



Utah 1115 Demonstration Waiver

**1115 Demonstration Waiver
Extension Request**

**Demonstration Project No. 11- W-00145/8
21- W-00054/8**

**Extension Period
January 1, 2016 through December 31, 2016**

TABLE OF CONTENTS

Section 1 Extension Request- Letter from Governor Gary Herbert

Section 2 History of Utah's 1115 Waiver

Section 3 Program Description and Objectives

Section 4 Compliance with Special Terms and Conditions

Section 5 Compliance with Budget Neutrality Requirements

Section 6 Program Evaluation

Section 7 Public Notice and Tribal Consultation

Section 8 Quality Initiatives

Attachments

Section 1: Extension Request

Utah is seeking a one-year extension of the Primary Care Network Demonstration Waiver. The Utah State Legislature continues to debate the issue of Medicaid expansion for the optional adults. Legislative Leadership indicates that this issue will be addressed further during the 2016 Legislative Session. The General session is scheduled to run from January 25, 2016 through March 10, 2016. In order to avoid any gap in coverage for the individuals currently covered under this waiver, Utah is asking for an additional one year extension. The State of Utah is not requesting any changes to the demonstration and the same waivers and expenditure authorities will apply in the extension period.

Should the Utah Legislature approve expansion for the optional adult population, Utah will seek to amend this waiver as mechanism to obtain CMS approval for Utah's expansion program. If the Utah Legislature chooses not to expand Medicaid, Utah will submit a request for a full renewal of this current waiver by summer 2016.

Letter from the Governor

The State has included the letter from Governor Gary R. Herbert to Secretary Sylvia Matthews Burwell, Department of Health and Human Services dated June 26, 2015, requesting an additional one year extension of Utah's 1115 waiver.

Section 2: History of Utah's 1115 Waiver

In the first few months of Governor Michael Leavitt's first term, Governor Leavitt introduced HealthPrint, a step by step incremental plan for reducing the rates of uninsured in Utah. Under HealthPrint, Utah implemented initiatives targeted at very specific populations to increase coverage for children, seniors and the disabled. These initiatives were very successful in reducing the uninsured in Utah. However, there was still a need to address the health care access needs of thousands of low income working adults who had no health care coverage at all. These Utahns may be working in some cases but have no access to health care through their employer. In some cases these are individuals with health issues not severe enough to qualify them as disabled for purposes of Medicaid, but clearly significant enough to interfere with their ability to find and maintain employment at a level that would also provide them with access to health care coverage. Many of them are seasonal employees.

The 2014 Utah Health Status Survey indicates that 10.3% of Utahns (303,500 individuals) remained uninsured. Of those uninsured, 82% (249,000) are adults between the ages of 19 and 64. With regards to income, approximately 85,600 uninsured adults are between 0-138 percent FPL.

The intent of Utah 's Primary Care Network Demonstration waiver is to allow up to 25,000 uninsured adults whose income is below 95% of the federal poverty level to access a limited health care benefit focused on preventative care. The Primary Care Network (PCN) provides these individuals with ongoing access to primary care, pharmacy (up to four prescriptions per month) and emergency room coverage as well as other limited services.

In order to fund the cost of providing services to a portion of uninsured adults, under 95 percent FPL, parent and care taker relatives with incomes below 46 percent FPL

receive a slightly reduced benefit package. While reduced, the benefit package is still comprehensive and meets essential benefit requirements.

HISTORY

- The Utah PCN 1115 demonstration waiver was submitted on December 11, 2001, approved on February 8, 2002, implemented on July 1, 2002, and was originally scheduled to expire on June 30, 2007.
- **Amendment #1** - This amendment made a technical correction needed to ensure that certain current Medicaid eligibles (i.e., those age 19 and above who are eligible through sections 1925 and 1931) in the demonstration who become pregnant get the full Medicaid State plan benefit package. It eliminated or reduced the benefit package for Current Eligibles to conform to 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 suspends Amendment #2 - for the CAW program, which was absorbed by the new HIFA-ESI program. (Approved on October 25, 2006, effective on November 1, 2006.)

This amendment provides the option of ESI premium assistance to adults with countable household income up to and including 150 percent of the FPL, if the employee's cost to participate in the plan is at least 5 percent of the household's countable income. The State subsidizes premium assistance through a monthly subsidy of up to \$150 per adult. The employer must pay at least half (50 percent) of the employee's health insurance premium, but no employer share of the premium is required for the spouse or children. Likewise, an ESI component for children provides CHIP-eligible children with family incomes up to and including 200 percent of the FPL with the option of ESI premium assistance through their parent's employer or direct CHIP coverage. The per-child monthly premium subsidy depends on whether dental benefits are provided in the ESI plan. If provided, the premium subsidy is \$140 per month; otherwise, it drops to \$120 per month. If dental benefits are not provided by a child's ESI plan, the State offers dental coverage through direct CHIP coverage. Families and children are subject to the cost sharing of the employee's health plan, and the amounts are not limited to the title XXI out-of-pocket cost sharing limit of 5 percent. Benefits vary by the commercial health care plan product provided by each employer. However, Utah ensures that all participating plans cover, at a minimum, well-baby/well child care services, age appropriate immunizations, dental services, 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 health 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 the American Recovery and Reinvestment Act of 2009 (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. 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 is of limited duration and eligibility is scheduled to end February 28, 2010. The ARRA COBRA subsidy can last for up to 9 months, whereby individuals qualifying on December 31, 2009 could receive a subsidy through September 30, 2010. Once the ARRA subsidy ends, or for those not eligible for the ARRA COBRA subsidy, the Utah CPAP will continue to provide a monthly payment for up to 18 months to offset the cost of COBRA coverage. Under the Utah program, the amount of premium assistance available to a family will be based on the number of programmatically-eligible individuals in the household. However, as with the existing ESI program, the State will use various administrative databases to ensure that it does not exceed the individual/family's share of the cost of the COBRA premium.

The Utah CPAP program will provide premium assistance to programmatically-eligible individuals and families with existing COBRA coverage, whether or not the individual qualifies for the ARRA COBRA subsidy. Individuals and families, who are COBRA-eligible but, uninsured, may also apply for enrollment in the Utah CPAP. Once the Utah CPAP has been implemented, the State may provide premium assistance for up to three months of retroactive eligibility, but the first date of retroactive eligibility may not pre-date the first day the State was approved to amend the section 1115 PCN Demonstration. 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 State plans to implement CPAP on or about November 1, 2009.

- **Amendment #11**-This amendment raised the income eligibility for premium assistance for adults between the ages of 19 and 64 [Demonstration populations III (ESI) and V (COBRA)] from 150% of the FPL to 200 % of the FPL. This amendment was approved by CMS on 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 February 3, 2010 the State of Utah formally requested an extension of their PCN 1115 Demonstration waiver 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.

Section 1115(f) Extension – On December 28, 2012 the State of Utah formally requested an extension of their PCN 1115 Demonstration waiver under the authority of Section 1115(f) of the Social Security Act. The demonstration was set to expire June 30, 2013. The request was to renew the waiver for the period of July 1, 2013-June 30, 2016. CMS never acted on the request for extension. The extension was informally placed on hold pending Utah’s decision to expand Medicaid to the optional adult population between 0-138 percent FPL.

Request for One Year Extension- Effective December 24, 2013, CMS extended the Waiver until December 31, 2014.

Request for One Year Extension- effective December 19, 2014, CMS extended the Waiver until December 31, 2015.

Section 3: Program Description and Objectives

Utah's Primary Care Network (PCN) is a statewide section 1115 Demonstration to expand Medicaid coverage to certain able-bodied adults who are not eligible for State plan services and to offer these adults and children eligible for CHIP an alternative to traditional direct coverage public programs. For State plan eligibles who are categorically or medically needy parents or other caretaker relatives, the Demonstration provides a reduced benefit package and requires increased cost-sharing. Savings from this State plan population fund a Medicaid expansion for up to 25,000 uninsured adults age 19 to 64 with family incomes up to 95 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 until January 1, 2014. The implementation of ACA eliminated the need for a waiver for this population.

The PCN Demonstration was amended in October 2006 to also use Demonstration savings to offer assistance with payment of ESI premiums 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 adult in families with income up to 150 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.

Effective December 18, 2009, the PCN Demonstration was further amended to enable the State to provide premium assistance to children and adults for coverage obtained under the provisions of COBRA.

Effective September 2012, the waiver was further amended to allow adults up to 200% of the FPL be eligible for premium assistance for ESI or COBRA continuation coverage. Effective January 1, 2014, the PCN Demonstration was amended to reduce the eligibility income level for Demonstration Population I to 100 percent FPL consistent with the changes in eligibility with the implementation of ACA. In addition, this extension required Utah to use MAGI based methodologies for determining income. Further the extension approved a transition plans to move Demonstration I individuals with incomes at 100 percent FPL or greater off of the PCN program and to the federal marketplace. Finally this extension also amended the waiver to require cost sharing for all demonstration populations, where applicable, consistent with the Utah Medicaid state plan.

