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

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

State/Territory:_____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))

/S/ Paul J. Leary_____ December 29, 2011_____
for Leslie M. Clement, Deputy Director Date
Idaho Department of Health and Welfare

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

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

Name: Paul J. Leary Position/Title: Administrator, Division of Medicaid
Name: David Taylor Position/Title: Chief Financial Officer
Name: Matt Wimmer Position/Title: Bureau Chief, Division of Medicaid

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

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

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

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

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

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

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

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

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

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

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

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

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

Date Original Plan Submitted: February 17, 1998
Date Approved: June 15, 1998
Effective Date: October 1, 1997

Amendment #1 Description: Change income limit from 160% FPG to 150% FPG
Submitted: October 13, 1998
Approved: December 4, 1998
Effective date: July 1, 1998

Amendment #2 Description: Program design changes to-

- increase coordination of efforts across agencies
- simplify the application process, and
- improve media and outreach approaches

Submitted: March 10, 2000
Approved: March 1, 2001
Effective date: January 1, 2000

Amendment #3 Description: Technical changes to conform to model template
Revised outreach strategies
Submitted: June 28, 2002
Approved: September 19, 2002
Effective date: July 1, 2002

Amendment #4 Description: Establish separate program
Submitted: February 25, 2004
Approved: June 10, 2004
Effective date: July 1, 2004

Amendment #5 Description: Revise benefit package of separate program
Submitted: August 30, 2004
Approved: January 13, 2005
Effective date: July 1, 2004

Amendment #6 Description: Removal of enrollment cap
Submitted: June 9, 2005
Approved: September 7, 2005
Effective date: June 1, 2005

Amendment #7 Description: Addition of child health services initiative (Healthy Schools)
Submitted: April 28, 2006
Approved: May 25, 2006
Effective date: July 1, 2006

Amendment #8 Description:

- Lower the income limit of separate program from 150% to 133%
- Remove resource limit
- Incorporate Basic and Enhanced Benchmark Benefit Packages
- Changes to premium structure

Submitted: May 5, 2006
Approved: May 25, 2006
Effective date: July 1, 2006

Amendment #9 Description: Addition of Wellness Preventive Health Assistance
Addition of co-pays
Submitted: January 24, 2007
Approved: September 28, 2007
Effective date: January 1, 2007 (Wellness PHA)
February 1, 2007 (co-pays)

Amendment #13 Description: Addition of Co-payments (co-pays) for certain services
Submitted: December 31, 2011
Approved:
Proposed Effective date: November 1, 2011
November 1, 2011 for Chiropractor, Optometrist and Podiatrist Services
January 1, 2012 for Physical Therapy, Occupational Therapy, Speech Therapy & Physician Office Visits

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

The State used its standard negotiated (with the Tribes of Idaho) process for Tribal Consultation

for this SPA. In May 2011, a Tribal notice was sent hard copy to Tribal Leaders and e-mailed to a contact list of Tribal Representatives. The notice was then posted to the Idaho Medicaid-Tribes website.

The proposed SPA was discussed as part of a standing agenda item to review all Medicaid/CHIP SPAs at the following Tribal quarterly meeting in August 2011.

Section 8. Cost-Sharing and Payment

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

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

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

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

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

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

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.

Wellness Preventive Health Assistance (PHA): 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: Not applicable.

8.2.3. Coinsurance or copayments:

Co-payment amount: Beginning on November 1, 2011, the nominal fee amount required to be paid by the participant as a co-payment is three dollars and 65 cents ($3.65). The reimbursable amount of the services rendered during a visit must be at least ten times the amount of the co-pay. Visits where the provider is reimbursed $36.50 or less for their services are not subject to co-pay and providers are directed not to assess co-pays for services where reimbursement is less than or equal to $36.50. Well-baby and well-child care as defined in 42 CFR 457.520 are not subject to co-pay.

The State will submit a State Plan Amendment for any future changes to the co-pay amount.

Co-pays for use of emergency services for a non-emergent medical condition

- 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.

Co-pays for other services

- Chiropractic services
- Occupational Therapy
- Optometric Services
- Physical Therapy
- Physician Office Visits
- Speech Therapy

The reimbursable amount of the services rendered during a visit must be at least ten times the amount of the co-pay. Otherwise, the visit is exempt from co-pay. The provider may provide the service and decline to collect the co-pay at the time

of service, if the participant can't pay. The provider may also choose not to bill the participant for the co-pay.

