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

October 31, 2017

Nathan Checketts
Deputy Director
Utah Department of Health
P.O. Box 143101
Salt Lake City, UT 84114

Dear Mr. Checketts:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved a five-year extension to Utah's section 1115 Primary Care Network (PCN) demonstration (Project Nos. 11-W-00145/8 and 21-W-00054/8), effective from November 1, 2017 through June 30, 2022. This demonstration extension approval is in accordance with section 1115(a) of the Social Security Act (the Act). The state may deviate from Medicaid state plan requirements only to the extent those requirements have been listed as not applicable to the expenditure approved for the demonstration.

As a result of this approval of the extension request, during the effective period of the demonstration extension, Utah will be authorized to provide full state plan benefits to Targeted Adults, who are adults without dependent children, ages 19-64, have incomes at zero percent of the federal poverty level (FPL) and are chronically homeless or involved in the criminal justice system, and in need of substance use or mental health treatment; or only in need of substance use or mental health treatment. Additionally, with this approval, the state will be also be authorized to restore full mental health benefits for the Current Eligibles (that is, beneficiaries eligible under the state plan) and cover former foster care youth who were covered by Medicaid in another state. The extension of the PCN demonstration is likely to promote the objectives of Medicaid because the extension will add covered benefits for and continue providing health coverage to vulnerable populations, some of whom are not eligible for Medicaid under the state plan.

The demonstration will also include a substance use disorder (SUD) program to ensure that a broad continuum of care is available to Utah's Medicaid beneficiaries with a SUD, which will help improve the quality, care, and health outcomes for all Utah Medicaid state plan beneficiaries and Targeted Adults in the demonstration. The SUD program will contribute to a comprehensive statewide strategy to combat prescription drug abuse and opioid use disorders and will expand the SUD benefits package to cover short-term residential services to all Medicaid enrollees.

CMS' approval of this demonstration is conditioned upon compliance with the enclosed list of expenditure authorities and special terms and conditions (STCs) defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Shanna Janu. She is available to answer any questions concerning your section 1115 demonstration. Ms. Janu's contact information:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
E-mail: Shanna.Janu@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Janu and to Mr. Richard Allen, Associate Regional Administrator for the Division of Medicaid and Children's Health in the Denver Regional Office. Mr. Allen's contact information is as follows:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health
Colorado State Bank Building
1600 Broadway, Suite 700
Denver, Colorado 80202-4367
Email: Richard.Allen@cms.hhs.gov

If you have any questions regarding this approval, please contact Ms. Judith Cash, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services at (410) 786-9686.

Sincerely,

/s/

Brian Neale
Director

Enclosures

cc: Richard Allen, Associate Regional Administrator, CMS Denver Regional Office
Mandy Strom, CMS Denver Regional Office

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

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 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, effective November 1, 2017 through June 30, 2022, be regarded as matchable expenditures under the state's Medicaid Title XIX state plan. The expenditure authorities listed below promote the objectives of title XIX.

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 95 percent of the federal poverty level (FPL) (effectively 100 percent with the 5 percent income disregard) who are not otherwise eligible for Medicaid, as described in the special terms and conditions (STC).

3. **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 and their children, age 19 through 26, who are enrolled in their parents' ESI plan, who are not otherwise eligible for Medicaid, as described in the STCs.

4. **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 not otherwise eligible for Medicaid, as described in the STCs.

5. **Individuals who are Blind or Disabled.** Expenditures for dental benefits for individuals who are blind or disabled and who are eligible for Medicaid, as described in the STCs.

6. **Former Foster Care Youth from Another State.** Expenditures to extend eligibility for full Medicaid state plan benefits to former foster care youth who are defined as individuals under age 26, that were in foster care under the responsibility of a state other than Utah or tribe in such other state on the date of attaining 18 years of age or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act, were enrolled in Medicaid on that date, and are now applying for Medicaid in Utah.

7. **Targeted Adults.** Expenditures to provide state plan coverage to certain individuals, age 19 through 64, without dependent children, who have incomes at zero percent of the FPL (effectively up to five percent with the five percent income disregard), as described in these STCs, who are not otherwise eligible for Medicaid.

8. **Substance Use Disorder.** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD).

Title XIX Requirements Not Applicable to the Demonstration Eligible Populations

All requirements of the Medicaid program expressed in law, regulation, and policy statement not expressly identified as not applicable to these expenditure authorities shall apply to the demonstration for the remaining period of this demonstration.

1. 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 the Former Foster Care Youth from another state to whom state plan services will be provided. In addition, this exemption from compliance enables the state to include additional benefits such as case management and health education not otherwise available to Medicaid beneficiaries who are enrolled in a managed care delivery system.

2. 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.

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

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

4. 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.

5. Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to restrict freedom of choice of providers for Title XIX populations affected by this demonstration.

6. Early Periodic Screening, Diagnosis, and Treatment (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 not applicable applies to 19 and 20 year olds for all Title XIX populations affected by this demonstration. This not applicable does not apply to blind and disabled enrollees who receive dental benefits through the demonstration.

Title XXI 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 of this demonstration, November 1, 2017 through June 30, 2022, 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 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 STCs, 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. 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.

Title XXI 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).

4. Cost Sharing Exemption for American Indian/Alaskan Native (Al/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.

5. 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.