Section 4: Compliance with Special Terms and Conditions

Utah has successfully completed all deliverables required by the Primary Care Network Special Terms and Conditions and continues to work diligently to assure compliance with all waiver requirements. The State maintains comprehensive administrative rules, eligibility policies, and provider manuals that are regularly updated to reflect the most current operational policies and procedures of the Primary Care Network demonstration waiver.

Utah has complied with all applicable Federal statues relating to nondiscrimination.

Utah has complied with all applicable requirements of the Medicaid and CHIP expressed in laws, regulations, and policy statements, not expressly waived or identified as non applicable in the Special Terms and Conditions (STCs), apply to Utah's 1115 Demonstration Waiver, Primary Care Network.

Utah has complied with and has come into compliance with all changes in Federal law affecting the Medicaid or CHIP program that have occurred after the approval of the demonstration award date.

Utah's 1115 Demonstration Waiver adheres to all requirements of the approved 1115 waiver.

Utah remains within the budget neutrality expenditure cap for all populations.

Section 6: Compliance with Budget Neutrality Requirements

See Attachment

Section 7: Program Evaluation

See Attachment

Section 8: Public Notice and Tribal Consultation

Public Notice of the State's request for renewal and amendment and notice of Public Hearing was published in the Utah State Bulletin on October 15, 2015

On October 22, 2015 the State held a public hearing from 3:30 PM to 5:30 PM to take public comment on the extension request.

On September 11, 2015, a presentation regarding the request for renewal of Utah's 1115 Waiver and amendments was provided to the Utah Indian Health Advisory Board. This is the first step in our approved consultation process. The Tribes did not request additional consultation.

On June 16, 2015, the State's request for an additional one year extension of the PCN Waiver was discussed during the Medical Care Advisory Committee from 1:30PM to 3:30 PM and took public comment on the PCN Demonstration Waiver extension request.

Section 9: Quality Initiatives

State plan eligibles in thirteen counties receive physical health services through full risk capitated Medicaid Accountable Care Organizations (ACO) managed care plans.

Mental health and Substance Use Disorder services for populations covered under this waiver are also provided through pre-paid mental health plans (PAHPs). A copy of the State's latest External Quality Review Organization report is included with this request for renewal.

A copy of Utah's most current Consumer Assessment of Health Plans Survey (CAHPS) is included with this request for renewal.



UTAH DEPARTMENT OF
HEALTH

Preliminary Evaluation of Utah's 1115 Primary Care Network Demonstration Waiver

Information about the Demonstration

Title: 1115 Primary Care Network Demonstration Waiver

Awardee: Utah Department of Health

Timeline:

December 11, 2001	Waiver submitted
February 8, 2002	Approved
July 1, 2002	Implemented
June 30, 2007	Original expiration date
June 30, 2010	Extension expiration date
June 30, 2013	Extension expiration date
December 31, 2014	Extension expiration date
December 31, 2015	Extension expiration date

A Brief History of the Demonstration

Utah's 1115 waiver is a statewide demonstration to cover previously uninsured individuals through alternative benefit packages. This demonstration uses increased flexibility with current State plan eligibles to fund a Medicaid expansion for uninsured adults age 19 and older with incomes up to 95 percent of the Federal poverty level (FPL). It is known as the Primary Care Network (PCN). The waiver also includes coverage for High-Risk pregnant women whose assets exceed the current Medicaid asset limit.

The demonstration also provides an employer-sponsored health insurance option for uninsured adults with incomes up to 200 percent of the FPL and for children with family incomes up to 200 percent of the FPL. This option is known as Utah's Premium Partnership for Health Insurance (UPP). Children eligible for the Children's Health Insurance Program (CHIP) can elect to enroll in UPP if a parent has a qualified plan through work.

In addition the demonstration includes an insurance subsidy option for uninsured adults (up to 200% FPL) and children (up to 200%FPL) who are eligible for coverage under COBRA.

The original Utah 1115 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. On December 21, 2006, the waiver was extended through June 30, 2010. On June 23, 2010, the waiver was extended through June 30, 2013. The waiver continues to be extended on a yearly basis pending the State of Utah determining whether or not it will expand Medicaid for optional adults.

Prior to the demonstration, Utah was providing a limited-benefit program for otherwise uninsured adults through the Utah Medical Assistance Program (UMAP). Coverage for UMAP adults was generally provided with 100% state funds. At the time of the waiver's implementation, the UMAP adults were enrolled in PCN and UMAP was discontinued.

Population Groups impacted

Current Eligibles: This demonstration includes some modifications to benefits received by currently eligible "Non-Traditional Medicaid" clients

Demonstration Population #1 – PCN enrollees: Previously uninsured parents and adults without dependent children who enroll in this limited benefit program.

Demonstration Population #2 – Pregnant women with High-Risk pregnancies: Previously uninsured women who face a \$5,000 asset co-pay to enroll in traditional Medicaid. With the implementation of ACA and the elimination of Utah's asset test, this population is no longer covered under the waiver.

Demonstration Population #3 – UPP adults: Previously uninsured parents and adults without dependent children who use the premium subsidy to enroll in private, employer-sponsored health insurance.

Current eligible CHIP Children (Formally Demonstration Population #4): UPP children - Previously uninsured children who use the premium subsidy to enroll in private, employer-sponsored health insurance.

Demonstration Population #5 – UPP adults: Previously uninsured parents and adults without dependent children who use the premium subsidy to enroll in COBRA continuation coverage.

Demonstration Population #6 – COBRA eligible children: previously insured children who use a premium subsidy to enroll in COBRA continuation coverage.

Purposes, aims, objectives, and goals of the demonstration

Overarching strategy, principles, goals, and objectives

The primary strategy for this demonstration is to provide valuable benefits to a greater population by slightly reducing benefits to some currently covered populations. The demonstration is founded on the principle that the highest value health care comes from coverage for primary and preventive care. The goal of the demonstration is to reduce the number of uninsured as well as the rate of un-insurance for Utahns while improving the quality, value and access of care received by beneficiaries.

To show that value can be added to the system without increasing costs by shifting some resources from fully indemnified populations to populations that currently have no health care coverage. In addition, the demonstration seeks to increase health insurance coverage without directly providing the coverage through government-managed programs.

State's hypotheses on outcomes of the demonstration

There are five hypotheses in this demonstration that will be evaluated

Hypothesis #1: The demonstration will not negatively impact the overall health well-being of Current Eligibles who experience reduced benefits and increased cost sharing.

Hypothesis #2: The demonstration will improve well-being in Utah by:

- a. Reducing the number of Utahns without coverage for primary health care.
- b. Improving PCN enrollees' access to primary care.
- c. Improving the overall well-being in the health status of PCN enrollees.

Hypothesis #3: The demonstration will reduce the number of unnecessary visits to emergency departments by PCN enrollees.

Hypothesis #4: The demonstration will increase the number of prenatal visits for High-Risk pregnancies in comparison to the general population.

Hypothesis #5: The demonstration will assist previously uninsured individuals in obtaining employer-sponsored health insurance without causing a decrease in employers' contributions to premiums that is greater than any decrease in contributions in the overall health insurance market.

Hypothesis #6: The demonstration will assist individuals currently eligible for or enrolled in COBRA with monthly premium reimbursement to help reduce the number of uninsured while reducing the rate of un-insurance.

Key interventions

Implementation and administration of the Primary Care Network program (PCN.)

Implementation and administration of the Utah's Premium Partnership for Health Insurance Program (UPP) for both employer-sponsored insurance and COBRA continuation coverage.

Evaluation Design

General Approach to Evaluation

Data Sources

Claims Data: The State has access to claims data for PCN through the State's fee for service system. We will use that data to monitor utilization patterns and costs. The State also has access to claims and encounter data for Current Eligibles who are affected by this demonstration. Current Eligibles in Weber, Davis, Salt Lake and Utah counties are enrolled in managed care. Effective July 1, 2015, Current Eligibles in nine (9) additional counties are now required to enroll in a MCO for their health care except for specific carved out services.

Outcome Tracking Data: Specialty care is not an included benefit in the PCN demonstration for Demonstration Population I. Primary care providers may contact PCN administration and request a referral for specialty care. Charitable Care Coordinators endeavor to fill this gap by seeking donated charitable care from providers and institutions. Outcomes of these endeavors are tracked and summarized.

Comparison groups

Where possible, the State compares PCN enrollee utilization and health status to similar populations within traditional Medicaid and eligibles.

Introduction

Historically, Utahns age 19 to 64 have the highest rate of un-insurance in the state. The rate of un-insurance is highest among adults with family incomes below 100 percent of the Federal Poverty Level (FPL)—the working poor—a group that, even though employed, is not able to acquire or afford health insurance through their employers.

In 2011, 18.7 percent of all Utahns age 19-64 declared that they were uninsured. During that same year (2011), 13.2 percent of Utahns employed full-time were uninsured while 41.3 percent of Utahns with a household income below 95 percent FPL were uninsured. As of 2014, the rate of uninsurance in this group dropped to 14.7%. This is still too high and this leaves many Utahns at risk. It is this group that Utah's Primary Care Network (PCN) was designed to serve by offering limited benefits to cover their day-to-day needs and to encourage them to appropriately use the health care system. The basic goal of PCN is to serve a larger percentage of this income group with basic benefits than could be served if the coverage were more comprehensive.

