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

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

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

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

State/Territory:_____Idaho_____
(Name of State/Territory)

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

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

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

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

Name: Robin Pewtress	Position/Title: State S/CHIP Coordinator Policy Specialist, Division of Medicaid
Name: Leslie Clement	Position/Title: State Medicaid Director Administrator, Division of Medicaid
Name: David Butler	Position/Title: Chief Financial Officer Deputy Director, Division of Management Services

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is

estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

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

1.1.3. ☒ A combination of both of the above.

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

The State of Idaho assures that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by the Centers for Medicare and Medicaid Services (CMS).

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

The State of Idaho assures that it complies with all applicable civil rights requirements, including Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR, part 80, part 84 and part 91, and 28 CFR part 35.

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Effective date: January 1, 2007

Implementation date: February 1, 2007

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

The following describes the extent to which children in the state, including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10).

Idaho is a predominantly rural state. Of Idaho's 44 counties, 17 are classified as frontier (less than 6 people per square mile) and an additional 19 are classified as rural (those that do not contain a population center of more than 20,000 people). The rural nature of Idaho has a significant impact on health care issues, including insurance enrollment and health access.

Idaho's largest ethnic minority is of Hispanic heritage. Southwest, southeast and south-central Idaho in particular have large concentrations of people with Hispanic heritage. Idaho also has five Native American tribes: the Shoshone and Bannock Tribes in eastern Idaho, the Shoshone and Paiute Tribes in Duck Valley, southwestern Idaho, the Nez Perce Tribe in north central Idaho, and the Coeur d'Alene Tribe in northern Idaho.

According to the 2004 Current Population Survey, there are 384,000 children ages 18 or under in Idaho, of whom 33,000 are without health insurance. This is a significant decrease from earlier estimates of uninsured children (51,000 in 2003, 50,000 in 2002, and 45,000 in 2001). The number of children in Idaho living in families with incomes at or below 200% of the Federal Poverty Guideline (FPG) is 169,000, using a three-year average of Current Population Survey data from 2002, 2003 and 2004 (from a three-year average total of 394,000 children). Of those 169,000 children at or below 200% FPG, 30,000 are estimated to have no health insurance.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

The Idaho Department of Health and Welfare (DHW) strives to increase Idaho children's enrollment in public health insurance programs by coordinating enrollment efforts across DHW divisions, coordinating with other public agencies, and by coordinating with other stakeholders. These coordination efforts include:

- **Medicaid & You—a brochure outlining the services available throughout DHW to families, including Title XIX and Title XXI child health programs.**
- **Idaho CareLine—an 800 number providing referral assistance to DHW customers throughout Idaho. The Idaho CareLine has a direct link to CHIP assistance. CHIP makes up the largest segment of callers on a regular basis. 888 KIDS NOW connects directly to the Idaho CareLine.**
- **Coordinated outreach and enrollment activities with the Idaho Department of Education and school lunch and child care food programs.**
- **Partnerships with stakeholder organizations that encourage posting of links to the State's CHIP website (www.chip.idaho.gov) on stakeholder web sites in order to provide current information to Idaho citizens.**

In addition, DHW provides potential enrollees with several types of application assistance by:

- **Providing mail-in/fax-in applications—the redesigned application allows potential CHIP enrollees to submit their application by mail or fax. Self-reliance specialists make CHIP eligibility determinations without a face-to-face visit. When information is missing, self-reliance specialists contact potentially eligible families by telephone.**
- **Using a simplified Application for Assistance for all benefit**

programs in the Self-Reliance Program (Health Coverage, Cash Assistance, Food Stamps, Child Care, Telephone Service and Nursing Home).

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

N/A

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (Previously 4.4.5.) (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

The State of Idaho will use routine stakeholder meetings to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

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

The same method of assuring delivery of insurance products and delivery of health care services is used for Title XXI and Title XIX. Providers are required by contract to assure that services are delivered in accordance with state and federal regulations. CHIP utilizes the same provider panel as Idaho Medicaid. Providers are primarily reimbursed on a fee-for-service basis under a Primary Care Case Management (PCCM) model of managed care.

