

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

Preamble

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

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

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

Form CMS-R-211

Effective Date:

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Approval Date:

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

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

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

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

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

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

The following state officials are responsible for program administration and financial oversight (42 CFR 457.40(c)): [Idaho Department of Health & Welfare](#)

Name: Joseph Brunson	Position/Title: State Medicaid Director Administrator, Division of Medicaid
Name: Gary Broker	Position/Title: Administrator, Division of Management Services
Name: Robin Pewtress	Position/Title: State S/CHIP Director Alternative Care Coordinator, Division of Medicaid

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

Effective Date:

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

- 1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):
- 1.1.1 ~ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); **OR**
 - 1.1.2 XX Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**
 - 1.1.3 ~ A combination of both of the above.
- 1.2 XX 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))
- 1.3 XX 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)
- 1.4 XX Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):
- Effective date: 7/1/02
- Implementation date: 7/1/02

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))

GEOGRAPHY: Idaho is a predominantly rural state. It has approximately 1.2 million people and is ranked 40th in the nation for population. It also occupies a land area of 83,557 square miles and is the thirteenth largest state in area. Additionally, Idaho has diverse geology and biology containing large areas of alpine mountainous regions, vast desert plains, farmland valleys, and deep canyons and gorges. Many areas of the state have few roads. Some areas are vast wildernesses with no roads. Only two out of 44 counties meet the criteria of a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget. The remaining counties are classified as rural (6 people per mile) or frontier (less than 6 people per square mile). Thirty-six percent of Idaho's population resides in these rural and frontier counties. Sixteen of Idaho's counties are considered frontier. These frontier areas comprise 59% of Idaho's total land area. Two-thirds of Idaho's landmass consists of state and federal public lands. The rural nature of Idaho has a significant impact on health care issues, including insurance enrollment and health access.

GENERAL POPULATION: From April 1, 1990 to July 1, 1997, Idaho’s population increased from 1,006,749 to 1,210,232 or 20% (an average rate of 2.5% annually), the third-highest increase in the nation. Three-fourths of the population growth has occurred in urban areas, especially Ada, and Canyon Counties in southwest Idaho and Kootenai County in northern Idaho. That growth has continued and is expected to be reflected in the 2000 census data.

Racial Demographics: According to 1998 projections using the 1990 census data, 97% of Idaho’s population is white (Persons of Hispanic heritage are included in this number). The racial composition of the remaining 3% of Idaho’s population is as follows:

African American	Native American	Asian/Pacific Islander	Other	Total % Population
.5%	1.3%	1.1%	.1%	3%

Ethnic Demographics: Idaho’s largest ethnic minority, representing 7.1% of the state’s total population, is of Hispanic heritage. Southwest and south central Idaho especially have large concentrations of people

Model Application Template for the State Children's Health Insurance Program

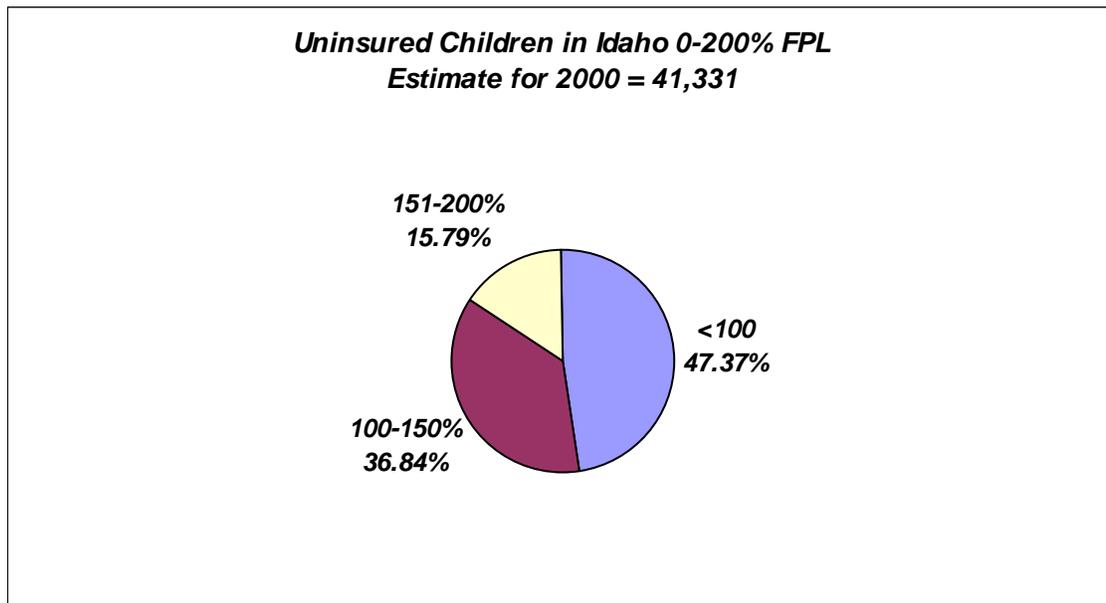
with Hispanic heritage. Up to 15% of these two region's total population is of Hispanic heritage and culture. Idaho also has five Native American tribes: the Shoshone and Bannock Tribes in eastern Idaho, the Shoshone and Paiute Tribes in Duck Valley, southwestern Idaho, the Nez Perce Tribe in north central Idaho, and the Coeur d'Alene Tribe in northern Idaho. Total tribal membership in Idaho is estimated at 15,750.