Total enrollment fluctuates as applications are only accepted during open enrollment periods, which are held when sufficient resources are available to cover more people. The federal government requires PCN to enroll more adults with children than people without children. Because of this, PCN may schedule separate enrollment times for parents and those without children. To qualify as a parent, the applicant must have children age 18 or younger living at home. Enrollment can be held at any time throughout the year as space becomes available.

The primary source for applicants to learn about Utah's Primary Care Network is from the Department of Workforce Services Eligibility Workers, as applicants are seeking public assistance.

During state fiscal year (SFY) 2008 and into SFY 2009, the Utah Department of Health increased the marketing, and subsequently the awareness, of PCN resulting in peak enrollment during SFY 2009. During that peak (SFY 2009), a total of over 35,242 distinct lives were served for at least one month during the year. Moreover, the all-time monthly peak enrollment occurred in June of 2009, with 24,405 individuals participating in the Primary Care Network.

PCN offers primary care services which include: primary care provider visits; four prescriptions per month; dental exams, dental x-rays, cleanings, and fillings; immunizations; an eye exam (no glasses or contacts); routine lab services and x-rays; limited emergency department visits; emergency medical transportation; and birth control.

Overnight hospital stays, MRIs, CT scans, and similar services, as well as visits to specialists such as orthopedists or cardiologists are not covered under PCN. To assist PCN clients who may be in need of non-covered services, a written request may be made by a participant's primary care provider for a PCN Specialty Care Coordinator to assist in finding providers who are willing to donate services or provide treatment for a minimal co-pay.

Evaluation of Hypotheses

Hypothesis 1: *The demonstration will not negatively impact the overall well-being, in relation to health status, of Current Eligibles (Non-Traditional Medicaid) who experience reduced benefits and increased cost sharing.*

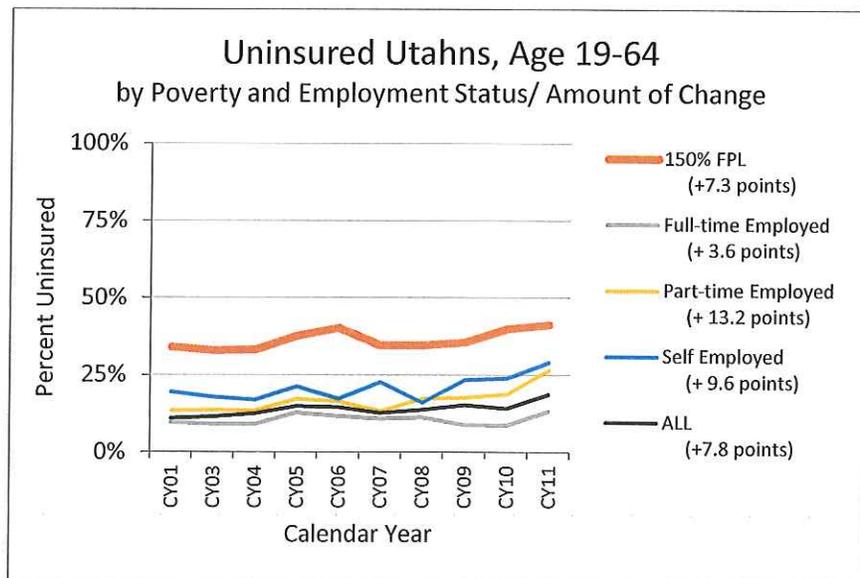
According to insurance claims filed with Utah medical assistance programs, during the first five years of the PCN program, many enrollees took advantage of the ability to see a primary care provider (PCP) as they had not access to basic health care for many years. The rate of individuals who accessed PCP care increased to a peak of 97 percent of enrollees in SFY 2006. During this same time period, Current Eligibles also increased their visits to PCPs to a peak of 69 percent in SFY 2006.

Rates of accessing a PCP diminished for both PCN and Current Eligibles from SFY 2006 to SFY 2009. However, with similar rates of decrease for both, one did not adversely affect the other.

During SFY 2009 and 2010, the Utah converted to a new eligibility enrollment system and PCN again experienced an increase in participants accessing a PCP, although not the degree experienced with the implementation of the PCN program (up to 68 percent in SFY 2011). At the same time, access to a PCP among Current Eligibles maintained an even rate between 38 percent and 40 percent. Again, there was no negative impact to the Current Eligibles as a result of the increase of PCN enrollees seeking PCP care. This data will be updated prior to submission of our next request to renew this waiver for an additional three years for the period if 2017-2020.

Hypothesis 2a: *The demonstration will improve well-being in Utah by reducing the number of Utahns without coverage for primary health care.*

Between 2001 and 2011, the percent of Utahns without health insurance increased among all adults age 19 to 64. This increase in uninsurance affected not only the PCN target group,)— but the three major employment groups as well: full-time, part-time, and self-employed.



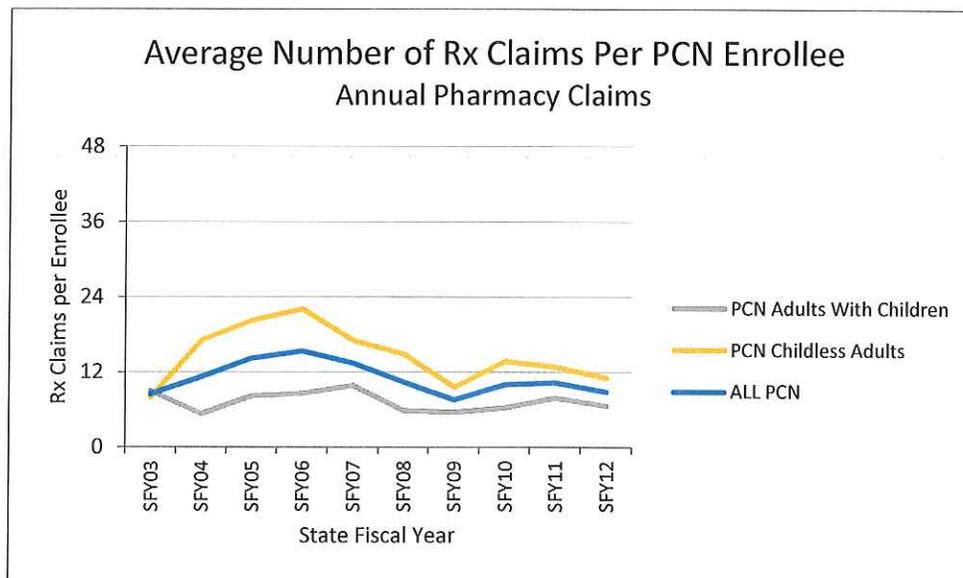
The PCN target group continues to have the highest rate of uninsurance, but the increase in the rate of uninsurance in the PCN target group is lower than for all of the employment groups except for adults employed full time. The PCN target group experienced an increase of 7.3 percentage points in uninsurance between 2001 (34.0 percent) to 2011 (41.3 percent), while the self-employed-adults group increased 9.6 points (2001: 19.5 percent to 2011: 29.1 percent), and the rate of uninsurance for the part-time-employed group nearly doubled, increasing 13.2 points (2001: 13.4 percent to 2011: 26.6 percent uninsured). Even the employed-full-time group experienced an increase in uninsurance, up 3.6 points (2001: 9.6 percent to 2011: 13.2 percent).

It is postulated that lower rate of increase in the target group is due, at least in part, to the availability of PCN insurance. Since the implementation of ACA, the rate of uninsurance in this group has decreased but, still remains at 27.8%. This data will be updated prior to submission of our next request to renew this waiver for an additional three years for the period if 2017-2020.

Hypothesis 2b: *The demonstration will improve well-being in Utah by improving PCN enrollees' access to primary care.*

The PCN benefit covers four prescriptions each month or a maximum of 48 per year. The number of prescriptions is not limited in the Medicaid and Non-Traditional Medicaid programs.

As reflected in Hypothesis 1 (PCP visits), the first few years of the PCN program ushered in a greater need to treat pent-up conditions among a group of people who had collectively been without health insurance for a number of years. Even so, with an allowable 48 prescription claims allowed per year, the highest average number of prescription claims filed among PCN enrollees is 15.3 in SFY 2006, including both PCN adults with children and PCN childless adults. As these initial needs were quelled, the average number of prescription claims per PCN enrollee has settled in at an average less than 12 per year.



Through PCN, approximately 24,000 individual lives each year since July 1, 2002 have been improved by having access to basic primary medical care and a limited number of prescriptions. This is coverage that is not available through any other source for this group of people. This data will be updated prior to submission of our next request to renew this waiver for an additional three years for the period if 2017-2020.

Hypothesis 2c: *The demonstration will improve well-being in Utah by improving the overall well-being in the health status of PCN enrollees.*

As a primary care program, PCN does not cover inpatient hospital services such as surgery or overnight hospital stays. If it is determined that a client needs to stay in the hospital for more than 24 hours, the client should contact the hospital's billing office to determine eligibility for the hospital's charity care program.

