APPLICATION 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: **Vermont**

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

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Cynthia D. LaWare, Secretary *Date*
Agency of Human Services

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: Joshua Slen,
Title: *Director, Office of Vermont Health Access*

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**

The Vermont SCHIP program is a separate child health program that operates exactly the same as the Medicaid program. In Vermont the term Dr Dynasaur refers to all children's State health care programs.

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))**

Vermont assures that expenditures for the State Child Health Insurance Plan will not be claimed prior to approval by CMS. Vermont has legislative authority to operate its State Child Health Insurance Program.

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)**

Vermont assures that the Title XXI State plan will be conducted in accordance with Title VI of the Civil Rights Act of 1964 (42U.S.C. 2000 [d] et seq.), Section 504 of the Rehabilitation Act of 1973 (2 U.S.C. 70[b] and the regulations at 45 C.F.R. Parts 80 and 84. No individual shall be subject to discrimination under this State plan on the grounds of age, sex, race, color, marital status, religion, national origin and handicap.

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)**:

Date Plan Submitted: November 6, 1998
Date Plan Approved: December 15, 1998
Effective Date: October 1, 1998

Amendment #1: Increase Premiums From $20 To $25 Per Month Per Family
Date Submitted: June 9, 1999
Date Approved: August 11, 1999
Effective Date: October 1, 1999

Amendment #2: Implement Primary Care Case Management (PCCM)
Date Submitted: December 1, 1999
Date Approved: February 28, 2000
Effective Date: December 1, 1999

Amendment #3: Increase Premiums From $25 To $50 Per Family Per Month and Exempt cost sharing for AI/AN children
Date Submitted: June 20, 2000
Date Approved: January 19, 2001
Effective Date: February 1, 2001

Amendment #4: Compliance Plan
Date Submitted: June 28, 2002
Date Approved: September 19, 2002

Amendment #5: Increase Premium From $50 To $70 Per Month Per Family
Date Submitted: August 15, 2003
Date Approved: November 10, 2003
Effective Date: July 1, 2003

Amendment #6: Change Premium Billing From Quarterly to Monthly
Date Submitted: April 14, 2004
Date Approved: July 12, 2004
Effective Date: December 1, 2003

Amendment #7: Increase Premium From $70 To $80 Per Month Per Family
Date Submitted: August 28, 2005
Date Approved: January 10, 2006
Effective Date: July 1, 2005

Amendment #8: Decrease Premium From $80 to $40 Per Month Per Family &
Increase Premium From $40 to $60 Per Month Per Family

Date Submitted: September 26, 2007
Date Approved: October 02, 2008
Effective Date: July 01, 2007

Effective Date: July 1, 2007
Approval Date:

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))**

Children	Medicaid	SCHIP	Uninsured
Totals	58605	3640	6091
Income Level			
< 100%	28733	117	1018
≤ 133%	7935	86	915
≤ 185%	11932	155	1219
≤ 200%	2472	60	206
> 200%; ≤ 300%	7301	3115	1556
> 300%	232	107	1277
Age			
0 - 1	3576	164	172
1 - 5	16662	934	903
6 - 12	23481	1483	2724
13 - 17	14886	1059	2392
Race & Ethnicity			
American Indian or Alaskan Native	110	12	7*
Asian or Pacific Islander	285	16	57*
Black, not of Hispanic origin	771	8	36*
Hispanic	219	16	19*
White, not of Hispanic origin	57220	3532	5844*

Location			
MSA	11947	782	501**
Non-MSA	46658	2858	5676**
* & ** Totals do not equal 6091 due to more than one choice or unknowns.			
Uninsured data from Department of Banking, Insurance, Securities, and Health Administration (BISHCA) 2000 Survey; other data from Medicaid MMIS for quarter ending March 2002.			