Population: All children 133% - 185% of the federal poverty guidelines.

8.2.4. Other: Not applicable

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS Premiums:
8.2.2-DS Deductibles:
8.2.3-DS Coinsurance or copayments:
8.2.4-DS Other:

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)(A)) (42CFR 457.505(b))

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

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.

The State informs families of the co-payment requirement and limitations in writing at the time of eligibility determination or re-determination. Idaho monitors co-payments and premiums on at least a monthly basis based on information from its systems that show the amount paid compared with family income. When the State identifies that co-pays and premiums assessed have reached 95% or more of the maximum amount for the eligibility period, a letter is sent to the family informing them that they are approaching their limit and that they will be exempted for the remainder of the eligibility period. The status of the beneficiary is changed to co-pay exempt in the information system at that point for the remainder of the eligibility period.

Providers are instructed to check each participant's eligibility prior to rendering services. The co-pay field of the eligibility response indicates whether the participant is subject to co-pay or is exempt.

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 asked to declare Native American/Alaskan Native status so that the cost sharing exemption can be processed.

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

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

Premiums
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.

Co-pays
If a participant is unable to make a co-pay the provider can bill the patient, waive the co-pay or refuse to provide services.

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

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

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

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

☒ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

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

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, copayments, 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)

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. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

When the State determines the need to submit a SPA, a Tribal Solicitation notice is sent to Tribal contacts. The notice is mailed hard copy to Tribal Leaders, e-mailed to a distribution list of Tribal contacts and posted to the Idaho Medicaid-Tribes Teamsite (web-based). The State also meets quarterly with the Tribes. A standing agenda item for these meetings is discussion of SPAs.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR457.65(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. Public notification of proposed changes to Administrative Rules is published the first Wednesday of each month in the Administrative Bulletin and also posted to the state's website.

- SPA #13: A public hearing was held on January 28, 2011 by the Idaho Legislature; Tribal Solicitation was initiated on April 8, 2011; the public notice (for rules) was published on October 5, 2011; a letter to participants was sent on September 30, 2011.

9.9.3 Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option. N/A

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

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.

- projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc. All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
    a. Total 1-year cost of adding prenatal coverage
    b. Estimate of unborn children covered in year 1

Benefit Costs	2011	2012	2013
Insurance payments	$ -	$ -	$ -
Managed Care	$ 4,749,876.14	$ 4,929,095.07	$ 5,341,223.10
Fee for Service	$ 42,748,885.25	$ 44,361,855.65	$ 48,071,007.92
Total Benefit Costs	$ 47,498,761.39	$ 49,290,950.73	$ 53,412,231.02
(Offsetting beneficiary cost sharing payments)	$ (2,057,606.18)	$ (2,407,109.77)	$ (2,580,836.83)
Net Benefit Costs	$ 45,441,155.21	$ 47,154,027.44	$ 51,192,613.87

Administration Costs

Personnel	$ -	$ -	$ -
General Administration	$ 638,106.95	$ 670,012.30	$ 703,512.92
Contractors/Brokers (e.g., enrollment contractors)	$ -	$ -	$ -
Claims Processing	$ 19,454.24	$ 20,426.95	$ 21,448.30
Outreach/Marketing costs	$ -	$ -	$ -
Other (e.g., indirect costs)	$ -	$ -	$ -
Health Services Initiatives	$ 2,254,930.67	$ 2,367,677.21	$ 2,486,061.07
Total Administration Costs	$ 2,912,491.87	$ 3,058,116.47	$ 3,211,022.29
10% Administrative Cap (net benefit costs ¸ 9)	$ 5,049,017.25	$ 5,239,336.38	$ 5,688,068.21

Federal Title XXI Share	$ 39,481,103.01	$ 41,475,924.95	$ 45,333,903.61
State Share	$ 11,009,069.44	$ 10,917,438.88	$ 11,546,778.46

TOTAL COSTS OF APPROVED CHIP PLAN	**$ 50,490,172.45**	**$ 52,393,363.83**	**$ 56,880,682.07**

	2011		2012		2013	
	# Elig	$ PMPM	# Elig	$ PMPM	# Elig	$ PMPM
Expansion	13,391	$ 158.93	13,246	$ 179.36	13,340	$ 198.82
Separate	11,767	$ 155.52	11,143	$ 155.41	10,701	$ 168.09

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.

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at http://www.nashp.org. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

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 uninsured low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

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.

10.3-DC ☒ Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.