In addition, Idaho Medicaid will promote wellness by financing preventive services for children in schools. Idaho Medicaid will award grants to schools to facilitate delivery of preventive health services to low-income students. These grants will be issued as Title XXI non-primary expenditures and as an alternative to School-Based Administrative Claiming.

Existing Idaho and federal law obligates Idaho Medicaid to pay schools for covered rehabilitative and health-related services under the Individuals with Disabilities Act (IDEA). These services are listed in Individualized Education Plans (IEPs) for children identified as having special health needs. Idaho Medicaid pays schools on a fee-for-service basis by certifying school funds. In order to provide preventive services through schools, Idaho Medicaid proposes to fund services through Title XXI non-primary expenditures rather than develop an administrative claiming mechanism.

Title XXI non-primary expenditures are those program expenditures that are not medical services provided under the benefit package as described in the Title XXI state plan. Non-primary expenditures are reimbursable at the enhanced federal financial participation rate but are capped at 10 percent of the cost of benefits. Per 42 CFR 457.618, there

are four categories of non-primary expenditures allowable under Title XXI, which include administrative expenditures, outreach, health initiatives and certain other child health assistance. Health Services Initiatives, defined in 42 CFR 457.10, means "activities that protect the public health, protect the health of individuals, improve or promote a State's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals relating to improving the health of children (including targeted low-income children and other low-income children)."

Initially, Idaho Medicaid will issue grants to ten (10) school districts in state fiscal year 2007 to assist schools with the salary expenses of registered nurses (RNs) working in schools or with related resource needs. Idaho Medicaid has partnered with the Idaho Department of Education and the Division of Health, Idaho Department of Health and Welfare, to establish criteria for school nurse programs eligible for Medicaid grant funding and to distribute these grants. Currently, 33 out of 114 Idaho school districts maintain school nurse programs, and Idaho schools' current RN to student ratio in Idaho is 1:2,393 (the national standard is 1:750 for the general, non-special-needs student population.) Increasing the nurse to student ratio will result in increased health counseling and education, health screenings, prevention services, health coordination, referral to care outside of school, and applications to and enrollment in Title XIX and Title XXI health coverage programs.

Grant criteria will include the percentage of low-income students and need for increased access to health services. Idaho Medicaid will fund grant amounts proportionate to percentages of low-income students in each grantee district. Idaho Medicaid will require semi-annual reports from grantee schools on provision of preventive health services and achievement of health services objectives as outlined in the grant program scope of work. Grant agreements will stipulate that grantee districts may not expend grant funds on services that may be billed through existing school-based services under a child's Individualized Education Plan.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))

This State Plan uses utilization controls from the Title XIX program, including prior approval controls, peer reviews, claims processing edits, post-audit and review procedures. Primary care providers are charged with making referrals for medically necessary specialty services. Health services providers are provided a handbook describing the benefit package including limitations. Participants are issued an identification card delineating the applicable benefit package. The card is used to determine covered services and service limitations.

Section 4. Eligibility Standards and Methodology. *(Section 2102(b))*

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1. ☒ Geographic area served by the Plan: **This State Plan applies to the entire State of Idaho.**

4.1.2. ☒ Age: **Children are eligible from birth through the month of the 19th birthday.**

4.1.3. ☒ Income: **Children with family incomes over 133% through 185% FPL are eligible for Idaho's stand-alone SCHIP under Title XXI. Children who have family incomes over 100% through 133% FPL are eligible for Idaho's Medicaid-expansion SCHIP under Idaho's Title XIX State Plan from the month of their 6th birthday through the month of the 19th birthday.**

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources): **There are no resource limits for children served by the plan.**

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state) : **Children served are residents of the State of Idaho.**