Vermont has made extensive efforts to ensure access to health care services for its children for over a decade. In 1989 Vermont started Dr Dynasaur, a 100% State funded program, which expanded eligibility to 150% FPL. In 1992 Dr Dynasaur was incorporated into the Medicaid program, covering the full range of Medicaid health care benefits. The State has since expanded eligibility for children in families with incomes up to 225 FPL, and in 1998 furthered that expansion through SCHIP and the 1115 Waiver to those up to 300% of FPL. In November 1998, when SCHIP began in Vermont there were 49,000 children enrolled in the Medicaid/Dr Dynasaur program, approximately 34% of children under age 18. In May 2007 there were 53,443 children covered through Medicaid/Dr.Dynasaur, and an additional 2,855 covered through the SCHIP program. At this time there are no public-private partnerships in Vermont.

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):

Efforts to identify and continue to enroll children have been ongoing since the early 1990's. The Department for Children and Families, Economic Services Division (formerly the Department of Prevention, Assistance, Transition, and Health Access (PATH)) and the Vermont Department of Health (VDH) have worked collaboratively over the years to reach out to those children who are uninsured or underinsured. Since the implementation of the Vermont Health Access Plan (VHAP) in 1995, the State's outreach activities to those without creditable coverage has been enhanced by the addition of a contracted benefit-counseling firm

MAXIMUS.

Economic Services Division (ESD), OVHA's contracted benefits-counseling firm, and the Vermont Department of Health coordinate outreach and enrollment efforts for all State health care programs. The Vermont Department of Health has the Medicaid EPSDT mandate for outreach and informing to potential Medicaid recipients. ESD district offices, the contracted benefits-counseling firm, and the VDH work together on outreach and enrollment activities. Since October 1998 outreach efforts have included information about Vermont's SCHIP program. Special outreach efforts through the Department of Health and school health nurses have been made to inform potentially eligible families of the availability of coverage through SCHIP.
In addition, ESD and VDH have reached out to community-based agencies and programs in contact with the uninsured or underinsured such as Parent-to-Parent, WIC Clinics, homeless centers, and the Office of Health Care Ombudsman to identify and assist those that are uninsured

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 has fully integrated the State Children's Health Insurance Program (SCHIP) with the current Medicaid Program, which includes the VHAP program for the uninsured covered under the Global Commitment to Health 1115 Research and Demonstration program. ESD is responsible for determining, and re-determining eligibility for all medical assistance programs, including eligibility for the Medicaid, VHAP, and SCHIP programs. The process for determining eligibility is essentially the same for all programs, requiring an application and evaluation of program requirements. The application process ensures that applications are processed using appropriate program standards and that eligibles can be

identified by program and fully integrated into the existing service delivery mechanisms.

As noted above, outreach efforts to inform the uninsured of health coverage programs are conducted by ESD, the State's contracted benefits-counseling firm, and the Vermont Department of Health (VDH). ESD and VDH have worked together to maximize outreach activities to the uninsured, and coordinated those activities with other VDH programs including Title V. Efforts are coordinated across programs like Maternal Child Health, Children with Special Health Needs (CSHN), WIC Clinics, Healthy Babies, Kids & Families,, and refugee resettlement. In addition, the Agency of Human Services through its Covering Kids Initiative, begun in 1999, has been working on both the state and local level, and with state and local stakeholders together, to reduce the number of uninsured children in the state.

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 Vermont SCHIP program is a separate child health program that operates exactly the same as the Medicaid program. Services under SCHIP are delivered using the same delivery systems that are used for Medicaid and VHAP. Services are delivered through Fee-for-Service or **Primary Care Plus**. **Primary Care Plus** is a primary care case management program (PCCM). In **Primary Care Plus** the beneficiary selects or is assigned to a primary care provider (PCP) who is responsible for delivering primary care services and authorizing referrals for other necessary care. PCCM programs are intended to substantially increase the physician's role in their patient's care.*

*Those who receive their health care in the fee-for-service delivery system include beneficiaries who have an insurance benefit that covers hospital and physician services; or who are receiving specialized care in a Home & Community-Based Waiver Services program or the children's High Tech Program; or are in a nursing home; or those who were receiving hospice care when they became eligible. In June 2003, 93.5% of those in SCHIP were being served in **Primary Care Plus** and 6.5% were served in Fee-for-Service delivery systems*

