHIPRA section 214)	Supersedes the current sections 4.1.0; 4.1-LR; 4.1.1-LR
UT-17-0003	MAGI Eligibility & Methods	CS15	MAGI-Based Income Methodologies (Estranged spouses)	Incorporate within a separate subsection under section 4.3

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Approval Date: 04/27/17 Effective Date: January 1, 2017				
UT-23-0030	Separate Child Health Insurance Program General Eligibility - Continuous Eligibility	CS27	Mandatory 12-Month Postpartum Continuous Eligibility in CHIP for States Electing this Option in Medicaid	
UT-24-0014 **Approval Date: September 16, 2024** **Effective Date: January 1, 2024**	Update section 8 on premiums to reflect that the state no longer disenrolls children from coverage due to nonpayment of premiums during the continuous eligibility period.	CS21	Non-Payment of Premiums	Supersedes the current sections 8.2.1; 8.2.4; 8.7; and 8.7.1
UT-25-0014	Update Sections on premiums to reflect that the state no longer charges families premiums for CHIP coverage	CS21	Separate Child Health Insurance Program Non-Financial Eligibility - Non-Payment of Premiums	Supersedes the current sections 8.2;8.7.1; 8.7.2 and the previously approved CS21

1.4- TC **Tribal Consultation (Section 2107(e)(1)(C))** Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

State Plan Amendments 10 & 11 was presented at the Indian Health Advisory Board meeting on October 7, 2011. There was no request for consultation.

State Plan Amendment 13 was presented at the Utah Indian Health Advisory Board meeting on August 3, 2012. Consultation was not requested.

State Plan Amendment 14 was presented at the Utah Indian Health Advisory Board meeting on 08/08/2014. Consultation was not requested.

State Plan Amendment 15 was presented at the Utah Indian Health Advisory Board meeting on 12/12/2014. Consultation was not requested.

State Plan Amendment 16 was presented at the Utah Indian Health Advisory Board meeting on 10/9/2015. Consultation was not requested.

State Plan Amendment 17 was presented at the Utah Indian Health Advisory Board meeting on 7/8/2016. Consultation was not requested.

State Plan Amendment 18 was presented at the Utah Indian Health Advisory Board meeting on 3/10/2017. Consultation was not requested.

State Plan Amendment 20 was presented at the Utah Indian Health Advisory Board meeting on June 7, 2018. Consultation was not requested.

State Plan Amendment 21 was presented at the Utah Indian Health Advisory Board meeting on June 7, 2019. Consultation was not requested.

State Plan Amendment 22 in concept was presented at the Utah Indian Health Advisory Board meeting on April 10. The final SPA was presented to the board on May 8, 2020, after the SPA was submitted to CMS. To address the Federal COVID-19 public health emergency, the State received waiver approval under section 1135(b)(5) of the Act, for flexibility to modify the timeframes associated with tribal consultation, including conducting consultation after submission of the SPA.

Consultation was not requested.

State Plan Amendment 23 was presented at the Indian Health Advisory Board meeting on August 14, 2020. There was no request for consultation.

State Plan Amendment 24 was presented to the Utah Indian Health Advisory Board meeting on February 12, 2021, again after CMS guidance on March 12, 2021, and finally a status update on April 9, 2021. Consultation was not requested.

State Plan Amendment 25 was presented to the Utah Indian Health Advisory Board meeting on August 13, 2021. Consultation was not requested.

State Plan Amendment 26 was presented to the Utah Indian Health Advisory Board meeting on March 11, 2022. Consultation was not requested.

State Plan Amendment UT-22-0027 was presented to the Utah Indian Health Advisory Board meeting on April 8, 2022. Consultation was not requested.

State Plan Amendment UT-23-0028 was presented to the Utah Indian Health Advisory Board meeting on January 13, 2023. Consultation was not requested.

State Plan Amendment UT-23-0029 was presented to the Utah Indian Health Advisory Board meeting on June 9, 2023. Consultation was not requested.

State Plan Amendment UT-24-0031 was presented to the Utah Indian Health Advisory Board meeting on June 21, 2024. Consultation was not requested.

State Plan Amendment UT-24-0014 was presented to the Utah Indian Health Advisory Board meeting on June 21, 2024. Consultation was not requested.

State Plan Amendment UT-25-0033 was presented to the Utah Indian Health Advisory Board meeting on May 10, 2024. Consultation was not requested.

3.1. Delivery Standards Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

☒ Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS' Regional Office for review and approval. (Section 2103(f)(3))

CHIP contracts with ~~two~~ three managed care organizations (MCO) to provide medical care for children enrolled in CHIP:
Select Health
Molina Health Care of Utah
Healthy U

CHIP contracts with Premier Access statewide to provide dental services for children enrolled in CHIP:

These managed care organizations have extensive provider networks and include all the major hospitals, physician groups and clinics (both primary care and specialists), dental and specialty providers such as mental health, home health, physical therapy, and hospice. The experience of CHIP, in contracting with multiple managed care organizations demonstrates an ability to develop and maintain provider networks. The availability of these extensive networks within the managed care organizations improves access and continuity of care provided to CHIP enrollees.

As the agency designated to implement the Utah Children's Health Insurance Program, CHIP and the DOH will offer its long-time experience in working with managed care organizations and negotiate contracts with any willing provider to serve CHIP enrollees in both urban and rural areas

of the state. Offering services through more than one network of providers will give CHIP enrollee's greater access and continuity of care through a greater choice of health care providers.