Likewise, specialty care services such as cardiology, gastroenterology, etc. are not covered by PCN. However, with a written referral that includes clinical notes from a primary care provider (PCP), PCN is committed to assisting with a search for donated services at little or no cost to the client.

Between April 2005 and June 2014, PCN Specialty Care Coordinators received a total of 19,360 referrals from PCPs. The Care Coordinators voluntarily tracked and categorized the outcomes of these referrals. Those tracked outcomes have been summarized into four categories.

Services Rendered: Successfully arranged specialty care, the requested service is a covered PCN benefit (specialty care was not required), clients arranged their own specialty service, and client obtained health insurance.

In Process: Outcome is pending, client is on the charitable-care waiting list at University Healthcare (U of U Medical Center), client has been contacted—awaiting a response, case was transferred, and duplicate referral.

Client's action: Client has not responded to communication, service was not required, client was not eligible for PCN, and client refused service.

Services Not Rendered: Client cannot pay fee, Intermountain Healthcare denied charity care, and service referral was unsuccessful/unavailable.

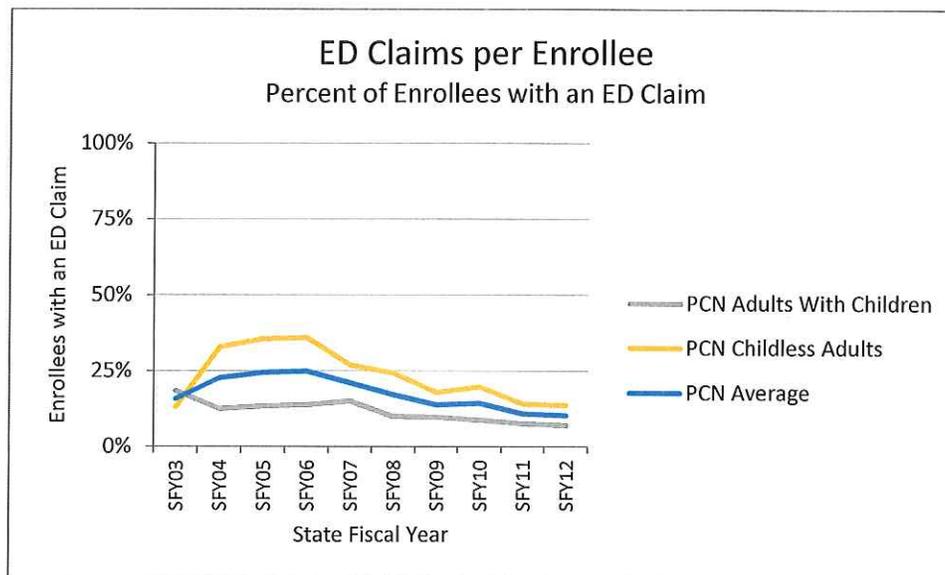
The majority of outcomes (those with the greatest proportion) falls in the "Services Rendered" category. Indeed, Specialty Care Coordinators have been able to report 37 percent (SFY 2010) to 47 percent (SFY 2014) of the referrals they have received have resulted in services being rendered.

By comparison, "Services Not Rendered" outcomes range from 18 percent (SFY 2009) to 23 percent (SFY 2006)—roughly half of what the "Services Rendered" percentages are for each fiscal year.

Outcomes identified as “In Process” in most cases were resolved in the following quarter. The group of outcomes categorized as “Client’s Action” were out of the Specialty Care Coordinator’s control, with the majority of them being a non-response from the client, even after the Coordinator attempted to contact them at a variety of times and using all available contact information. This data will be updated prior to submission of our next request to renew this waiver for an additional three years for the period if 2017-2020.

Hypothesis 3: *The demonstration will reduce the number of unnecessary visits to emergency departments by PCN enrollees.*

Consistent with Hypotheses 1 (PCP visits) and 2b (Rx claims), there were a higher percentage of PCN enrollees with emergency department (ED) claims in the first few years of the PCN program, primarily among childless adults, as multiple years of untreated conditions were being addressed. Indeed in state fiscal years 2004 through 2006, over one-third (33 to 36 percent) of PCN childless adults had an ED claim. In the subsequent years, the percent of PCN clients with an ED claim has maintained a downward trend, with 10 percent of PCN childless adults filing an ED claim in SFY 2012—a drop of 26 percentage points. Even among PCN adults with children, the percent with an ED claim started at 18 percent in SFY 2003 and was down to 7 percent in SFY 2012.

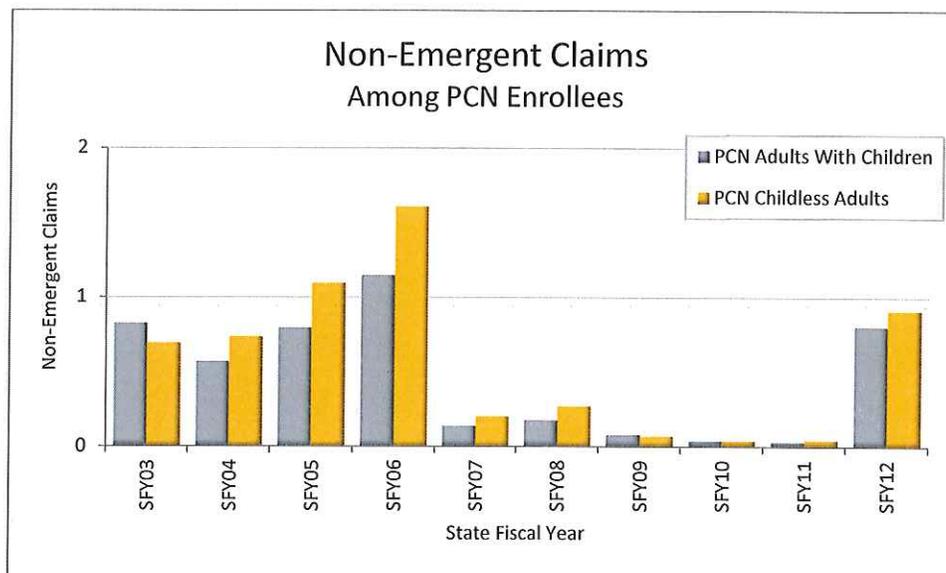


Looking deeper at the status of ED claim—whether they were coded as emergent or non-emergent by the provider—reveals that 0.8 claims per PCN adult with children and 0.7 claims per PCN childless adult were non-emergent in SFY 2003. That rate continued to increase and

reached a high in SFY 2006 with 1.1 non-emergent claims per PCN adult with children and 1.6 non-emergent claims per PCN childless adult.

In SFY 2007, efforts to educate all Medicaid enrollees about appropriate emergency department use increased and the overall number of ED claims decreased as did the incidence of non-emergent claims, dropping to 0.1 (PCN adults with children) and 0.2 (PCN childless adults) non-emergent claims per recipient.

The incidence of non-emergent ED claims has increased in SFY 2012 to levels that surpass SFY 2003 (0.8 and 0.9 claims per enrollee, respectively); this calls for a renewed effort to educate public health recipients about appropriate emergency department use.

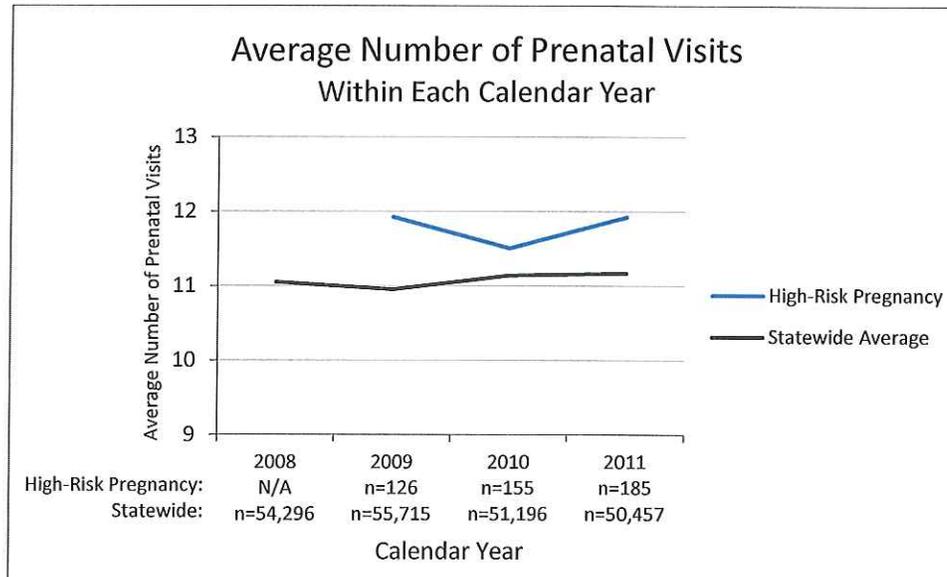


Hypothesis 4: *The demonstration will increase the number of prenatal visits for High-Risk pregnancies in comparison to the general population.*

According to the birth records within the Utah Office of Vital Records and Statistics, Utah women who give birth during 2008 had an average of 11.05 prenatal visits, which serves as a baseline for this comparison. This includes all women, regardless of health insurance coverage or risk level. In 2009, the statewide average number of prenatal visits decreased slightly to 10.95, but has consistently increased to an annual average of 11.17 prenatal visits in 2011.