*While the SCHIP program is a separate program, it operates the same as the Medicaid program using the same eligibility system, benefits-counseling firm, provider network, billing, authorizations, and utilization systems, and other infrastructure to deliver health care services to beneficiaries. Financing includes fee-for-service rates for procedures and a monthly per member per month payment to primary care providers for those beneficiaries in **Primary Care Plus.***

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))**

Utilization controls to ensure that children in SCHIP receive only appropriate and medically necessary health care consistent with the benefit package are the same as those used for Medicaid/Dr Dynasaur. For the majority of children in SCHIP utilization is managed by the PCP and through the use of prior authorizations (PA's). PA's are managed by the OVHA Clinical Unit and through OVHA's pharmacy benefit manager – Med Metrics. For those in Fee-for-Service utilization is managed by the primary insurer, and PA's when appropriate.

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))**

In general, existing Vermont methodologies for establishing Medicaid/Dr. Dynasaur/VHAP eligibility and enrolling recipients in managed care, when applicable, applies to Title XXI. Related Medicaid, Dr. Dynasaur, and VHAP policy and procedures, and the procedures and protocols of our benefits counseling and enrollment contractor, Maximus, are available upon request.

Currently, uninsured children (up to age 18) up to 225% of poverty are eligible for Medicaid benefits. The State SCHIP program has expanded eligibility to 300% of the Federal Poverty Level (FPL). SCHIP eligibles are entitled to the full range of health services covered under the State's Medicaid plan.

To be eligible, children must meet the following specific requirements (as well as all the general types of eligibility requirements used for Medicaid/Dr Dynasaur):

***AGE**: the child must be under age 18 years.*

***INCOME**: the child must reside in a household with an income up to 300% of the FPL.*

***RESOURCES**: current Medicaid standards are used; no resource test applies.*

***UNINSURED**: the child must not have or qualify for Medicaid, or have coverage under a group health plan or under health insurance coverage, and must not have dropped such health insurance coverage without good cause in the month prior to the date of eligibility.*

A child who is an inmate in a public institution or a patient in an institution for mental diseases, at the time of initial application or any redetermination of eligibility, is not eligible for the SCHIP program.

4.1.1. ☐ Geographic area served by the Plan:

4.1.2. ☒ Age: under 18 years of age.

4.1.3. ☒ Income: Between 225 – 300% FPL

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. ☐ Residency (so long as residency requirement is not based on length of time in state):

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7. ☒ Access to or coverage under other health coverage: Children with health insurance are not covered in SCHIP.

4.1.8. ☒ Duration of eligibility: *Can be up to 12 months.*

4.1.9. ☒ Other standards (identify and describe): *All applications for healthcare require a social security number, but ESD may disregard the requirement for a member of a religious organization that objects to furnishing a social security number.*

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)**

The ESD is responsible for determining, and re-determining eligibility for all medical assistance programs, including eligibility for the Medicaid, VHAP, and SCHIP programs. The process for determining eligibility is essentially the same, requiring an application and evaluation of program requirements. Applications for medical assistance are processed in the local District Offices or at the centrally located Health Access Eligibility Unit in Waterbury. The rules for eligibility are found in the Medicaid Policy Manual. This application process ensures that applications are processed using appropriate program standards and that eligibles can be identified by program and fully integrated into the existing service delivery mechanisms. Individuals under the SCHIP program are given unique eligibility codes, which allow access to SCHIP services, assure appropriate payments to providers, and facilitate expenditure tracking under the State's MMIS system.

Vermont uses an automated, integrated eligibility system called ACCESS. Criteria for each of ESD's medical assistance programs are programmed into ACCESS. Applicant information is entered into this system. It is reviewed in conjunction with programmed criteria for medical assistance programs. If eligibility criteria are not met, an "edit" is created and reported to the eligibility specialist for resolution. Once edits are cleared, the system produces an eligibility result requiring action by the eligibility specialist. This can be an approval or denial.