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility): **No child will be denied eligibility based on disability status. If the child receives SSI, the child will be denied coverage based on their eligibility for Medicaid, not for reasons of disability status.**

4.1.7. ☒ Access to or coverage under other health coverage: **A child will be ineligible for coverage under this plan if they have access to or are enrolled in other health coverage, including the following scenarios.**

- **The child is covered by creditable health insurance at the time of application.**
- **The child has been voluntarily dropped from creditable coverage in the six months preceding application with the intention of qualifying for public coverage.**

- **The child is eligible under Idaho's Title XIX State Plan.**
- **The child is eligible to receive health insurance benefits under Idaho's state employee benefit plan.**

4.1.8. ☒ Duration of eligibility: **The duration of eligibility is 12 months unless the child is terminated for one of the reasons described below.**

- **The child loses his or her Idaho residency.**
- **The child attains 19 years of age.**
- **The child becomes eligible for and is enrolled in Medicaid.**
- **The child's parent or adult who is legally responsible for the child's health care makes a written request to terminate coverage.**
- **The application is found to have inaccurate information which effected an incorrect eligibility determination.**
- **The child dies.**

- 4.1.9. ☒ Other standards (identify and describe):
  - **At the time of application, a) the child must not be a patient in an institution for mental diseases, or b) an inmate of a public institution.**
  - **The Social Security number, proof of application for a Social Security number or resident alien card number must be provided for applicants who are requesting coverage. Individuals on the application that are not requesting coverage are not required to provide Social Security numbers.**
  - **The State does not exclude individuals based on citizenship or nationality, to the extent that the child is a U.S. citizen, U.S. national or qualified alien (as defined at section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, as amended by the BBA of 1997, except to the extent that section 403 of PRWORA precludes them from receiving Federal means-tested public benefits).**

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☒ Within a defined group of covered targeted low-income children,

these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

Methods of establishing eligibility and continuing enrollment include a combined application for all Idaho children's health insurance programs. The application can be mailed to DHW. Face-to-face interviews are not required. All eligibility determinations will be made within the 45 days following receipt of the application. All applicants are notified in writing regarding the outcome of their eligibility and enrollment status.

An annualized gross income figure is used to determine eligibility. There are no earned income disregards. There is no resource limit. The number of persons in the family determines the applicable income standard.

The eligibility redetermination process entails checking all available interfaces and databases for current pertinent information prior to contacting the participant by phone. If the renewal is not completed at this point, a renewal form is sent to the family at least 45 days before their health coverage will end. The form instructs the family to review the information on the form, provide any updated information, sign and return the form or call and report that there are no changes.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

☒ Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))

The State of Idaho will ensure that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. The application for

assistance requires information on when the child was last covered by health insurance. Creditable insurance determinations are made if the applicant indicates current health insurance coverage. Place of employment is also required on the application which is used to determine if the applicant is a dependent of a State employee with access to coverage.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

Through the single application process, all children are first reviewed for Title XIX eligibility. Those that are found eligible are enrolled in Title XIX. Those who are ineligible for Title XIX and meet the income standards for Title XXI are considered for Title XXI enrollment. Eligibility determinations for both Medicaid and SCHIP are handled by State employees.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

The insurance provided under the state child health plan does not substitute for coverage under group health plans. A six month period of uninsurance is incorporated as an eligibility requirement for CHIP.

The application requires information on when the child was last covered by health insurance. Exceptions to the period of uninsurance will be made if the applicant lost private insurance through no fault of their own (i.e., due to employer decisions) or due to hardship. The State monitors the number of eligibility denials of children that have creditable insurance who subsequently become eligible within six months.