6. 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.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

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

TITLE: **Primary Care Network**

AWARDEE: **Utah Department of Health**

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I. PREFACE

The following are the Special Terms and Conditions (STC) for Utah's Primary Care Network (PCN) Medicaid section 1115 demonstration program (hereinafter referred to as "demonstration") under section 1115 of the Social Security Act (the Act). 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. 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. 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, schedule of state deliverables during the demonstration extension, and substance use disorder.

II. PROGRAM DESCRIPTION AND OBJECTIVES

Utah's PCN is a statewide section 1115 demonstration to expand Medicaid coverage to certain 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. When the demonstration was first approved in 2002, state plan eligibles (referred to as Current Eligibles), who are categorically or medically needy parents or other caretaker relatives, were provided a reduced benefit package and required to pay increased cost-sharing. Savings from this state plan population funded 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, were covered under the demonstration for the full Medicaid benefits package. Currently, the demonstration covers Current Eligibles and the population above parent and caretaker state plan levels up to 95 percent of the FPL.

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.

On June 29, 2017, CMS approved an amendment that provides dental benefits to individuals, 18 and older, with disabilities or blindness (effective on July 1, 2017). In addition, approval of this amendment removes the sub-caps on the number of parents/caretaker relatives and childless adults who can enroll in Demonstration Population I (while leaving in place the overall cap of 25,000 combined parent/caretaker relative and childless adult enrollees) and removes Demonstration Population II since changes to federal law rendered this group obsolete and it has not had individuals covered under this population since 2014.

On October 31, 2017, CMS approved the state's request that extends the demonstration through June 30, 2022. In addition, the state received approval to extend state plan benefits to a targeted group of adults, without dependent children, age 19-64, who meet defined criteria including being chronically homeless, justice involved, and/or needing substance use disorder or mental health treatment. This extension also provides coverage for former foster care youth who were in foster care in another state or tribe of such other state up to age 26, and restores mental health benefits for the Current Eligibles. In addition, this extension provides expenditure authority for Medicaid services provided for adult Medicaid beneficiaries residing in an Institution for Mental Disease (IMD) to help the state provide the full continuum of care for beneficiaries suffering from drug and/or alcohol dependence or abuse.

The state hypothesizes that the demonstration will improve the health of Utahns by increasing the number of low-income individuals without access to primary care coverage, which will allow more Medicaid beneficiaries to receive regular care instead of relying on the hospitals for emergency care. The state also hypothesizes that by providing Medicaid benefits for beneficiaries residing in IMDs and the full continuum of SUD care, the state will be able to provide more extensive care to individuals suffering from SUD and in turn make this population healthier and more likely to remain in recovery.

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 ages 19 and above who are eligible through sections 1925 and 1931) in the demonstration that 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 five 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 five 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 nine 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 percent of the FPL to 200 percent of the FPL. This amendment was approved by CMS on September 28, 2012.

- **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.

- **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, was approved for a 3-year extension from July 1, 2010, through June 30, 2013. The demonstration was temporarily extended through December 31, 2013.

- **Temporary Extension –** The December 24, 2013 amendment and temporary extension, changed the STCs so beginning on January 1, 2014, the cost-sharing for Current Eligibles and adults in the PCN program was required to align with Medicaid regulations and state plan requirements. In addition, the income eligibility for the PCN program decreased from 150 percent FPL to 100 percent FPL.

- **Temporary Extension –** The December 19, 2014 approval amendment and temporary extension changed the STCs so the FPL for Demonstration Population I was decreased to 95 percent (effectively 100 percent of the FPL because of the 5 percent income disregard) in order to ensure that eligible individuals above 100 percent of the FPL would be able to receive APTC to help purchase insurance through the federally facilitated marketplace (FFM).

- **Temporary Extension –** On November 19, 2015, the demonstration was temporarily extended through December 31, 2016.

- **Temporary Extension –** December 16, 2016 , the demonstration was temporarily extended on through December 31, 2017.

- **Amendment #12 –** On June 29, 2017, CMS approved an amendment which allows the state to provide state plan dental benefits to adults with disabilities or blindness, age 18 and older, removed the sub-caps for enrollment of Demonstration Population I, and removed Demonstration Population II (high risk pregnant women) since changes to federal law rendered this group obsolete and it has not had individuals covered under this population since 2014.

- **Amendment #13 –** On October 31, 2017 (effective on November 1, 2017), CMS approved an extension that creates a new demonstration population, under which eligible beneficiaries receive state plan services. This new population is made of adults without dependent children, age 19 through 64 years of age, whose income is at zero percent of FPL. In addition, they must meet at least one of three criteria; chronically homeless, involved in the justice system and in need of substance use and mental health treatment, or those who are just in need of substance use or mental health treatment. In addition, under this approval, the state has expenditure authority to restore full mental health benefits for Current Eligibles and remove the exclusion of Norplant as a covered benefit.

- **Amendment #14** -This amendment would have terminated the EPSDT waiver of Section 1902(a)(43) for individuals ages 19 and 20 for all Title XIX populations affected by this waiver. The state withdrew this amendment.

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, including the protections for Indians pursuant to section 5006 of the American Recovery and Reinvestment Act of 2009.

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. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to provide the state with additional notice of the changes.

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 day such legislation was required to be in effect under federal law.