A review of eligibility will be completed prior to the end of each certification period to assure uninterrupted coverage if the individual has retained eligibility and complies with review requirements and/or the payment of any premiums. An individual who fails to comply timely with review requirements and the payment of any required premium shall receive a termination notice mailed at least 11 days before the termination date. A failure to comply timely may result in a gap in coverage or termination of coverage.

All family Medicaid eligibility requirements will apply to SCHIP with the exception of the higher income test. ACCESS assigns eligibility category codes to children found eligible for coverage. Medicaid/Dr Dynasaur codes will be assigned to children found eligible for Medicaid/Dr Dynasaur. SCHIP codes will be assigned to children with incomes greater than 225% of the FPL who have no other insurance. ACCESS will not allow benefits

program specialist to change codes to SCHIP if income is less than or equal to 225% of FPL.

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 access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)); (42 CFR 457.310(b), 42CFR 457.350(a)(1), 457.80(c)(3))**

On the application forms for health care programs applicants are required to complete a section on health insurance coverage. Vermont uses an automated, integrated eligibility system called ACCESS. Criteria for SCHIP are programmed into ACCESS. Applications for SCHIP are reviewed for determination by the benefits program specialist. Application information is entered into the ACCESS system. It is reviewed in conjunction with programmed criteria for SCHIP. Children between 225% - 300% FPL with other insurance, including access to state health benefits plan, are not enrolled in SCHIP. In addition, the Coordination of Benefits (COB) Unit flags individual cases where ACCESS indicates there is no TPL Segment but claims indicate there is other insurance paying claims for that individual. The TPL information is entered into ACCESS and eligibility is changed accordingly.

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))**

See 4.3

Applications for Medicaid and SCHIP are reviewed for determination by the same benefits program specialist. The State assures that children

determined to be eligible for Medicaid are not reviewed or determined eligible for the SCHIP program.

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))**

See 4.3

Applications for Medicaid and SCHIP are reviewed for determination by the same benefits program specialist. The State assures that children determined not to be eligible for Medicaid are reviewed for eligibility for the SCHIP program. Children found eligible are enrolled in the SCHIP program.

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.

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.

See 4.4.4.3

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.

The State has always believed that eligibles should be encouraged to obtain and retain any insurance coverage available to them. Vermont has discouraged substitution by offering coverage in the 225% - 300% FPL range to those with other insurance through its' 1115 Waiver. The SCHIP application form includes information on current and past availability of insurance coverage. Applicants with creditable coverage will not be eligible for SCHIP. Benefits program

specialist will note if applicants report that employers have dropped insurance coverage. To be eligible for SCHIP a person must not have dropped health insurance coverage without good cause in the month prior to the date of eligibility. The one month waiting period can be waived because of loss of employment; death or divorce; or loss of eligibility for coverage as a dependent under a policy held by a parent(s).

The Third Party Liability Unit flags individual cases where ACCESS indicates there is no TPL Segment but claims indicate there is other insurance paying claims for that individual. The TPL information is entered into ACCESS and eligibility is changed accordingly.

The goal in Vermont has been to provide universal health care coverage for all children through a combination of public and private insurers. The Department of Banking, Insurance, Securities, and Health Care Administration conduct periodic household surveys of Vermonters. Results from these surveys are used to monitor changes / fluctuations in the mix of public-private insurers covering children.

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

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

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))**

The SCHIP program, and all other children's health care programs, provide child health assistance to targeted low-income children in the

state, including children who are American Indian and Alaska Native.

Vermont has no federally recognized Indian tribes. Approximately 50% of Indians in Vermont populate the northwest area of the state, most in the St. Albans area. The St. Albans Regional Partnership, that includes local District Offices and VDH offices, conducts outreach activities and provides for interaction with individuals or tribal organizations on issues related to health care. In addition, individuals or tribal organizations have the opportunity under the public notification requirements used for public policy promulgated under Vermont's Administrative Procedures Act to participate in the development of the SCHIP or other health care programs.

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 has coordinated SCHIP outreach efforts with the existing outreach and enrollment activities performed by ESD, the State's benefits-counseling firm, and VDH. The State contracts with the benefits counseling firm for a toll-free telephone line individuals can contact for information about health care programs, how to apply, and to request application forms. All outreach materials include information about all health care programs including SCHIP.