4.4.4.2. ☐ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

Not applicable.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

Not applicable.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

Idaho's premium assistance programs are described in and administered under Idaho's Section 1115 HIFA waiver.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. Indian Health Service and tribal clinics are included as CHIP service providers. Idaho Medicaid and Tribal representatives formally meet on a routine basis. Tribal representatives can request that CHIP information be presented at any of these meetings. Additionally, regional Healthy Connections

Representatives (primary care case management program coordinators) work with providers and enrollees (both Medicaid and SCHIP) to resolve issues and help ensure assistance is appropriately provided.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

The State of Idaho places equal emphasis on outreach and education activities, which are those administrative procedures and program features that inform and recruit children and their families into potential enrollment. DHW directs outreach and education to the following groups.

- **Health Care Providers**
- **Schools**
- **HeadStart/Child Care Providers**
- **Child Advocacy Groups**

Idaho has developed a multi-dimensional approach to outreach including but not limited to the following.

- **Support of stakeholder efforts to conduct targeted, grass-roots outreach.**
- **Supporting regional efforts by supplying professionally designed promotional materials.**
- **Provision of technical assistance to regional efforts through central office support staff.**

In addition, regional outreach activities are conducted by regional Healthy Connections Representatives (primary care case management program coordinators). Healthy Connections Representatives are part of the Division of Medicaid but are located in regional offices, and coordinate outreach and education for CHIP throughout the state.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

Idaho is providing Secretary-Approved coverage for the CHIP population, defined in SCHIP Statute as "coverage that provides appropriate coverage for the population of targeted low-income children covered under the program."

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

- 6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)
- 6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☐ Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

- 6.1.4.1. ☐ Coverage the same as Medicaid State plan
- 6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
- 6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
- 6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage
- 6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage
- 6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)
- 6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

The State of Idaho will provide one of two benefit packages to children eligible for Title XXI coverage. The Basic Benchmark Benefit Package is attached as Appendix 2. All other provisions of the Basic Benchmark Benefit Package are administered by the Department in accordance with statutory authority granted under Chapter 2 of Title 56, Idaho Code. The Enhanced Benchmark Benefit Package is attached as Appendix 3. All other provisions of the Enhanced Benchmark Benefit Package are administered by the Department in accordance with statutory authority granted under Chapter 2 of Title 56, Idaho Code.

To ensure that children are provided with the benefit package that will lead most directly to desired health outcomes, and to ensure that these benefits represent the most effective and efficient use of scarce health resources, Idaho Medicaid will incorporate a health risk assessment into Idaho's eligibility determination process and primary care case management (PCCM) program, Healthy Connections.

Applicants for medical assistance will complete an accompanying health questionnaire designed to assess general health status and health behaviors. The questionnaire will also serve as a screening tool to determine whether the applicant has special health needs. DHW will also assess whether the applicant requires special education services or is enrolled in Idaho's Children's Special Health Program, Infant and Toddler Program, Children's Mental Health Program or Adult Mental Health Program.

Eligibility for Idaho's Children's Mental Health Program requires a diagnosis of "serious emotional disturbance (SED). SED in children is defined in Idaho Code 16-2403(13).

Children with special health needs will be enrolled in the Enhanced Benchmark Benefit Package. Individuals without such needs will be enrolled in the Basic Benchmark Benefit Package. In addition, the questionnaire will determine whether the applicant is currently under treatment by a physician or has a medical home. If not, the applicant will receive information about Healthy Connections providers and will be asked to select a primary care provider as part of the eligibility determination process.

Failure to complete a health questionnaire will not prohibit an applicant from being determined eligible for medical assistance. However, without a completed health questionnaire, children cannot be immediately provided with the Enhanced Benchmark Benefit Package.

Subsequent to selection of a Healthy Connections provider, the participant will visit a physician for a comprehensive exam and health education. This assessment will comply with federal requirements for EPSDT for children. If the health risk assessment indicates a previously unknown special health need, the participant will be provided with the Enhanced Benchmark Benefit Package. The health risk assessment process will therefore act as both a component of eligibility determination and a safeguard to ensure that benefits address beneficiary health needs by providing access to needed services available under the appropriate benefit package.