The average number of prenatal visits for the High-Risk Pregnancy group has been consistently higher than the statewide average, with an average of 11.93 prenatal visits in 2009 (compared to 10.95 statewide). The rate of prenatal visits for the High-Risk Pregnancy

group dipped to 11.51 in 2010 and rebounded to 11.93 in 2011. It should be noted, however that the number of births under the 1115 Waiver (3-year average: 155) is significantly smaller than the total number of births in Utah (3-year average: 52,456).



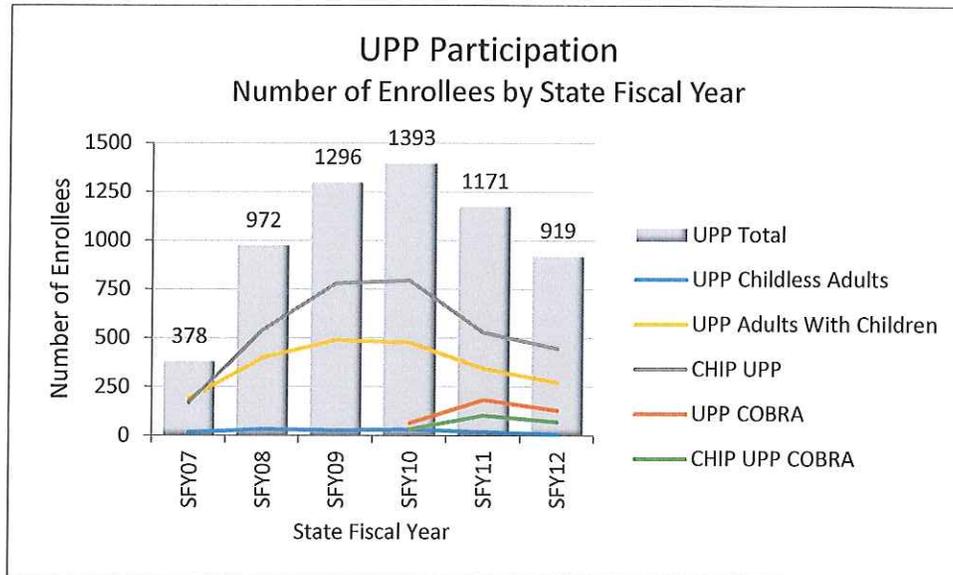
This hypothesis is no longer relevant with the elimination of the high risk pregnant woman’s program.

Hypothesis 5: *The demonstration will assist previously uninsured individuals in obtaining employer-sponsored health insurance without causing a decrease in employers' contributions to premiums that is greater than any decrease in contributions in the overall health insurance market.*

In November 2006, Utah’s Premium Partnership for Health Insurance (UPP) was implemented to create opportunities for qualified individuals and their family members under age 18 to purchase employer-sponsored health insurance by reimbursing health insurance premiums up to \$150 per adult and \$120 per child (\$140 per child if dental coverage is also purchased) every month.

The Utah Department of Health implemented a marketing push for UPP in SFY 2008 and SFY 2009, when total enrollment in UPP reached its peak of 1,393 participants. Then in March 2010, President Obama issued an Executive Order that clarified how rules limiting the use of federal funds for abortion services would be applied to the new health insurance exchanges. It was determined that the Executive Order in conjunction with the intent of the state law created new expectations for the UPP subsidy. In April 2010, an emergency rule was filed to prohibit UPP from reimbursing participants who were enrolled in plans covering abortion

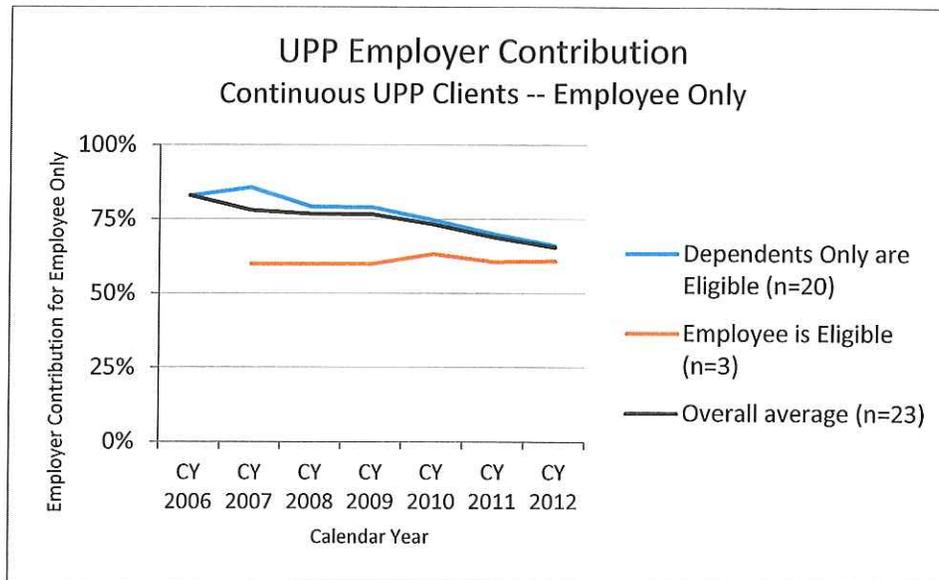
services beyond the circumstances allowed for the use of federal funds (i.e., life of the mother, rape, or incest). Subsequently, enrollment in UPP in SFY 2012—919 participants—is approximately two-thirds of what it was at its peak.



The population served by UPP is relatively small, a total of about 3,250 distinct lives over six years, counting both adults and their dependent children.

Just 23 clients have been continuously enrolled in UPP for the last five years. Of these individuals, 20 were not eligible for the employer reimbursement for their personal premium, but utilized UPP to assist with health insurance premium payments for their dependents. The three individuals who have received UPP assistance with their health insurance premium have experienced no decrease in employer contributions. Indeed, their employers were paying an average of 60 percent of the premium in 2007 and an average of 61 percent in 2012.

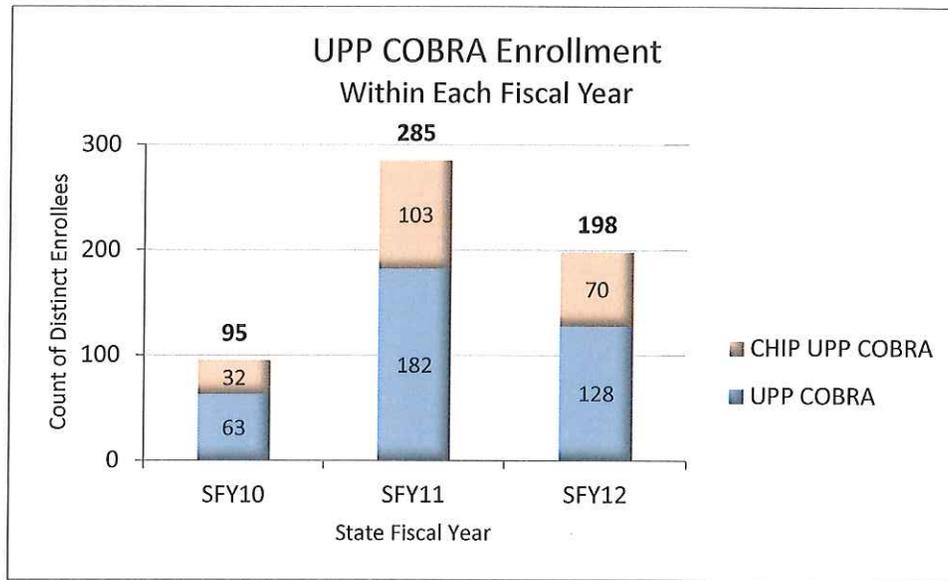
For individuals using UPP to assist with premiums for their dependents only, the employer contribution for their personal premium (not the premium of their dependents) has decreased from an average of 83 percent in 2006 to an average of 66 percent in 2012. However, UPP was not reimbursing this premium and is therefore not accountable for the decrease in the employer contribution. This data will be updated prior to submission of our next request to renew this waiver for an additional three years for the period of 2017-2020.



Hypothesis 6: *The demonstration will assist individuals currently eligible for or enrolled in COBRA* with monthly premium reimbursement to help reduce the number of uninsured while reducing the rate of uninsurance.*

Utah's 1115 Waiver was amended in SFY 2010 to allow for premium assistance for COBRA coverage. Based on family size, income, and if the former employer's health insurance coverage meets basic guidelines, UPP COBRA recipients may be reimbursed for up to \$150 per adult and up to \$120 per child in the family (up to \$140 per child, if the child is enrolled in dental coverage) every month.