5. **State Plan Amendments.** The state will not be required to submit Title XIX or Title XXI state plan amendments (SPA) 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. In the event of a conflict between the provisions of the Medicaid or CHIP state plan and these STCs with respect to a population eligible through the Medicaid or CHIP state plan, the provisions of the Medicaid or CHIP state plan govern.

    As outlined in CMS' November 21, 2016 CMCS Informational Bulletin, *Section 1115 Demonstration Opportunity to Allow Medicaid Coverage to Former Foster Care Youth Who Have Moved to a Different State*, the state shall submit a conforming amendment to the

Medicaid state plan for the "out-of-state" former foster care youth affected by the implementation of this demonstration. After the associated Medicaid SPA is effectuated, the state will not be required to submit any additional title XIX SPAs for changes affecting this former foster care youth population made eligible solely through this demonstration.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, delivery systems, 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 STC 7, except as provided in STC 3.

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. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein.

    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 STC 14, 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) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets the requirements of 42 Code of Federal Regulations (CFR) §431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.

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. Exemption from Public Notice Procedures 42.CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR section 431.416(g).

e. 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.

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 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 STC 6, are proposed by the state.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR section 431.408(b), State Medicaid Director Letter #01-024, and contained in the state's approved Medicaid State plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

15. **Federal Finanaical Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

16. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** The state must comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information regarding T-MSIS is available in the August 23, 2013 State Medicaid Director Letter.

17. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities which may be authorized and/or required by this demonstration for projects which are conducted by or subject to the approval of CMS, and which are designed to study, evaluate, or otherwise examine the Medicaid program – including procedures for obtaining Medicaid benefits or services; possible changes in or alternatives to those programs or procedures; or possible changes in methods or level of payment for benefits or services under those programs. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ELIGIBILITY

18. **Use of Modified Adjusted Gross Income (MAGI) Based Methodologies For Eligibility Groups Affected By or Eligible Only Under the Demonstration.** Mandatory and optional state plan groups 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 in this demonstration and as described in these STCs. Any Medicaid state plan amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a MAGI standard January 1, 2014, will apply to this demonstration. These state plan eligible beneficiaries are included in the demonstration for access to additional benefits not described in the state plan. Expansion groups which are not eligible under the state plan and are eligible only for benefits under this demonstration are subject to all Medicaid requirements except as expressly waived in this demonstration, or expressly listed as not applicable to the specific expansion group. These requirements include determination of income using the same MAGI-based methodologies applicable to populations eligible under the Medicaid state plan.

19. **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.

20. 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 postpartum. 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 incomes at or below 95 percent of the FPL (effectively 100 percent of the FPL considering a disregard of 5 percent of income), who are U.S. citizens/legal residents, are residents of Utah, are not otherwise eligible for Medicaid, do not qualify for Medicare or Veterans benefits, and do not have other health insurance. 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, which have a combined annual average enrollment limit of 25,000:

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.

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

c. Demonstration Population III is comprised of working adults, age 19 through 64, their spouses, and their children who are ages 19 through 26, 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 at or below 95 percent of the FPL (effectively 100 percent of the FPL considering a disregard of 5 percent of income), 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 three 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.

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

iii. Adult Children of Custodial Parents/Caretaker Relatives: A demonstration eligible population that meets the eligibility requirements of Demonstration Population III, as well as being age 19 through 26, enrolled in their caretaker's ESI plan, and live in their caretaker's household.

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 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 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.

i. The Targeted Adults are comprised of adults, ages 19-64, with incomes at zero percent of the FPL (effectively five percent of the FPL with the five percent disregard) and no dependent children, who meet one of the following additional criteria:

i. Be chronically homeless, defined as:
(1) An individual who has been continuously homeless for at least 12 months or on at least four separate occasions in the last three years (totaling at least 12 months); and has a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability; or
(2) An individual currently living in supportive housing who has previously met the definition of chronically homeless (1) above.

ii. Involved in the criminal justice system and in need of substance use or mental health treatment, defined as:
(1) An individual who has complied with and substantially completed a substance use disorder treatment program while incarcerated in jail or prison, including Tribal jails (requirements regarding the type and length of qualifying programs will be established in the Utah Administrative Code);
(2) An individual discharged from the Utah State Hospital who was admitted to the civil unit of the hospital in connection with a criminal charge, or admitted to the forensic unit due to a criminal offense with which the individual was charged or of which the individual was convicted; or
(3) Individual involved with a Drug Court or Mental Health Court, including Tribal courts, related to a criminal charge or conviction.

iii. Needing substance use or mental health treatment, defined as:
(1) An individual living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for 6 months within a 12-month period; and has a diagnosable substance use disorder or serious mental health

disorder;

(2) An individual receiving General Assistance from the Department of Workforce Services (DWS), who has been diagnosed with a substance use or mental health disorder; or

(3) An individual recently discharged from the Utah State Hospital who was civilly committed, to be further specified in the Utah Administrative Code.

j. Former Foster Care Youth from Another State are defined as individuals under age 26, who were in foster care under the responsibility of a state other than Utah or a tribe in such other state when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were enrolled in Medicaid on that date , are now applying for Medicaid in Utah, and are not otherwise eligible for Medicaid.