6.2.1. ☐ Inpatient services (Section 2110(a)(1))
6.2.2. ☐ Outpatient services (Section 2110(a)(2))
6.2.3. ☐ Physician services (Section 2110(a)(3))
6.2.4. ☐ Surgical services (Section 2110(a)(4))
6.2.5. ☐ Clinic services (including health center services) and other

ambulatory health care services. (Section 2110(a)(5))

6.2.6. ☐ Prescription drugs (Section 2110(a)(6))
6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))
6.2.8. ☐ Laboratory and radiological services (Section 2110(a)(8))
6.2.9. ☐ Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))
6.2.10. ☐ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
6.2.11. ☐ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)
6.2.12. ☐ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
6.2.13. ☐ Disposable medical supplies (Section 2110(a)(13))
6.2.14. ☐ Home and community-based health care services (See instructions) (Section 2110(a)(14))
6.2.15. ☐ Nursing care services (See instructions) (Section 2110(a)(15))
6.2.16. ☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)
6.2.17. ☐ Dental services (Section 2110(a)(17))
6.2.18. ☐ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
6.2.19. ☐ Outpatient substance abuse treatment services (Section 2110(a)(19))
6.2.20. ☐ Case management services (Section 2110(a)(20))
6.2.21. ☐ Care coordination services (Section 2110(a)(21))
6.2.22. ☐ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
6.2.23. ☐ Hospice care (Section 2110(a)(23))
6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))
6.2.26. ☐ Medical transportation (Section 2110(a)(26))
6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))

6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6

6.4. Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

N/A

6.4.1. ☐ Cost Effective Coverage. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an

average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

6.4.2. ☐ Purchase of Family Coverage. Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

Section 7. Quality and Appropriateness of Care

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☐ Quality standards
7.1.2. ☒ Performance measurement
7.1.3. ☐ Information strategies
7.1.4. ☐ Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

Enrollment in Idaho's primary care case management program (Healthy Connections) is required in most areas of the state, which helps to ensure that enrollees have a usual source of care. Primary care providers are required by contract to provide primary care services to their enrollees. This includes wellness care and immunizations. In addition, Healthy Connections Representatives (primary care case management program coordinators) work with enrollees and providers to help ensure appropriate covered services are provided.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

The State of Idaho will ensure access to covered services, including emergency services as defined in 42 CFR 457.10. Referrals are not required to access emergency services. All provider types necessary to provide covered services are included in the provider panel.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

The State of Idaho will ensure access to appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition.

Contractually, primary care providers are required to make referrals for most medically necessary specialty services. All provider types necessary to provide covered services are included in the provider panel. In addition, Healthy Connections Representatives (primary care case management program coordinators) work with enrollees and providers to help ensure appropriate covered services are provided.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

Decisions related to prior authorization of health services will be completed in accordance with State law and/or Administrative Rule and the medical needs of the patient.

Section 8. Cost Sharing and Payment *(Section 2103(e))*

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

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505)

8.1.1. ☒ YES
8.1.2. ☐ NO, skip to question 8.8.

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

8.2.1. Premiums: **Enrollees in the Basic Benchmark Benefit Package with family incomes at or above 150% FPL will be subject to a premium in the amount of $10 per member per month for medical services and an additional $5 per member per month for dental services. Premium amounts paid apply first to medical services in determining delinquency. Enrollees in the Basic Benchmark Benefit Package with family incomes above 133% FPL up to 150% FPL will be subject to a premium in the amount of $10 per member per month for medical services and are not subject to the dental premium. Delinquent payments must be paid before re-enrollment (see Section 8.7 for further delinquency and disenrollment protection information). Enrollees in the Enhanced Benchmark Benefit Package are not subject to premiums.**

<u>Wellness Preventive Health Assistance (PHA):</u> The state has established a mechanism to assist participants with their premium payment obligations. This mechanism is called Wellness PHA. Each participant who is required to make premium payments can earn 30 points every 3 months by receiving recommended wellness visits from their PCP and demonstrating up-to-date immunizations. These Wellness PHA points can be used to offset premium payments. Each point equals one dollar.