Outreach efforts include:

- *A multi-media campaign, including print, brochures, and flyers, targeting individuals eligible for enrollment in VHAP, the State's program for the uninsured, SCHIP, and Medicaid. The efforts of the benefit-counseling firm have been supplemented by press stories and television and radio interviews with State officials about the State's efforts to reduce the number of uninsured and to provide health insurance coverage to eligible populations;*

- *Outreach through community groups and organizations;*

- *Educational sessions in community locations such as churches, WIC clinics, health clinics, schools, health fairs, local food banks and the local ESD and VDH district offices, for eligible and other interested individuals about health insurance programs; and*

    - *Activities of VDH to identify eligible children through WIC clinics, local school health nurses, and local offices of the Department.*

    - *Education and training sessions on the eligibility standards and current procedures for application with organizations that serve the target populations, such as public schools, community-based service organizations, hospitals, FQHCs and RHCs, etc.*

    As noted above, outreach efforts to inform the uninsured of health coverage

programs are conducted by ESD, the State's contracted benefits-counseling firm, and the VDH. In addition, there has been a statewide effort to utilize schools as a vehicle to inform families about health insurance. Each spring, the Regional Partnerships work with their local schools to distribute brochures to all families with school age children that inform them about Dr Dynasaur. Tear off sheets on the brochures allow families to request more information on Dr. Dynasaur as well as application forms.

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))**

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)**

Vermont provides the same amount, duration and scope of services to SCHIP children as are provided under its Medicaid plan.

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)**

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**

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. (**Section 2102(a)(7)(A)); (42CFR 457.495(a))**

Vermont uses the same methods to assure the quality and appropriateness of care, and to assure access to covered services as are used under its Medicaid plan.

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: (**Section 2102(a)(7)(B)); (42CFR 57.495)**

The Vermont SCHIP program is a separate child health program that operates exactly the same as the Medicaid program, and provides the same amount, duration and scope of services to SCHIP children as are provided under its Medicaid plan.

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))**

DCF's Healthy Babies, Kids & Families Program works with parents and providers to ensure children receive well-baby care and well-child care. In addition VDH has a periodicity schedule for physicians regarding

immunizations and well-child/adolescent care The SCHIP program utilizes the same provider network as do all Medicaid recipients.

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 SCHIP program utilizes the same provider network as do all Medicaid recipients.

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))**

Vermont provides SCHIP enrollees with the same amount, duration and scope of services as is provided under its Medicaid plan. The SCHIP program utilizes the same provider network as do all Medicaid recipients.

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))**

The Vermont SCHIP program is a separate child health program that operates exactly the same as the Medicaid program. Decisions related to prior authorizations are made in accordance with state law and the medical needs of the patient, using the same process and criteria used for Medicaid.

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))**

Nominal cost sharing is required for SCHIP just as it is currently required under the Dr. Dynasaur and Vermont Health Access Plan (VHAP) programs. The State believes that the incomes of these families is sufficient to currently allow them to pay out-of-pocket for many covered services, so that the added coverage will represent a substantial benefit despite the requirement for payments for a program fee. The State further believes that it can reasonably assure that the cost sharing does not favor children from higher income families over lower income families and that costs will not exceed five percent (5%) of any family's income in a given year. No deductibles, coinsurance, or copayments are required for those in SCHIP.

8.2.1. Premiums:

The state charges a premium for all children enrolled in SCHIP. The monthly premiums are charged per family to cover all eligible children in the family. Beginning July 1, 2007, children in families with income from 225 to 300% of the FPL will have an SCHIP premium of $40.00 per month. The $40.00 premium amount will be in effect through June 30, 2008. On July 1, 2008 the SCHIP premium will be $60.00 per month. The changes in premium levels and effective dates are in the table below.