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	Not Applicables	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	Statewideness, Comparability, Freedom of Choice, EPSDT	PCN Current Eligibles	Current eligible
Section 1902(a)(1)(C)/42 CFR 435.322 & 435.330 adults who are blind or disabled	No income standard	Comparability	Blind and Disabled Adults–Dental	1902(a)(1)(C) -Blind and Disabled Adults –Dental
Optional Medicaid State Plan Groups				
Medically Needy adults who are not pregnant/postpartum, aged, blind, or disabled	Individual must "spend down" to a Medically Needy Income Standard set by the state	Statewideness, 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 I	Individuals with incomes at or below 95% FPL	Comparability, Freedom of Choice, EPSDT, Cost Sharing, FQHC, Retroactive Eligibility	PCN Adults w/Children(1) (parents/ caretaker relatives) PCN Childless Adults(1) (childless	PCN PCN Adults w/ Children (1) PCN Childless Adults(1) (childless

Mandatory Medicaid State Plan Groups	FPL and/or Other Qualifying Criteria	Not Applicables	Expenditure Reporting Form (see paragraph X.1(c), Medicaid, unless otherwise indicated)	Member-Month Reporting Category in section X.5, if applicable)
			adults/noncustodial parents)	adults/non-custodial parents)
Targeted Adults	Individuals with incomes at 0% FPL	Statewideness, Comparability, Freedom of Choice, EPSDT	Targeted Adults	Targeted Adults
Former Foster Care Youth	No income standard	N/A	FFCY	FFCY
ESI Demonstration Eligible Groups				
Adult custodial parents/caretaker relatives and childless adults/noncustodial parents and adult children (19-26) of parents/caretakers Demonstration Population III	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) ESI Adult Children (Title XIX)(3)	ESI Adults with Children ESI Childless Adults(3) (childless adults/non-custodial parents) ESI Adult Children
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 V	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)	COBRA Adults with children COBRA Childless Adult (5) (childless adults)

Mandatory Medicaid State Plan Groups	FPL and/or Other Qualifying Criteria	Not Applicables	Expenditure Reporting Form (see paragraph X.1(c), Medicaid, unless otherwise indicated)	Member-Month Reporting Category in section X.5, if applicable)
CHIP children of unemployed adults eligible for COBRA benefits Demonstration Population VI	Up to and including 200% F PL	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

21. 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

Service	Special Limitations for Current Eligibles
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 Sterilizations	Same as traditional Medicaid with exclusions. (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: infertility drugs, in-vitro fertilization, genetic counseling
Dental	See Utah Medicaid Provider Manual, Dental Services
Outpatient Substance Abuse	Services for substance abuse disorder according to certain exclusions (See Utah Medicaid Provider Manual, Non-Traditional Medicaid Plan)
Other Outside Medical Services	Services provided in freestanding ambulatory surgical centers

22. 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

Service	Special Limitations for Demonstration Population I
'Inpatient Treatment for Substance Abuse and Dependency	Not covered
Organ Transplants	Not covered
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

21. Benefit Definition

a. **For Adults and Adult Children 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. However, 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. In this case, 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 STC 22, 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.

22. 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.

23. 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 STC 23(c), is:

   • **For ESI plans** –

   Adults and Adult Children = $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 STC 23(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 STC 23(b)

24. Dental Benefit for Enrollees who are Blind or Disabled. All individuals who are blind or disabled, 18 and older, who are enrolled in the state plan under Section 1902(a)(10)(C) of the

Act and 42 CFR 435.322, 435.324 and 435.330, will receive dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services.

25. Targeted Adults. Beneficiaries enrolled in this eligibility category will receive full Medicaid state plan benefits.

26. Former Foster Care Youth from Another State. Beneficiaries enrolled in this eligibility category will receive full Medicaid state plan benefits.

VI. ENROLLMENT AND IMPLEMENTATION

27. 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.

28. 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.

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.

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

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

a. Adults with incomes at or below 95 percent 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 percent 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 ten 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.

30. Enrollment in Utah COBRA Premium Assistance Program

a. Adults with incomes at or below 95 percent of the FPL who have been determined eligible for the PCN (Demonstration Population I) 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 percent 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.

30. 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 a FPL at or below 95 percent. 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.

31. 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.

32. Enrollment in Dental Benefits. There is no separate enrollment process required for individuals who are blind or disabled and otherwise enrolled in the state plan to receive dental services through this demonstration.

33. Targeted Adults Enrollment. As of November 1, 2017, individuals who are currently eligible for Demonstration Population I and can be identified as eligible for this demonstration population, may be moved to the Targeted Adults eligibility group. Current Demonstration Population I eligible individuals who cannot be identified as eligible for the Targeted Adults population will be sent notification informing them of the availability of this program.

a. Individuals applying for Medicaid will be screened for eligibility in other Medicaid programs before being enrolled in the Targeted Adults eligibility group.

b. The state will provide for a redetermination of eligibility at least once every 12 months.

c. The Targeted Adults group or any subset of this group may be closed to new enrollment at the state's election. If this eligibility group is closed to new enrollment, the state will stop taking applications. Applications will not be held over for a new enrollment period.

d. The state will provide continuous eligibility for a period of twelve (12) months to the Targeted Adults. Income and other changes during the continuous eligibility period will not affect a beneficiary's eligibility with the exception of the following reasons:
   - Moving out of state;
   - Death;
   - Determined eligible for another Medicaid eligibility category;
   - Fraud; or
   - Client request.

e. All eligibility criteria, including income, will be considered at the time of the individual's annual eligibility redetermination to determine if the individual continues to meet eligibility for Medicaid.