A child with family income below 150% FPG may have all his premium obligations met by utilizing Wellness PHA. Children in families 150-185% FPG may offset up to two-thirds (two out of every three) of their payments.

8.2.2. Deductibles: **N/A**
8.2.3. Coinsurance or copayments:

- **A participant who seeks care at a hospital emergency department for a condition that is not an emergency medical condition may be required to pay a co-payment to the provider. The determination that the participant does not have an emergency medical condition is made by the emergency room physician conducting the medical screening and using the prudent layperson standard.**
- **A participant who accesses emergency transportation services for a condition that is not an emergency medical condition may be required to pay a co-payment to the provider of the service. The determination that the participant did not have an emergency medical condition is made by Idaho Medicaid.**
- **Beginning on February 1, 2007, the nominal fee amount required to be paid by the participant as a co-payment is three dollars ($3.00). This nominal amount will be adjusted annually as determined by the Secretary of Health and Human Services.**

8.2.4. Other: **N/A**

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)((1)(B)) (42CFR 457.505(b))

Changes to cost-sharing requirements are communicated through the public legislative process. DHW also adheres to a public rules promulgation process in order to communicate cost-sharing and other program changes.

In addition, the public is made aware of cost-sharing requirements through the following communication methods.

- **Publication on the State's Medicaid website.**
- **Program information materials including brochures and applications.**
- **Program notices to participants at eligibility determination and redetermination.**
- **Public hearings held in conjunction with Administrative rules promulgation.**

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

The State of Idaho will ensure that the annual aggregate cost-sharing for a family does not exceed five (5) percent of such family's income for the length of the child's eligibility period in the State. Upon enrollment participants are sent a notice advising them of their cost-sharing responsibilities. This includes notice of the five percent maximum.

Cost-sharing in the Idaho plan is set so low that very few families will reach their 5% limit. Additionally, a family that does exceed the limit will do so due to inappropriate use of emergency services.

Through the various information strategies such as the use of eligibility workers and other avenues of information dissemination, participants and their families are informed as to the limits of their financial liability for the coverage. The first direct written communication with families instructs parents that the expenditures on their child(ren)s health care should not exceed 5% of family income.

Benefit booklets are provided to all participants at initial eligibility determination and upon request thereafter. Information is included which directs families to inform the state whenever the 5% maximum is met or exceeded.

The State has adopted the "shoe box" approach to reimburse families who exceed the 5% limit. Families are required to track expenditures based on he calculation of family income provided by the state and to submit receipts for all expenditures in excess of the 5% limit. The family will receive a refund in an amount equal to their excess payments.

Once the maximum out of pocket is met, the family is not required to pay premiums for the remainder of the eligibility period.

8.6. Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

The state will ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. Native American and Alaskan Native children will not be charged monthly premiums or co-payments. The family will be required to declare tribal membership so that the cost sharing exemption can be processed.

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

Renewal: If premium payments are two or more months in arrears at the time of renewal, the child(ren) will lose eligibility for the program and be prohibited from participation until the delinquency is paid. Delinquent accounts will be sent a delinquency notice monthly. The notice includes the amount of the delinquency, their right to be considered for Medicaid eligibility and the consequence of not bringing their account current. The notice also includes a reminder that the family may receive help with their premium payments by participating in Wellness PHA.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
- ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
- ☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
- ☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8. The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays,

coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

Strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children are listed in Table 9.1.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

Performance goals are listed in Table 9.1.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Performance under the plan will be measured through objective, independently verifiable means, listed in Table 9.1, and will be compared against performance goals. The state also uses the following performance measures.

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☒ The increase in the percentage of children with a usual source of care.
9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ☒ Other child appropriate measurement set. List or describe the set used.
- Well child visits for children in the first 15 months of life.

- Well child visits in the 3rd, 4th, 5th, and 6th years of life.
- Use of appropriate medications for children with asthma.
- Comprehensive diabetes care (hemoglobin A1c tests).
- Children's access to primary care services.