In SFY 2011, the American Recovery and Reinvestment Act (ARRA) provided an additional subsidy for employers to pay for COBRA benefits resulting in higher UPP COBRA enrollment until the subsidy ended in February 2011. The end of this subsidy, combined with the 2010 executive order limiting which COBRA plans qualify for UPP assistance, resulted in 30 percent fewer UPP COBRA enrollees in SFY 2012



From its inception in SFY 2010 through the end of state fiscal year 2012, there have been 257 adults and 144 children (a total of 401 lives) who have received UPP assistance with their COBRA premiums.

Conclusion and Recommendations

Utah's 1115 Primary Care Network Demonstration Waiver has proved to provide a significant benefit to Utah residents who would otherwise have no health insurance coverage and would likely go without health care. Until such time, as the State of Utah determines how or if it will expand Medicaid coverage under the provisions of the federal Affordable Care Act, Utah's 1115 Primary Care Network Demonstration Waiver should continue. Without this waiver, thousands of Utahns would go without needed healthcare. The State will continue to gather additional data and will provide a formal analysis and recommendations when an application for a three year renewal is submitted to CMS in 2016.

I. CALCULATION OF BUDGET NEUTRALITY LIMIT (Without Waiver Ceiling)

Medicaid Eligibility Group	SFY 2001 Per Member Per Month (PMPM) (Base Year)	Demonstration Year (DY) #1	Member Months				Total	Budget Neutrality Limit DY 1 (TF)	Effective FMAP	Budget Neutrality Limit DY 1 (FF)
			QE 9/02	QE 12/02	QE 3/03	QE 6/03				
Current eligibles 1902(r)(2) - PCN	\$333.55	1.08	\$389.05	223,729	\$87,042,376	62,978	\$61,739,157.29	70.93%	\$61,739,157.29	
	n/a	1.08	\$54.00	\$90,449,188	\$90,449,188		\$64,151,353.24	70.93%	\$64,151,353.24	
Total BN Limit										
Current eligibles 1902(r)(2) - PCN		DY #2	Member Months <td rowspan="2">Total <th rowspan="2">Budget Neutrality Limit DY 2 (TF)</th> <th rowspan="2">Effective FMAP</th> <th rowspan="2">Budget Neutrality Limit DY 2 (FF)</th> </td>				Total <th rowspan="2">Budget Neutrality Limit DY 2 (TF)</th> <th rowspan="2">Effective FMAP</th> <th rowspan="2">Budget Neutrality Limit DY 2 (FF)</th>	Budget Neutrality Limit DY 2 (TF)	Effective FMAP	Budget Neutrality Limit DY 2 (FF)
		PMPM	QE 9/03	QE 12/03	QE 3/04	QE 6/04				
Current eligibles 1902(r)(2) - PCN		1.08	\$420.18	257,558	\$105,639,870		\$75,680,390.97	71.60%	\$75,680,390.97	
		1.08	\$89.92	\$115,212	\$5,715,164	\$112,418,034	\$4,810,921.31	71.60%	\$4,810,921.31	
Total BN Limit										
Current eligibles 1902(r)(2) - PCN		DY #3	Member Months <td rowspan="2">Total <th rowspan="2">Budget Neutrality Limit DY 3 (TF)</th> <th rowspan="2">Effective FMAP</th> <th rowspan="2">Budget Neutrality Limit DY 3 (FF)</th> </td>				Total <th rowspan="2">Budget Neutrality Limit DY 3 (TF)</th> <th rowspan="2">Effective FMAP</th> <th rowspan="2">Budget Neutrality Limit DY 3 (FF)</th>	Budget Neutrality Limit DY 3 (TF)	Effective FMAP	Budget Neutrality Limit DY 3 (FF)
		PMPM	QE 9/04	QE 12/04	QE 3/05	QE 6/05				
Current eligibles 1902(r)(2) - PCN		1.08	\$453.75	269,541	\$122,345,395		\$88,115,945.64	72.04%	\$88,115,945.64	
		1.08	\$62.98	\$138,562	\$8,727,411	\$137,092,716	\$6,287,226.67	72.04%	\$6,287,226.67	
Total BN Limit										
Current eligibles 1902(r)(2) - PCN		DY #4	Member Months <td rowspan="2">Total <th rowspan="2">Budget Neutrality Limit DY 4 (TF)</th> <th rowspan="2">Effective FMAP</th> <th rowspan="2">Budget Neutrality Limit DY 4 (FF)</th> </td>				Total <th rowspan="2">Budget Neutrality Limit DY 4 (TF)</th> <th rowspan="2">Effective FMAP</th> <th rowspan="2">Budget Neutrality Limit DY 4 (FF)</th>	Budget Neutrality Limit DY 4 (TF)	Effective FMAP	Budget Neutrality Limit DY 4 (FF)
		PMPM	QE 9/05	QE 12/05	QE 3/06	QE 6/06				
Current eligibles 1902(r)(2) - PCN		1.08	\$490.09	264,052	\$129,470,461		\$92,010,795.28	71.10%	\$92,010,795.28	
		1.08	\$68.02	\$116,364	\$7,915,957	\$137,325,998	\$5,627,989.37	71.10%	\$5,627,989.37	
Total BN Limit										
Current eligibles 1902(r)(2) - HIFA*		DY #5	Member Months <td rowspan="2">Total <th rowspan="2">Budget Neutrality Limit DY 5 (TF)</th> <th rowspan="2">Effective FMAP</th> <th rowspan="2">Budget Neutrality Limit DY 5 (FF)</th> </td>				Total <th rowspan="2">Budget Neutrality Limit DY 5 (TF)</th> <th rowspan="2">Effective FMAP</th> <th rowspan="2">Budget Neutrality Limit DY 5 (FF)</th>	Budget Neutrality Limit DY 5 (TF)	Effective FMAP	Budget Neutrality Limit DY 5 (FF)
		PMPM	QE 9/06	QE 12/06	QE 3/07	QE 6/07				
Current eligibles 1902(r)(2) - HIFA*		1.08	\$29.99	214,792	\$113,669,820		\$79,923,943.63	70.30%	\$79,923,943.63	
		1.08	\$73.47	\$9,830,760	\$70,300	\$175,350	\$6,911,024.21	70.30%	\$6,911,024.21	
Total BN Limit										
Current eligibles 1902(r)(2) - HIFA*		DY #6	Member Months <td rowspan="2">Total <th rowspan="2">Budget Neutrality Limit DY 6 (TF)</th> <th rowspan="2">Effective FMAP</th> <th rowspan="2">Budget Neutrality Limit DY 6 (FF)</th> </td>				Total <th rowspan="2">Budget Neutrality Limit DY 6 (TF)</th> <th rowspan="2">Effective FMAP</th> <th rowspan="2">Budget Neutrality Limit DY 6 (FF)</th>	Budget Neutrality Limit DY 6 (TF)	Effective FMAP	Budget Neutrality Limit DY 6 (FF)
		PMPM	QE 9/07	QE 12/07	QE 3/08	QE 6/08				
Current eligibles 1902(r)(2) - PCN		1.066	\$564.24	194,914	\$109,977,468		\$78,369,943.69	71.26%	\$78,369,943.69	
		1.066	\$73.32	\$148,028	\$11,562,840	\$121,969,739	\$8,261,058.09	71.26%	\$8,261,058.09	
Current eligibles 1902(r)(2) - HIFA		1.066	\$159.99	2,498	\$399,430		\$284,633.96	71.26%	\$284,633.96	
							\$86,915,635.74	71.26%	\$86,915,635.74	
Total BN Limit										

Budget Neutrality

Budget

BN Ceiling Calculation

IX. Member Month Reporting

Enter the member months for each of the eligibility groups for the quarter

A. For Use in Budget Neutrality Calculations Eligibility Group

	Month 1 Jul 2014	Month 2 Aug 2014	Month 3 Sep 2014	Month 4 Oct 2014	Month 5 Nov 2014	Month 6 Dec 2014	Month 7 Jan 2015	Month 8 Feb 2015	Month 9 Mar 2015	Month 10 Apr 2015	Month 11 May 2015	Month 12 Jun 2015	Total for Quarter Ending 06/15
Current Eligibles	32,346	31,720	31,218	30,641	30,289	30,428	30,793	31,105	31,943	32,856	32,537	32,422	377,798
PCN Demonstration Population (DP) #1 (PC1 & PC2)	15,111	17,666	19,882	20,078	19,820	19,552	18,703	17,610	16,215	15,228	14,220	12,898	206,983
High Risk Pregnancy DP #2	0	0	0	0	0	0	0	0	0	0	0	0	0
HIFA DP #3	207	223	250	273	275	304	370	397	413	409	423	432	3,976
HIFA COBRA DP #5	5	5	5	9	9	8	8	8	8	8	7	6	86

Update cell ref in pivot table
Update cell ref from HRP tab
Update cell ref in pivot table
Update cell ref in pivot table