VII. COST SHARING

34. Cost Sharing. Cost sharing must comply with Medicaid requirements that are set forth in statute, regulation and policies and be reflected in the state plan. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR §447.52(b) applies to the demonstration

35. 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 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.

36. 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 of 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.

37. Enrollment Fee. The state must not impose an enrollment fee on any demonstration populations.

VIII. DELIVERY SYSTEMS

38. Enrollment in Managed Care. The state may require Current Eligibles, Demonstration Population I, and Targeted Adults 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.*

39. 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.

40. 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.

41. Dental Services. As of July 1, 2017, dental services will be delivered fee-for-service (FFS). In future years, the state may continue delivery of these services through FFS or may transition delivery of these services to managed care under 1915(b) authority or by amendment to this demonstration.

42. Targeted Adults Delivery System. As of November 1, 2017, health care benefits will be delivered FFS. At a future date, the state may transition delivery of these services to managed care under 1915(b) authority or by amendment to this demonstration.

IX. GENERAL REPORTING REQUIREMENTS

43. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of $5,000,000 ($5M) (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).

   i. CMS may decline the extension request.

   ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.

   iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.

c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, and timely and complete submission of required deliverables is necessary for effective testing, a state's failure to submit all required deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example what quarter the deferral applies to, and how the deferral is released.

44. Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones. Up to $5M in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in Table 3 and the required performance measures in the monitoring protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5M will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

45. Submission of Post-Approval Deliverables. The state will submit all deliverables using the process stipulated by CMS and within the timeframes outlined within these STCs.

46. 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.

47. Reporting Requirements Related to Budget Neutrality. The state shall comply with all reporting requirements for monitoring budget neutrality set forth in Section XII of these STCs.

48. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

49. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 43.

50. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each DY. The information for the fourth quarterly report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60 days) following the end of each demonstration quarter. The compiled Annual Report is due no later than ninety (90 days) following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates - Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics – Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements – Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality, including baseline cost and member months, set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

51. Close out Report. Within 120 days prior to the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

a. The draft final report must comply with the most current Guidance from CMS. ‘

b. The state will present to and participate in a discussion with CMS on the Close-Out report.

c. The state must take into consideration CMS’ comments for incorporation into the final Close Out Report.

d. The final Close Out Report is due to CMS no later than thirty (30) days after receipt of CMS’ comments.

e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 43.

X. MONITORING CALLS AND DISCUSSIONS

52. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

53. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration’s implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (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 must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

54. 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 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 STC 55. DY1 is the year beginning July 1, 2002 and ending June 30, 2003, and subsequent DYs are 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 found in 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. ESI Adults w/Children (3)/ ESI Adult Children (3)/COBRA Adults with Children (5)
    v. ESI Childless Adults (3)/ COBRA Childless Adults (5)
    vi. Current Eligible CHIP Children (4) and COBRA Children (6) are reported on the applicable CMS-21 form.
    vii. Dental Services for Section 1902(a)(1)(C)/42 CFR 435.322 & 435.330 Blind and Disabled Adults (“Dental”)
    viii. Targeted Adults
    ix. Former Foster Care Youth From Another State ("FFCY")
    x. SUD

d. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a federal medical assistance percentage (FMAP) of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state will exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent.

55. 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 III, Demonstration Population V, Dental Services, Targeted Adults, Former Foster Care Youth from Another State, and SUD as defined in STC 54(c)(*i-x*) of the STCs).

56. 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”.

57. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within two 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 two 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.

58. 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 STC 20. 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 three months contributes three eligible member/months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member/months.

b. There will be eight 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 groups used for calculating the budget neutrality expenditure limit are described below:

i. "PCN Current Eligibles," as defined in section IV of these STCs.

ii. "PCN Adults with Children(1)" is a hypothetical group under “PCN Adults with Children" and members of the Demonstration Population I, as defined in section IV 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 Population III.

iii. “ESI Adults with Children(3)”is a hypothetical group under "ESI Adults with Children" and are members of the Demonstration Population III, as defined in section IV 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. "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.

iv. “COBRA Adults with children(5)” is a hypothetical group under “COBRA Adults with Children” and are members of the Demonstration Population V, as defined in section IV 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. "COBRA Adults w/Children(X)" does not include members of Demonstration Population III, or members of Demonstration Populations I.

v. 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.

vi. “Blind and Disabled Adults” is a group as defined in section IV of these STCs whose enrollees receive hypothetical dental services.

vii. “Former Foster Care Youth from Another State” ("FFCY") is a hypothetical budget neutrality coverage group as defined in section IV of these STCs.

viii. “SUD” is a group as defined in section IV of these STCs whose beneficiaries receive hypothetical services.

59. 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.

60. 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 XIII:

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.

61. 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.

62. 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.

63. State Assurances.

a. 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 FRT 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. 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.

XII. GENERAL FINANCIAL REQUIREMENTS

65. 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.

66. 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).

67. Claiming Period. All claims for expenditures related to the demonstration (including any cost settlements) must be made within two 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 two 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.

68. **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.

69. **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.

70. **Limitation 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.

71. **Adminstrative 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.

72. **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.

73. **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.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

74. 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.

75. 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.

76. 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 STC 74. 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 STC 81.

77. 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.