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1. ☐ Immunizations
9.3.7.2. ☐ Well childcare
9.3.7.3. ☐ Adolescent well visits
9.3.7.4. ☐ Satisfaction with care
9.3.7.5. ☐ Mental health
9.3.7.6. ☐ Dental care
9.3.7.7. ☐ Other, please list:

9.3.8. ☐ Performance measures for special targeted populations.

Table 9.1

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (specify data sources, methodology, time period, etc.)
Objectives related to Reducing the Number of Uninsured Children		
To increase the number of children participating in Title XIX and XXI health programs.	The targeted increase in enrollment is 8,000 children annually	New/Revised Continuing X Data Sources: Enrollment data from the Division of Medicaid AIM system. • Methodology: Annual increase in enrollment of uninsured children in both programs compared to the previous federal fiscal year. • The total number of new uninsured children enrolled in both programs compared to the base number of enrollees as of 9/30/99 • Numerator: Number of enrollees on 9/30/03: 112,678 • Denominator: Number of enrollees on 9/30/99: 54,824 Progress Summary: Idaho achieved its annual target by increasing enrollment an additional 8001 children in FFY03. As of 9/30/03, Idaho has enrolled an additional 57,854 children, more than doubling the number of children covered by Title XIX & Title XXI in the past 4 years.
Objectives Related to SCHIP Enrollment		
To increase the number of children enrolled in the Title XXI. program	The targeted increase in enrollment is 2,000 children annually.	New/Revised Continuing X Data Sources: Enrollment data from the Division of Medicaid AIM system • Methodology: Annual increase in enrollment of uninsured children compared to the previous federal fiscal year. • The total number of children enrolled each year. • Numerator: Number of enrollees on 9/30/03: 10,954 • Denominator: Number of enrollees on 9/30/99: 3,735

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (specify data sources, methodology, time period, etc.)
		Progress Summary: The number of Title XXI children decreased this year for the first time in 4 years. The number decreased by 1,022 in FFY03 resulting in an 8.5% decline. It is believed that with the downturn in the economy, children applying for assistance are qualifying for Title XIX instead of Title XXI. The statistics bear this out. As of 9/30/03, overall Idaho had increased enrollment since 1999 by 7,219 children, a 193% increase.
Objectives Related to Increasing Medicaid Enrollment		
To increase the number of children enrolled in Title XIX health programs	The targeted increase in enrollment is 6,000 children annually.	New/Revised Continuing X Data Sources: Enrollment data from the Division of Medicaid AIM system. • Methodology: Annual increase in enrollment of uninsured children in Title XIX programs compared to the previous federal fiscal year. • The total number of new uninsured children enrolled in Title XIX programs compared to the base number of enrollees as of 9/30/99 • Numerator: Number of enrollees on 9/30/03: 101,724 • Denominator: Number of enrollees on 9/30/99: 51,089 Progress Summary: The number of children enrolled in Title XIX increased by 9,023 or nearly 10% in FFY03. As of 9/30/03, Idaho had increased enrollment by 50,635 children, an increase of 99%.
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
To ensure that enrolled children have a medical home.	There will be a 10% annual increase in the number of children participating in Healthy Connections and having a primary care provider as a "medical home".	New/Revised Continuing X Data Sources: Division of Medicaid, Healthy Connections (PCCM) Program • Methodology: Baseline data on the number of children in the Healthy Connections is known. The data system will track new enrollees in the program • Numerator: Number of children enrolled in HC at the end of the FFY 9/30/03: 88,415 • Denominator: Number of children enrolled in HC at the beginning of the FFY 10/1/00: 25,661 Progress Summary: Healthy Connections enrollment increased by 37,058 children in FFY 03, a 72% increase for the year and a 244% increase over the baseline. Percent of children participating rose from 49% to 80%.
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
To ensure that enrolled children receive appropriate and necessary medical care.	90% of enrolled children will have up-to-date, age-appropriate vaccinations. 80% of enrolled children age 12 months and younger will have received	New/Revised Continuing X Data Sources: Division of Medicaid information system, Division of Health Immunization Registry • Methodology: Claims data will be reviewed for immunization and preventive care visits. The immunization registry is being used to track immunization levels. • Numerator: Number of children with up-to-date immunizations and preventive care visits. • Denominator: Total number of Title XIX and XXI children.