B. Not Used in Budget Neutrality Calculations Eligibility Group

	Month 1 Jul 2014	Month 2 Aug 2014	Month 3 Sep 2014	Month 4 Oct 2014	Month 5 Nov 2014	Month 6 Dec 2014	Month 7 Jan 2015	Month 8 Feb 2015	Month 9 Mar 2015	Month 10 Apr 2015	Month 11 May 2015	Month 12 Jun 2015	Total for Quarter Ending 06/15
CHIP Current Eligibles (C1-C13)	15,377	15,506	15,675	15,852	14,966	15,045	15,460	15,834	16,149	16,274	16,223	16,171	188,532
CHIP HIFA COBRA DP #6 (C14-C19)	280	273	291	297	290	298	345	376	401	403	409	433	4,096

Federal Title XXI Share	\$	125,459	\$	397,392	\$	288,567	\$	500,147	\$	469,930	\$	369,548	\$	366,105
State Share	\$	32,936	\$	100,094	\$	68,575	\$	124,958	\$	118,291	\$	94,068	\$	97,495
TOTAL COSTS FOR DEMONSTRATION	\$	158,395	\$	497,486	\$	337,142	\$	625,105	\$	588,222	\$	463,616	\$	463,600
TOTAL PROGRAM COSTS (State Plan + Demonstration)	\$53,552,416	\$57,880,792	\$70,495,510	\$77,840,594	\$74,794,443	\$71,261,016	\$67,663,064							
Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	\$79,238,025	\$81,673,666	\$96,694,753	\$110,996,579	\$115,402,178	\$131,736,149	\$74,933,993							
Total Federal Title XXI Program Costs (State Plan + Demonstration)	\$42,416,994	\$46,235,177	\$56,156,723	\$62,120,239	\$69,763,280	\$68,802,156	\$53,433,522							
Unused Title XXI Funds Expiring (Allotment or Reallocated)	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	\$36,821,031	\$35,438,489	\$40,528,030	\$48,876,340	\$55,648,898	\$74,933,993	\$21,500,471							
Source of Funds: Tobacco Settlement Funds	\$40,836,058	\$51,847,482	\$54,376,807	\$59,400,825	\$72,395,510	\$76,212,798	\$70,063,000							

= Actual Costs
 = Estimated Costs

III. SUMMARY BY DEMONSTRATION YEAR AND CUMULATIVELY (Federal Funds)

	Budget Neutrality Limit	Waiver Costs on CMS-64	Annual Variance	Variance As % of Annual BN Limit	Cumulative Budget Neutrality Limit	Cumulative Waiver Costs on CMS-64	Cumulative Variance	Variance As % of Cumulative BN Limit
DY #1 (SFY 2003)	\$64,151,353	\$68,519,660	-\$4,368,307	-6.81%	\$64,151,353	\$68,519,660	-\$4,368,307	-6.81%
DY #2 (SFY 2004)	\$80,491,312	\$77,006,658	\$3,484,654	4.33%	\$144,642,666	\$145,526,318	-\$883,652	-0.61%
DY #3 (SFY 2005)	\$94,403,172	\$90,341,017	\$4,062,155	4.30%	\$239,045,838	\$235,867,335	\$3,178,503	1.33%
DY #4 (SFY 2006)	\$97,638,785	\$87,381,267	\$10,257,518	10.51%	\$336,684,622	\$323,248,602	\$13,436,020	3.99%
DY #5 (SFY 2007)	\$86,958,239	\$85,043,241	\$1,914,998	2.20%	\$423,642,861	\$408,291,843	\$15,351,018	3.62%
DY #6 (SFY 2008)	\$86,915,636	\$83,042,595	\$3,873,041	4.46%	\$510,558,497	\$491,334,438	\$19,224,059	3.77%
DY #7 (SFY 2009)	\$107,710,583	\$98,021,370	\$9,689,213	9.00%	\$618,269,080	\$589,355,808	\$28,913,272	4.68%
DY #8 (SFY 2010)	\$136,144,532	\$118,491,483	\$17,653,049	12.97%	\$754,413,612	\$707,847,291	\$46,566,321	6.17%
DY #9 (SFY 2011)	\$165,352,483	\$113,974,083	\$51,378,400	31.07%	\$919,766,095	\$821,821,374	\$97,944,721	10.65%
DY #10 (SFY 2012)	\$204,481,176	\$103,738,251	\$100,742,925	49.27%	\$1,124,247,271	\$925,559,625	\$198,687,646	17.67%
DY #11 (SFY 2013)	\$219,132,390	\$122,359,381	\$96,773,009	44.16%	\$1,343,379,661	\$1,047,919,006	\$295,460,655	21.99%
DY #12 (SFY 2014)	\$231,717,424	\$126,974,320	\$104,743,104	45.20%	\$1,575,097,084	\$1,174,893,326	\$400,203,758	25.41%
DY #13 (SFY 2015)	\$235,389,242	\$134,454,146	\$100,935,096	42.88%	\$1,810,486,326	\$1,309,347,472	\$501,138,854	27.68%
DY #14 (SFY 2016)	\$246,983,414	\$141,178,000	\$105,805,414	42.84%	\$2,057,469,741	\$1,450,525,472	\$606,944,269	29.50%
DY #15 (SFY 2017)								
Only two quarters estimated. Waiver extension ends 12/31/2016.	\$129,666,292	\$74,118,450	\$55,547,842	42.84%	\$2,187,136,033	\$1,524,643,922	\$662,492,111	30.29%

Legend

- = Estimated Figures
- = Neutrality Limit without waiver ceiling QTD Amount
- = Actual Expenditures 1115 Waivers QTD Amount

Row #	B	C	D	E	F	G	H	I	J	K	
	II. WAIVER COSTS AND VARIANCE FROM BUDGET NEUTRALITY LIMIT BY QUARTER (Federal Funds)										
	EXPENDITURES (Federal Funds)										
	Current Eligibles	Demo Population I - PCN	Demo Population II	Demo Population III - HIFA	Adults w/Children (Section 1902(r)(2) Adults; also Known as Hypothetical	Childless Adults (PCN) Adults in Demo Population I = 1115	Childless Adults (Section 1902(r)(2) Adults; also Known as Hypothetical	Adults w/Children (Section 1902(r)(2) Adults; also Known as Hypothetical	Childless Adults (HIFA) Adults in Demo Population III = 1115	Expansion Group	Expansion Group
State Fiscal Year (SFY)- Demonstration Year (DY)	Adults)	State Plan Eligibles	Expansion Group)	Expansion Group)	State Plan Eligibles	Expansion Group)	Expansion Group)	State Plan Eligibles	Expansion Group)	TOTAL	VARIANCE
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											

Legend

- = Estimated Figures
- = Neutrality Limit without waiver ceiling
- = Actual Expenditures from MBES/CBES reports including prior period adjustments

Row #	B	C	D	E	F	G	H	I	J	K	
II. WAIVER COSTS AND VARIANCE FROM BUDGET NEUTRALITY LIMIT BY QUARTER (Federal Funds)											
EXPENDITURES (Federal Funds)											
State Fiscal Year (SFY)- Demonstration Year (DY)	Budget Neutrality Limit (FF)	Current Eligibles (Sections 1925 and 1931 Adults and Medically Needy)	Demo Population I - PCN (Section 1902(f)(2) Adults; also Known as Hypothetical)	Childless Adults (PCN) Adults in Demo Population I = 1115	Expansion Group	Demo Population II (High-Risk Pregnant Women = 1115)	Expansion Group	Demo Population III - HIFA (Section 1902(f)(2) Adults; also Known as Hypothetical)	Childless Adults (HIFA) Adults in Demo Population III = 1115	Expansion Group	Variance
		Adults	State Plan Eligibles	Expansion Group	Expansion Group	State Plan Eligibles	Expansion Group	State Plan Eligibles	Expansion Group	TOTAL	VARIANCE
SFY14-DY12	\$231,717,423.84	\$117,401,623	\$2,805,566	\$5,712,481	\$846,706	\$196,273	\$11,671	\$126,974,320	\$104,743,104		
QE 9/13		\$30,520,807	\$808,907	\$1,413,888	\$370,570	\$50,241	\$2,088	\$33,166,501			
QE 12/13		\$28,785,389	\$719,994	\$1,529,438	\$336,585	\$47,608	\$3,843	\$31,422,857			
QE 3/14		\$27,956,030	\$750,936	\$1,513,147	\$152,256	\$49,361	\$3,504	\$30,425,234			
QE 6/14		\$32,146,166	\$620,106	\$1,496,500	\$24,242	\$50,315	\$2,447	\$34,339,776			
								\$129,354,368			
SFY15-DY13	\$235,389,241.99	\$121,303,682	\$3,696,542	\$9,081,566	\$17,994	\$344,314	\$10,048	\$134,454,146	\$100,935,096		
QE 9/14		\$28,420,265	\$757,709	\$2,117,542	\$13,523	\$66,794	\$2,315	\$31,370,148			
QE 12/14		\$32,199,953	\$1,035,542	\$2,615,201	\$4,226	\$73,983	\$2,295	\$35,931,200			
QE 3/15		\$28,594,171	\$1,153,257	\$2,481,997	\$165	\$100,649	\$2,499	\$32,332,758			
QE 6/15		\$32,089,293	\$750,094	\$1,866,826	\$60	\$110,888	\$2,939	\$34,820,040			
								\$134,454,146			
TOTAL	\$1,810,478,997							\$1,309,347,472	\$501,131,525 SFY15		
QE 9/15								\$0	\$0		
QE 12/15								\$0	\$0		
QE 3/16								\$0	\$0		
QE 6/16								\$0	\$0		
SFY16-DY14	\$246,983,414.23	\$127,369,000	\$3,881,000	\$9,536,000	\$19,000	\$362,000	\$11,000	\$141,178,000	\$105,805,414.23		
TOTAL	\$2,057,462,412							\$1,450,525,472	\$606,936,940 SFY16		
QE 9/16		\$33,434,363	\$1,018,753	\$2,503,200	\$4,988	\$95,025	\$2,888	\$37,059,225	-\$37,059,225		
QE 12/16		\$33,434,363	\$1,018,753	\$2,503,200	\$4,988	\$95,025	\$2,888	\$37,059,225	-\$37,059,225		
End of Waiver Extension								\$0	\$0		
SFY17-DY15	\$129,566,292.47	\$66,868,725	\$2,037,525	\$5,006,400	\$9,975	\$190,050	\$5,775	\$74,118,450	\$55,547,842.47		
TOTAL	\$2,187,128,704							\$1,524,643,922	\$662,484,782 Cumulative savings in Federal Funds at the end of waiver extension 12/31/2016		