78. "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 "PCN Adults with Children," "ESI Adults with Children," "COBRA Adults with Children," groups, and "Former Foster Care Youth from Another State." 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.

79. Supplemental Budget Neutrality Test: Substance Use Disorder Expenditures. As part of the SUD initiative, the state may receive FFP (once the Implementation Protocol is approved) for the continuum of services to treat opioid use disorders (OUD) and other SUDs, provided to Medicaid enrollees in an IMD. These are state plan services that would be eligible for reimbursement if not for the IMD exclusion. Therefore, they are being treated as hypothetical. The state may only claim FFP via demonstration authority for the SUD services listed in Table 3 in STC 96 that will be provided in an IMD. However, the state will not be allowed to obtain budget neutrality "savings" from these services. Therefore, a separate expenditure cap is established for SUD services. The SUD MEG listed in the table in STC 80 is included in the SUD Supplemental Budget Neutrality Test.

a. The SUD expenditures cap is calculated by multiplying the projected PMPM for the SUD MEG, each DY, by the number of actual eligible SUD member months for the same MEG/DY—and summing the products together across all DYs. The federal share of the SUD expenditure cap(s) is/are obtained by multiplying those caps by the Composite Federal Share (see STC 81).

b. SUD Supplemental Budget Neutrality Test is a comparison between the federal share of SUD expenditure cap(s) and total FFP reported by the state for the SUD MEG.

80. 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 "PCN," "ESI," and "COBRA" are designated by the initials "BY." The trend rate of 5.3 percent for DY 16 is based on the FY2017 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.

Eligibility Group	Trend Rate	DY 16 PMPM	DY 17 PMPM	DY 18 PMPM	DY 19 PMPM	DY 20 PMPM
Current Eligibles	5.3%	$999.33	$1,052.29	$1,108.07	$1,166.79	$1,228.63
Demo Pop I – Adults with Children	5.3%	$48.63	$51.21	$53.92	$56.78	$59.79

Demo Pops III & IV – Adults with Children	5.3%	$158.03	$166.41	$175.23	$184.51	$194.29
Dental Services	3.0%	$18.42	$18.97	$19.54	$20.13	$20.73
Former Foster Care Youth	4.8%	$990.87	$1,038.43	$1,088.28	$1,140.51	$1,195.26
SUD Services	5.0%	$3,321.96	$3,488.06	$3,662.46	$3,845.58	$4,037.86

81. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of 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.

82. Exceeding Budget Neutrality. The budget neutrality limit calculated in STC 80 will 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.

83. 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.

84. Enforcement of Budget Neutrality. CMS shall enforce the budget neutrality agreement over the life of the demonstration extension, which for this purpose will be from July 1, 2017 – June 30, 2022. The budget neutrality test for the demonstration extension may incorporate net savings from the immediately prior demonstration periods of July 1, 2013 through June 30, 2017, but not from any earlier approval period.

Year	Cumulative target definition	Percentage
DY 16	DYs 1 through 16 combined budget neutrality limit	0 percent
DY 17	DYs 1 through 17 combined budget neutrality limit	0 percent
DY 18	DYs 1 through 18 combined budget neutrality limit	0 percent
DY 19	DYs 1 through 19 combined budget neutrality limit	0 percent
DY 20	DYs 1 through 20 combined budget neutrality limit	0 percent

85. Budget Neutrality Savings Phase-Down. Beginning with the demonstration period that begins on July 1, 2017, the net variance between the without-waiver and actual with-waiver costs will be reduced. The reduced variance, calculated as a percentage of the total variance, is used in place of the total variance to determine overall budget neutrality of the demonstration. The formula for calculating the reduced variance is, reduced variance equals total variance times applicable percentage. The percentages are determined based on how long Medicaid populations have been subject to the demonstration. In the case of Utah, the program will retain 25 percent of the total variance as future savings for the demonstration. Should the state request an extension of its demonstration beyond June 30, 2022, budget neutrality will be adjusted again to reflect revised PMPMs based on the data from the current extension.

XIV. EVALUATION OF THE DEMONSTRATION

86. Independent Evaluator. Upon approval of the demonstration, the state must begin arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

87. Evaluation Budget. A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

88. Draft Evaluation Design. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred twenty (120) days after the effective date of these STCs. Any modifications to an existing approved Evaluation Design will not affect previously

established requirements and timelines for report submission for the demonstration, if applicable. The state may choose to use the expertise of the independent party in the development of the draft Evaluation Design.

89. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

90. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

91. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.

b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the

approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the final Interim Evaluation Report 60 days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.

e. The Interim Evaluation Report must comply with Attachment B (Preparing the Evaluation Report) of these STCs.

92. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Evaluation Report) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 days of receiving comments from CMS on the draft.

b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

93. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

94. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

95. Additional Publications and Presentations. For a period of twenty-four (24) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given thirty (30) days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

XV. SUBSTANCE USE DISORDER

96. Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program. Effective upon CMS' approval of the SUD Implementation Protocol, the demonstration benefit package for Medicaid recipients will include OUD/SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Disease (IMD), which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Medicaid recipients residing in IMDs under the terms of this demonstration for coverage of medical assistance and OUD/SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD once CMS approves the state's Implementation Protocol. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from acute withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

The coverage of OUD/SUD residential treatment and withdrawal management in IMDs will expand Utah's current SUD benefit package available to all Medicaid recipients as outlined in Table 3. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Table 3: Utah OUD/SUD Benefits Coverage with Expenditure Authority

SUD Benefit	Medicaid Authority	Expenditure Authority
Early Intervention (Screening, Brief Intervention and Referral to Treatment)	State plan (Individual services covered)	
Outpatient Therapy (Individual; Group; Family; Collateral)	State plan (Individual services covered)	
Intensive Outpatient Program	State plan (Individual services covered)	
Partial Hospitalization Treatment (including Day Treatment for children/youth under the age of 21)	State plan (Individual services covered)	
Residential Treatment	State plan (Individual services covered)	Services provided to individuals in IMDs
Withdrawal Management	State plan	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT)	State plan	Services provided to individuals in IMDs
Peer Support (including Parent/Family Peer Support)	State plan	Services provided to individuals in IMDs

Crisis Intervention (including Mobile Crisis)	State plan (Individual services covered)	
Residential Crisis Stabilization	State plan (Individual services covered)	Services provided to individuals in IMDs

97. SUD Implementation Protocol. The state must submit an SUD Implementation Protocol within 90 calendar days after approval of this demonstration. The state may not claim FFP for services provided in IMDs until CMS has approved the Implementation Protocol. Once approved, the Implementation Protocol will be incorporated into the STCs, as Attachment C, and once incorporated, may be altered only with CMS approval. After approval of the Implementation Protocol, FFP will be available prospectively, not retrospectively. Failure to submit an Implementation Protocol or failure to obtain CMS approval will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral.

At a minimum, the SUD Implementation Protocol will describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD component of this demonstration project:

a. **Access to Critical Levels of Care for SUDs:** Service delivery for new benefits, including residential treatment, crisis stabilization and withdrawal management within 12-24 months of OUD/SUD program demonstration approval;

b. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;

c. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of demonstration approval;

d. **Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in Utah Administrative Code. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet

program standards in the ASAM Criteria or other comparable, nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

e. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

f. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval;

g. **Sufficient Provider Capacity at Critical Levels of Care including MAT:** An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval;

h. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand access to naloxone;

i. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in this STC; and

j. **Improved Care Coordination and Transitions:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of demonstration approval.

98. SUD Monitoring Protocol. The state must submit a SUD Monitoring Protocol within 150 calendar days after approval of SUD program under this demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment D. At a minimum, the SUD Monitoring Protocol will include reporting relevant to each of the program implementation areas listed in STC 97. The protocol will also describe the data collection, reporting and analytic methodologies for performance measures identified by the state and CMS for inclusion. The SUD Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section IX of the demonstration. In addition, for each performance measure, the SUD Monitoring Protocol will identify a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points. Where

possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements.

99. Mid-Point Assessment. The state must conduct an independent mid-point assessment between DYs 17 and 18 of the demonstration. The assessor must collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The assessment will include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Protocol, and toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol. The assessment will also include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. The mid-point assessment will also provide a status update of budget neutrality requirements. For each milestone or measure target at medium to high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The assessor will provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. A copy of the report will be provided to CMS. CMS will be briefed on the report.

For milestones and measure targets at medium to high risk of not being achieved, the state will submit to CMS modifications to the SUD Implementation Plan and SUD Monitoring Protocols for ameliorating these risks subject to CMS approval.

100. Deferral for Insufficient Progress Toward Milestones and Failure to Report Measurement Data. If the state does not demonstrate sufficient progress on milestones in the SUD Implementation Protocol, as determined by CMS, or fails to report data as approved in the SUD Monitoring Protocol, CMS will defer funds in the amounts specified in STC 43 for each incident of insufficient progress and failure to report in each reporting quarter.

101. SUD Evaluation. The SUD Evaluation will be subject to the same terms as the overall demonstration evaluation, as listed in Sections IX (General Reporting Requirements) and XIV (Evaluation of the Demonstration) of the STCs.

102. SUD Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred twenty (120) days after the effective date of these STCs. Failure to submit an acceptable and timely evaluation design along with any required monitoring, expenditure, or other evaluation reporting will subject the state to a $5 million deferral. The state must use an independent evaluator to design the evaluation.

a. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Quarterly Reports and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs.

b. **Evaluation Questions and Hypotheses.** The state must follow the general evaluation questions and hypotheses requirements as specified in STC 90. In addition, hypotheses for the SUD program should include an assessment of the objectives of the SUD component of this section 1115 demonstration, to include (but is not limited to): initiation and compliance with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes such as deaths due to overdose.

103. SUD Health Information Technology (Health IT). The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it will submit to CMS a plan to develop the infrastructure/capabilities. This "SUD Health IT Plan," or assurance, will be included as a section of the state's Implemenation Protocol (see STC 97) to be approved by CMS. The SUD Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement.

a. The SUD Health IT section of the Implementation Protocol will include implementation milestones and dates for achieving them (see Attachment D).

b. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.

c. The SUD Health IT Plan will describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP).[1]

d. The SUD Health IT Plan will address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] This will also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state

[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

[2] *Ibid*.

will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

e. The SUD Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

f. The SUD Health IT Plan will describe how the activities described in (a) through (e) above will: (a) support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns[3] and (b) ensure that Medicaid does not inappropriately pay for opioids–and that states implement effective controls to minimize the risk.

g. In developing the Health IT Plan, states shall use the following resources.

   i. States may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."

   ii. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

   iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration.

h. The state will include in its Monitoring Protocol (see STC 98) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.

i. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Reports (see STC 50).