Federal Poverty Level	*Premium amount*	*Effective Date of Premium*	*Expiration Date of Premium*
225-300%	*$80.00*	*July 1, 2005*	*June 30, 2007*
225-300%	*$40.00*	*July 1, 2007*	*June 30, 2008*
225-300%	*$60.00*	*July 1, 2008*	

8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:

8.2.4. 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)(B)); (42CFR 457.505(b))**

Notification for past, current, and future cost sharing amounts has been provided under the same public notification requirements used for public policy promulgated under Vermont's Administrative Procedures Act. Information on the specific cost sharing amounts is included in outreach activities. Additionally, the State will continue to use the below listed groups established for the VHAP/Medicaid program as sources of input and feedback.
The committees are:

Medicaid Advisory Board
Quality Improvement Advisory Committee
Health Access Legislative Oversight Committee
Primary Care Advisory Committee of the Department of Health
Administrative Rules Committee of the Vermont Legislature
Vermont Legislature

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))**

Vermont has established a single annual maximum for households with incomes 225% - 300% FPL. This maximum will be an amount that does not exceed 5% of the 225% for a household of two. This assumes that at least one child must be in the household to qualify for Title XXI and that selecting the 225% FPL income level to set the maximum assures that no household in the income bracket will exceed the 5% level. Premiums will count toward the family out-of-pocket limit.

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)**

Vermont notifies individuals on application that membership in the designated tribes excludes families from cost sharing. If the applicants disclose membership the information is included in the ACCESS system. This will exclude those of designated tribes from being included in billing files.

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))**

The Vermont SCHIP program is a separate child health program that operates exactly the same as the Medicaid program. Individuals in the SCHIP program must pay a monthly premium that is billed monthly. The premiums are billed prospectively and individuals lose coverage if the fee is not paid.

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))**

SCHIP enrollees are required to pay a monthly premium that is billed prospectively every month. Enrollees will be notified of their premiums for coverage on or about the beginning of the month and will have until the end of the month (approximately four weeks) to pay the premium prior to losing coverage.

☒ 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))**

Enrollees are required to report any changes in income to their benefits program specialist when changes occur. If during the process of disenrollment the enrollee presents information that shows that family income has changed, the new information is entered into ACCESS and changes in eligibility are made if warranted. If the information indicates the family income has declined, ACCESS would reassign the child to the Medicaid program if all the eligibility criteria for that program had been met.

☒ 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))**

Applications for Medicaid and SCHIP are reviewed for determination by the same benefits program specialist. The State assures that children determined to be eligible for Medicaid are not reviewed or determined eligible for the SCHIP program. Vermont uses an automated, integrated eligibility system called ACCESS. Criteria for SCHIP, Medicaid and all other aid programs are programmed into ACCESS. ACCESS would automatically change the beneficiary's category code to Medicaid if warranted.

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

Individuals have the opportunity for an impartial review of any adverse eligibility determination through the Fair Hearing process.

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))**

The strategic objectives of the Vermont SCHIP program are:

- *Children have adequate insurance to pay for needed care;*
- *Improved health care for children;*
- *Improved care coordination and utilization for children;*
- *Access to primary care provider; and*
- *Children are satisfied with their health care.*

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

The performance goals for each strategic objective and the source for the data for the performance goals are as follows:

Children have adequate insurance to pay for needed care.
97% percent of Vermont children have creditable health care coverage
BISHCA Survey of Uninsured

Improved health care for children
90% of children 2 years old will receive recommended vaccines.
Vermont Department of Health, ***Healthy Vermonters 2010 Annual Report***

Improved care coordination and utilization for children
90 % of SCHIP children enrolled in Primary Care Case Management Program
SCHIP children in Primary Care Plus as reported in Medicaid MMIS

Access to primary care provider
90% of children in PC Plus will see a primary care provider during 12 month period
HEDIS Data children aged 1-11 years.

Children are satisfied with their health care
90% (Children/parents) Rate Personal Doctor a score of 7 (or greater) out of 10
Annual Office of Vermont Health Access CAPHS Survey

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 of SCHIP will be measured utilizing data from both external independent sources and from the Medicaid MMIS. Annual CAPHS Survey, BISHCA Uninsured survey, and Department of Health reports are all independent and all provide data on the whole Medicaid population on 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.