Row #	B	C	D	E	F	G	H	I	J	K
2	II. WAIVER COSTS AND VARIANCE FROM BUDGET NEUTRALITY LIMIT BY QUARTER (Federal Funds)									
3	EXPENDITURES (Federal Funds)									
4			Current Eligibles	Demo Population I - PCN	Demo Population II	Demo Population III - HIFA				
5			(Sections 1925 and 1931 Adults and Medically Needy)	Childless Adults (PCN)	(High-Risk Pregnant Women = 1115)	Childless Adults (HIFA)				
6				Adults in Demo Population I = 1115	Adults in Demo Population III = 1115	Adults in Demo Population III = 1115				
7				State Plan Eligibles	Expansion Group	Expansion Group	Expansion Group			
8				Adults						
9				\$28,929,148	\$1,170,194	\$419,020	\$43,026	\$835	\$31,188,602	
10										
11										
12										
56										
57										

Row#	B	C	D	E	F	G	H	I	J	K		
II. WAIVER COSTS AND VARIANCE FROM BUDGET NEUTRALITY LIMIT BY QUARTER (Federal Funds)												
EXPENDITURES (Federal Funds)												
State Fiscal Year (SFY)- Demonstration Year (DY)	BUDGET NEUTRALITY LIMIT (FF)	Current Eligibles			Demo Population I - PCN			Demo Population II			TOTAL	VARIANCE
		Adults (Sections 1925 and 1931 Adults and Medically Needy)	Adults w/Children (Section 1902(f)(2) Adults; also Known as Hypothetical	Childless Adults (PCN) Adults in Demo Population I = 1115	Expansion Group)	Adults w/Children (Section 1902(f)(2) Adults; also Known as Hypothetical	Childless Adults (HIFA) Adults in Demo Population III = 1115	Expansion Group)				
SFY03-DY1	\$64,151,353	\$61,595,233	\$2,809,194	\$4,115,233	\$604,159	\$679,517	\$604,159	\$679,517	\$118,491,483	\$118,491,483	\$-4,368,307	
SFY04-DY2	\$80,491,312	\$64,047,444	\$5,102,354	\$7,856,860	\$604,159	\$679,517	\$604,159	\$679,517	\$118,491,483	\$118,491,483	\$3,484,654	
SFY05-DY3	\$84,403,172	\$75,766,088	\$5,025,695	\$8,945,075	\$604,159	\$679,517	\$604,159	\$679,517	\$118,491,483	\$118,491,483	\$4,062,155	
SFY06-DY4	\$97,638,785	\$73,867,437	\$5,003,894	\$7,830,419	\$604,159	\$679,517	\$604,159	\$679,517	\$118,491,483	\$118,491,483	\$10,257,518	
SFY07-DY5	\$86,938,233	\$69,226,888	\$6,689,112	\$8,423,719	\$604,159	\$679,517	\$604,159	\$679,517	\$118,491,483	\$118,491,483	\$1,914,998	
SFY08-DY6	\$86,915,636	\$64,034,372	\$7,816,087	\$10,288,425	\$604,159	\$679,517	\$604,159	\$679,517	\$118,491,483	\$118,491,483	\$3,873,041	
SFY09-DY7	\$107,710,583	\$80,057,050	\$7,678,231	\$9,135,522	\$604,159	\$679,517	\$604,159	\$679,517	\$118,491,483	\$118,491,483	\$9,689,213	
SFY10-DY8	\$136,144,532	\$88,953,823	\$7,113,145	\$10,884,573	\$604,159	\$679,517	\$604,159	\$679,517	\$118,491,483	\$118,491,483	\$17,653,049	
Q.E. 9/09	\$25,404,224	\$25,089,905	\$3,213,039	\$3,213,039	\$232,319	\$232,319	\$232,319	\$232,319	\$31,021,018	\$31,021,018	\$3,732	
Q.E. 12/09	\$24,615,745	\$1,874,409	\$3,044,399	\$3,044,399	\$347,954	\$347,954	\$347,954	\$347,954	\$29,963,790	\$29,963,790	\$4,565	
Q.E. 3/10	\$24,962,162	\$24,962,162	\$1,689,854	\$2,599,851	\$267,213	\$267,213	\$267,213	\$267,213	\$29,611,262	\$29,611,262	\$6,686	
Q.E. 6/10	\$24,021,210	\$1,461,277	\$2,038,639	\$2,038,639	\$392,409	\$392,409	\$392,409	\$392,409	\$27,988,661	\$27,988,661	\$4,829	
SFY11-DY9	\$165,352,483	\$97,505,075	\$6,667,985	\$7,558,191	\$2,065,494	\$2,065,494	\$2,065,494	\$2,065,494	\$113,974,083	\$113,974,083	\$51,378,400	
Q.E. 9/10	\$23,642,606	\$1,593,935	\$1,378,275	\$1,378,275	\$470,913	\$470,913	\$470,913	\$470,913	\$27,149,949	\$27,149,949	\$3,671	
Q.E. 12/10	\$21,985,218	\$1,448,113	\$1,409,797	\$1,409,797	\$568,743	\$568,743	\$568,743	\$568,743	\$25,470,411	\$25,470,411	\$2,444	
Q.E. 3/11	\$26,748,422	\$2,022,504	\$2,547,211	\$2,547,211	\$519,788	\$519,788	\$519,788	\$519,788	\$31,896,585	\$31,896,585	\$1,247	
Q.E. 6/11	\$25,483,124	\$1,609,947	\$2,252,914	\$2,252,914	\$508,848	\$508,848	\$508,848	\$508,848	\$29,912,746	\$29,912,746	\$1,193	
SFY12-DY10	\$204,481,176	\$92,082,713	\$4,062,659	\$5,229,714	\$2,178,598	\$2,178,598	\$2,178,598	\$2,178,598	\$103,738,251	\$103,738,251	\$100,742,925	
Q.E. 9/11	\$21,287,271	\$907,793	\$1,421,012	\$1,421,012	\$489,245	\$489,245	\$489,245	\$489,245	\$24,158,284	\$24,158,284	\$896	
Q.E. 12/11	\$24,518,095	\$871,277	\$1,252,389	\$1,252,389	\$562,692	\$562,692	\$562,692	\$562,692	\$27,255,049	\$27,255,049	\$1,270	
Q.E. 3/12	\$24,001,563	\$1,065,431	\$1,072,774	\$1,072,774	\$478,982	\$478,982	\$478,982	\$478,982	\$26,661,940	\$26,661,940	\$1,255	
Q.E. 6/12	\$25,124,250	\$1,271,595	\$1,751,893	\$1,751,893	\$660,865	\$660,865	\$660,865	\$660,865	\$28,846,411	\$28,846,411	\$963	
SFY13-DY11	\$219,125,060,336	\$113,323,744	\$2,995,349	\$3,582,897	\$2,310,740	\$2,310,740	\$2,310,740	\$2,310,740	\$122,359,381	\$122,359,381	\$95,765,679	
Q.E. 9/12	\$24,949,124	\$1,018,742	\$1,563,872	\$1,563,872	\$519,334	\$519,334	\$519,334	\$519,334	\$28,083,161	\$28,083,161	\$1,116	
Q.E. 12/12	\$27,674,525	\$864,079	\$1,479,990	\$1,479,990	\$867,999	\$867,999	\$867,999	\$867,999	\$30,921,732	\$30,921,732	\$940	
Q.E. 3/13	\$32,399,012	\$493,117	\$824,287	\$824,287	\$515,655	\$515,655	\$515,655	\$515,655	\$34,271,956	\$34,271,956	\$731	