[3] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

j. The state shall advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

i. Wherever it is appropriate, the state must require that contractors providing services paid for by funds authortized under this demonstration shall adopt the standards, referenced in 45 CFR Part 170.

ii. Wherever services paid for by funds authorized by this demonstration are not addressed by 45 CFR Part 170 but are addressed by the ISA, the state should require that contractors providing such services adopt the appropriate ISA standards.

104. SUD Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.

b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design will be adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the final Interim Evaluation Report 60 days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.

e. The Interim Evaluation Report must comply with Attachment B of these STCs.

105. SUD Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs. The state must submit a draft

Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 days of receiving comments from CMS on the draft.

b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

Attachment A: Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

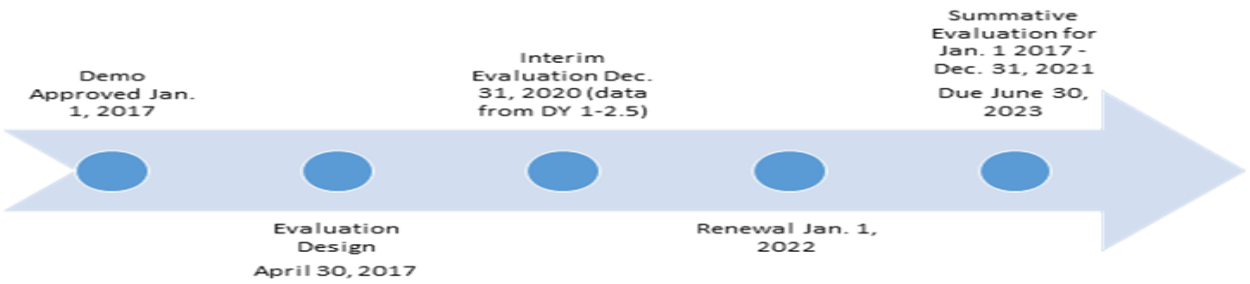
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended

outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3) Identify the state's hypotheses about the outcomes of the demonstration:
   a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
   b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) Evaluation *Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
   a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
   b. Qualitative analysis methods may be used, and must be described in detail.

c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

   If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
   b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
   c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
   d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

E. Special Methodological Considerations- CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:

1) When the state demonstration is:
    a. Long-standing, non-complex, unchanged, or
    b. Has previously been rigorously evaluated and found to be successful, or
    c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes; and

b. No or minimal appeals and grievances; and
c. No state issues with CMS 64 reporting or budget neutrality; and
d. No Corrective Action Plans (CAP) for the demonstration.

F. Attachments

A. Independent Evaluator. This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. This includes "No Conflict of Interest" signed conformation statements.

B. Evaluation Budget. A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

C. Timeline and Major Milestones. Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment B: Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

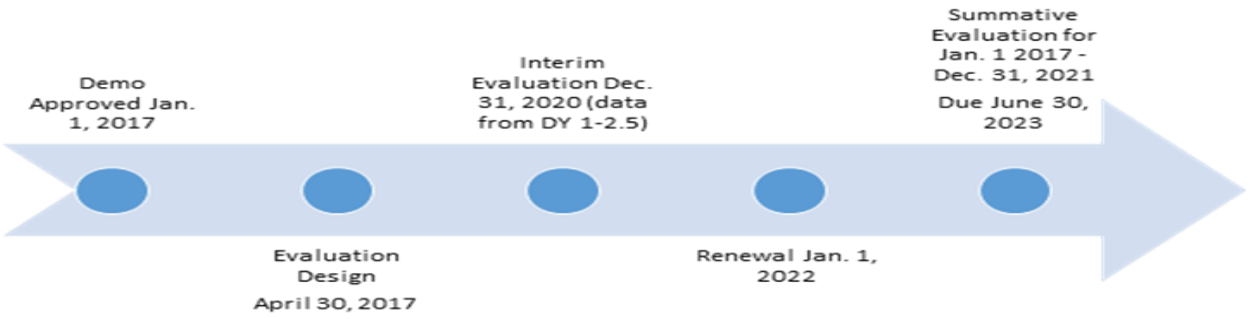
The format for the Interim and Summative Evaluation reports are as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;

D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

d. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

i. The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.

ii. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

iii. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;

iv. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.

v. Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2. Identify the state's hypotheses about the outcomes of the demonstration;
    a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
    b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
    c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Evaluation Design*—Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
2. *Target and Comparison Populations*—Describe the target and comparison populations; include inclusion and exclusion criteria.
3. *Evaluation Period*—Describe the time periods for which data will be collected
4. *Evaluation Measures*—What measures are used to evaluate the demonstration, and who are the measure stewards?
5. *Data Sources*—Explain where the data will be obtained, and efforts to validate and clean the data.
6. *Analytic methods*—Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations

This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. **Results** – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. **Conclusions** – In this section, the state will present the conclusions about the evaluation results.

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other

Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

1. Evaluation Design: Provide the CMS-approved Evaluation Design

Attachment C: SUD Implementation Protocol
[To be incorporated after CMS approval]

Attachment D: SUD Monitoring Protocol
[To be incorporated after CMS approval]