	appropriate preventive care.	Progress Summary: No change- At this time, Idaho is examining the data collection criteria to report wellness visits. The FFY02 HCFA416 report indicates that the screening ratio for children <1 year of age has dropped to 25%. However this is believed to be currently underreported. FFY03 data is not available at the time of this report. Medicaid will be addressing the issue of correct coding for wellness visits in FFY04. Immunizations: No change. For the first three series of shots, Idaho's rate of immunizations is in the low 90s. By the time children are ready to go to school the rate is approximately 95%. Similar to other states, rates reflect a decline in the percentage for the 2 year old age group.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42CFR 457.120(c))

Idaho Medicaid and Tribal representatives formally meet on a quarterly basis. Tribal representatives can request that program information be presented at any of these meetings. The Department requests time for program updates to be presented as

needed.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d).

Public hearings, advertised through prior public notice, are held in conjunction with Administrative Rules promulgation required to amend eligibility or benefits for the Children's Health Insurance Program. These hearings allow public comment on the entire program.

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

- Planned use of funds, including --
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

State match for CHIP participants with family incomes between 150% and 185% FPL is collected through a state-imposed premium tax on insurance policies sold within the State. A portion of these funds is dedicated to CHIP funding via Idaho statute. The premium tax that funds this portion of the program is imposed on all entities that sell insurance (not just health insurance) in Idaho. Less than 85 percent of the premium tax burden falls on health care providers. The premium tax collections from health insurance are treated the same as premium tax collections from other types of insurance. Therefore, this premium tax does not meet the definition of a "health-care related tax" as defined in 42 CFR §433.55.

State match for CHIP participants with family incomes between 133% and 150% FPL is appropriated from the state General Fund.

Benefit Costs	**FFY06**	**FFY07**
Insurance payments, PCCM (PMPM x # eligibles)	**$9,176,418**	**$10,743,319**
Insurance payments, Fee for Service (PMPM x # eligibles)	**$1,619,367**	**$1,895,880**
Total Benefit Costs	**$10,795,786**	**$12,639,199**
(Offsetting beneficiary cost sharing payments)	**($242,715)**	**($548,770)**
Net Benefit Costs	**$10,553,071**	**$12,090,429**
Administration Costs		
Personnel	**$638,000**	**$650,760**
General Administration	**$223,321**	**$227,788**

Contractors/Brokers (e.g., enrollment contractors)		
Claims Processing		
Outreach/Marketing Costs		
Healthy Schools (Health Services Initiatives)	**$100,000**	**$410,000**
Other		
Total Administration Costs	**$961,321**	**$1,288,548**
10% Administrative Cap	**$1,172,563**	**$1,343,381**
Federal Title XXI Share	**$9,089,461**	**$10,507,848**
State Share	**$2,424,931**	**$2,871,128**
TOTAL COSTS OF APPROVED SCHIP PLAN	**$11,514,392**	**$13,378,977**
Average Monthly Eligibles	**7,139**	**8,021**
Average PMPM Cost (Prior to Offsets)	**$126.02**	**$131.32**

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment.

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1. ☐ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

- 11.2.1. ☐ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. ☐ Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. ☐ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. ☐ Section 1128A (relating to civil monetary penalties)
- 11.2.5. ☐ Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. ☐ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections ***(Sections 2101(a))***

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.

12.1. Eligibility and Enrollment Matters

Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

12.2. Health Services Matters

Please describe the review process for health services matters that comply with 42 CFR 457.1120.

12.3. Premium Assistance Programs

If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.