The issues of language and hours of service barriers will be critical in serving CHIP enrollees. CHIP contracts require interpretive services to be provided. For example, current contracts state:

Health and Dental Plans shall provide interpretive services for languages on an as needed basis at no cost to the enrollees. These requirements shall extend to both in-person and telephone communications to ensure that enrollees are able to communicate with the Health and Dental Plan and Health and Dental Plan providers and receive covered benefits. Professional interpreters shall be used when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend, as interpreter is inappropriate. Family members may be used as interpreters at the enrollee's request only after enrollee has been notified that professional interpreters are available at no cost. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical…

Materials written in a language other than English are a contract requirement of MCOs when the non-English speaking population represents 5% of the total population.

Hours of service barriers are a general problem of the health delivery system-—public or private. CHIP and its contracting MCO's use Community Health Centers, extended hour clinics, and urgent care centers to partially address this systemic problem. In addition, divisional contracts hold the HMOs/MCOs responsible for all covered emergency services 24 hours a day and 7 days a week, whether services were provided in or out of the respective managed care organization.

Standards for waiting times for appointments and office waiting times have been established with all contracting MCOs. These standards are monitored.

The described requirements and standards are part of the contracts the Department has developed with participating HMO's to serve the Children's Health Insurance Program.

All of the above areas are part of the state's MCO Quality Assurance Monitoring Plan and are monitored during annual on-site reviews. CHIP will be included in this monitoring.

Section 8. Cost-Sharing and Payment

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☒ Yes
8.1.2. ☐ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☒ No, skip to question 8.8.

Guidance: It is important to note that for families below 150% of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50-.59). For families with incomes of 150% of poverty and above, cost sharing for all children in the family cannot exceed 5% of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

There are two levels of coverage: Plan B for enrollees up to150% of the federal poverty level; and Plan C for enrollees 151% through 200% of the federal poverty level.

~~**8.2.1.** Premiums:~~

~~Enrollees up to150% of the federal poverty level (Plan B) will be charged a quarterly premium of $30.00 per family; 151% through 200% of the federal poverty level (Plan C) will be charged a quarterly premium of $75.00 per family. Although premiums are charged quarterly, enrollees have the option of paying~~

~~monthly.~~

~~Non-payment of premium or premium late fees may be temporarily forgiven-waived for all CHIP applicants during the Federal COVID-19 public health emergency. The state will not seek premium back payments after the public health emergency ends.~~

Co-Insurance and Co-payment requirements for CHIP clients/enrollees who are Native American.

No co-payments ~~or premiums~~ are charged to CHIP enrollees who are American Indian/Alaska Native

Co-Insurance and Co-payments requirements for COVID-19 Vaccines, Testing and Treatment under the American Rescue Plan Act of 2021 (ARP)

Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan, the state assures the following:

COVID-19 Vaccine:

- The state provides coverage of COVID-19 vaccines and their administration without cost sharing, in accordance with the requirements of section 2103(c)(11)(A) and 2013(e)(2) of the Act.

COVID-19 Testing:

- The state provides coverage of COVID-19 testing without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

COVID-19 Treatment:

- The state provides coverage of COVID-19-related treatments without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without cost sharing, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act. This coverage includes items and services, including drugs, that were covered by the state as of March 11, 2021.

8.7

Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

~~Approval notices sent at application and renewal inform enrollees of the amount of their quarterly premium, that they will receive a premium invoice when a premium is due, and requests that they pay timely. An invoice regarding the quarterly premium is mailed to enrollees on the 1st day of the first month of the quarter notifying families when the quarterly premium payment is due. Children will not be disenrolled for failure to pay CHIP premiums during the 12-month continuous eligibility period.~~

Consequences for an enrollee or applicant who does not pay copayments or coinsurance will be handled between the enrollee or applicant and the health care provider who has rendered the services.

8.7.1 Waive Premium Lock Out Policy

Families are not subject to premiums.~~who do not pay their premium during the 12-month continuous eligibility period are not subject to a lock-out period for re-enrollment.~~

8.7.2 Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (42CFR 457.570(a))

☐☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.

☐☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

☐☒ In the instance mentioned above, that the State will facilitate

enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

☐☒ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

The state assures that the above disenrollment protections are being applied. If the client chooses to appeal their disenrollment, the Medicaid fair hearing applies.

Guidance: Section 8.8.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health

9.10 Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc. All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing

Express Lane Eligibility.

- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
    - Total 1-year cost of adding prenatal coverage
    - Estimate of unborn children covered in year 1

HIP Budget

STATE:	**FFY Budget**
Federal Fiscal Year	**2025**
State's enhanced FMAP rate	**24.95%**
Benefit Costs	
Insurance payments	$280,800
Managed care	$35,331,700
Managed Care Payments (MCHIP)	$124,422,400
per member/per month rate	$192.63
Fee for Service	$189,400
Health Services Initiatives	$1,560,700
Total Benefit Costs	**$161,785,000**
(Offsetting beneficiary cost sharing payments)	-5,386,500
Net Benefit Costs	**$156,398,500**

STATE:	**FFY Budget**
Cost of Proposed SPA Changes – Benefit	**$0**
Administration Costs	
Personnel	$409,400
General administration	$718,100
Contractors/Brokers	$2,346,400
Claims Processing	$0
Outreach/marketing costs	$660,200
Other	$1,571,400
Total Administration Costs	**$5,705,500**
10% Administrative Cap	$17,377,600
Cost of Proposed SPA Changes	
Federal Share	$121,662,300
State Share	$40,441,700
Total Costs of Approved CHIP Plan	**$162,104,000**

STATE:	FFY Budget

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: State General Funds/Tobacco Settlement Funds

CHIP Eligibility

State Name: Utah

OMB Control Number: 0938-1148

Transmittal Number: UT - 25 - 0014

Separate Child Health Insurance Program Non-Financial Eligibility - Non-Payment of Premiums	**CS21**
42 CFR 457.570	
Non-Payment of Premiums	
Does the state impose premiums or enrollment fees?	No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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