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 child care

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: Some HEDIS measures for children up to 12 years of age.

9.3.8. ☐ Performance measures for special targeted populations.

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)**

Vermont will utilize assessments of SCHIP to inform stakeholders and decision-makers about progress towards performance goals. The State will utilize the BISHCA Survey on Uninsured as a baseline number of uncovered children in Vermont.

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))**

The State involves the public in the design and implementation of the SCHIP program in a number of ways. The State uses feedback from individual beneficiaries or providers that comes to the State's attention to inform the design and implementation of programs. The State also utilizes standing committees (See Section 8.3) established for the VHAP/Medicaid program as sources of input and feedback on the SCHIP program. Formal participation is provided under the same public notification requirements used for public policy promulgated under Vermont's Administrative Procedures Act.

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))**

Vermont has no federally recognized Indian tribes. Approximately 50% of Indians in Vermont populate the northwest area of the state, most in the St. Albans area. The St. Albans Regional Partnership, that includes local ESD and VDH offices, conducts outreach activities and provides for interaction with individuals or tribal organizations on issues related to health care. In addition, individuals or tribal organizations have the opportunity under the public notification requirements used for public policy promulgated under Vermont's Administrative Procedures Act to

participate in the development of the SCHIP or other health care programs.

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).

The public notice process for reducing premiums began in May 2007. Public notice for amendments relating to eligibility or benefits is under the same public notification requirements used for public policy promulgated under Vermont's Administrative Procedures Act. The public notice for this cost sharing state plan amendment is consistent with Vermont's APA.

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)**

SCHIP Budget

STATE: Vermont	**Current FFY Budget**	**Enrollment Change**	**New Budget with SPA Budget Increase/ decrease**
Federal Fiscal Year	**FFY 2008**	**FFY 2008**	**FFY 2008**
State's enhanced FMAP rate	**71.32%**	**71.32%**	
Benefit Costs			
Insurance payments	$ 5,658,735	$ 808,952	$ 6,467,687
Managed care			$
per member/per month rate	*$160.49*	*$160.49*	
Fee for Service	$ 361,196	$ 51,635	$ 412,831
Total Benefit Costs	**$ 6,019,931**	**$ 860,587**	$ 6,880,518
(Offsetting beneficiary cost sharing payments)	$ 1,026,112	$ 128,359	$ 1,154,471
Net Benefit Costs	**$ 4,993,819**	**$ 732,228**	$ 5,726,047
Administration Costs			
Personnel	$ 37,681	$ 1,983	$ 39,664
General administration	$ 6,280	$ 331	$ 6,610
Contractors/Brokers	$ 77,455	$ 4,077	$ 81,532
Claims Processing	$ 88,904	$ 4,679	$ 93,583
Outreach/marketing costs	$ 142,588	$ 7,505	$ 150,093
Other	$ -	$ -	$ -
Total Administration Costs	**$ 352,908**	**$ 18,574**	**$ 371,482**
10% Administrative Cap	$ 469,350	$ 81,359	$ 550,708
Federal Share	$ 3,813,286	$ 535,472	$ 4,348,758
State Share	$ 1,533,441	$ 215,330	$ 1,748,771
TOTAL COSTS OF APPROVED SCHIP PLAN	**$ 5,346,727**	**$ 750,802**	**$ 6,097,529**

The Source of State Share Funds has not changed.

*Premiums were reduced in July 2007 from $80 to $40 for a reduction in premium collections of $897,892. Premiums were increased in July 2008 from $40 to $60 which will increase premium collections by $128,220.

Effective Date: July 1, 2007
Approval Date:

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, 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.

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))**

The Vermont SCHIP program is a separate child health program that operates exactly the same as the Medicaid program.

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**.

Eligibility and Enrollment Matters

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

The State follows state and federal due process laws (including our program regulations), and affords any individual the right to a fair hearing. The State Human Services Board provides an impartial review.

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR 457.1120.

The State follows state and federal due process laws (including our program regulations), and affords any individual the right to a fair hearing. The State Human Services Board provides an impartial review.

Premium Assistance Programs

12.3 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.

N/A