CHILD POPULATION: Estimates of the number of children in Idaho and the number of uninsured children have been developed from 1990 Census data, Census Bureau Current Population Survey data, and data developed for the Casey Foundation through the University of Louisville. From these sources, the estimate of the number of children in Idaho in 2000 is 399,167. Of those, 192,515 children live in families with incomes at or below 200% of the Federal Poverty Level. Of those children, Idaho estimates that 41,331 are without health insurance. Of all children, there are an estimated 59,821 who are uninsured, or 15% of the total.

CHILDREN POPULATION AND INSURANCE DATA: YEAR 2000

FPL	Children	Children w/o insurance	% w/o insurance	Children w/o insurance cumulative	
<100%	76,135	19,578	26%	19,578	
101-124%	31,542	8,701	28%	28,279	
125-149%	26,104	6,526	25%	34,805	Idaho target
150-174%	29,367	3,263	11%	38,068	
175-199%	29,367	3,363	11%	41,331	Federal target
22-249%	47,857	5,438	11%	46,769	
250+%	158,797	13,052	8%	59,821	
Total	399,167	59,821	15%		

The 1998 Idaho Legislature reviewed the Children's Health Insurance Program and set the upper limit for eligibility at 150% of the Federal Poverty Level. At that level, Idaho estimates that there are 34,805 uninsured children potentially eligible for either Medicaid Title XIX or CHIP Title XXI health insurance. That number represents 79% of the estimated number of uninsured children in Idaho and 84% of the uninsured children potentially eligible for CHIP under the federal standard.



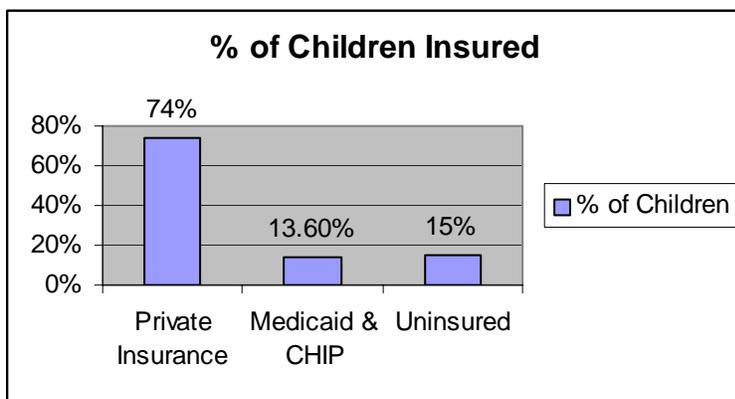
In addition to the estimates on the number of uninsured children in Idaho, the Department of Health and Welfare has data on actual enrollment of children in Title XIX and Title XXI programs from July, 1996 to September, 1999. Those figures indicate that a total of 54,172 children are enrolled in these programs. That figure represents 13.6% of all children and 40.5% of all children at or below 150% of the Federal Poverty Level.

HISTORICAL MEDICAID ENROLLMENT DATA

CHILD MEDICAID ENROLLEES (7/96)	42,765		
PRE-CHIP CHILD MEDICAID ENROLLEES (9/97)	37,013		
	TITLE XIX	TITLE XXI	TOTAL
MEDICAID/CHIP ENROLLEES (9/99)	50,437	3,735	54,172
MEDICAID/CHIP ENROLLEES (9/01)	83,461	11,504	94,965
ENROLLMENT INCREASE SINCE 9/97	46,448	11,504	57,952

In 1996, the best estimate of insurance coverage for Idaho children projected that 13.2% of the children were uninsured, 19.8% were enrolled in Medicaid, and 74.2% had some form of private insurance during

the year. These numbers add up to more than 100% because some children were counted in more than one category during the year. Census Bureau data for 1998 estimate at a national level that 15.4% of children were uninsured, 19.8% were covered by Medicaid, and 67.5% had private coverage. The 1999 Idaho data indicate 15% of children are uninsured, 13.6% of children are covered by Medicaid, and, extrapolating, 74% of children are covered by private insurance. These estimates approximate the 1998 Census Bureau national data on percentages of children insured.



To estimate the number of uninsured children who are potentially eligible for the Title XXI Children's Health Insurance Program, the Department started with the 34,805 uninsured children at or below 150% of FPL. Based upon enrollment experience and the percentages of children who are eligible through the Pregnant Women and Children Program and other Title XIX programs, the Department is estimating that 25% of the target population could be enrolled in CHIP. That number amounts to 8,701 children.

In 1999, the Department of Health and Welfare, with the endorsement of Governor Kempthorne, made the decision to continue operation of CHIP as a Medicaid expansion and coordinate all enrollment efforts between CHIP and Medicaid. DHW developed a unified approach to CHIP implementation using a single message, streamlined application, and outreach/education effort targeted all uninsured children at or below 150% of FPL. This approach is designed to make it easy for families to apply for and have their children enrolled in either program in a customer friendly, seamless manner. Annualization of income, self-declaration of income and assets, and 12-month continuous eligibility for both programs enhances the opportunity to enroll uninsured children. Significant partnerships have been developed with national and state businesses, health providers, and community agencies to promote CHIP.

The 1999 Idaho Legislature authorized a legislative interim committee to review the levels of uninsured families in Idaho and develop a set of recommendations on how to make insurance more affordable and available to Idaho residents. That committee is to present its recommendations to the 2000 Legislature. Its goal is to identify financial, business, legislative, and taxation strategies that would make it more feasible for uninsured individuals to become insured.

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):

This section of the plan describes the structure DHW has established to facilitate program coordination across the umbrella agency and enrollment activities designed to increase Idaho children's enrollment in public health insurance programs. A description of the state's outreach efforts through the Medicaid and state-only program are presented in Section 5.1. Enrollment and outreach activities are designed to be complimentary functions.

CHIP Process and Structure

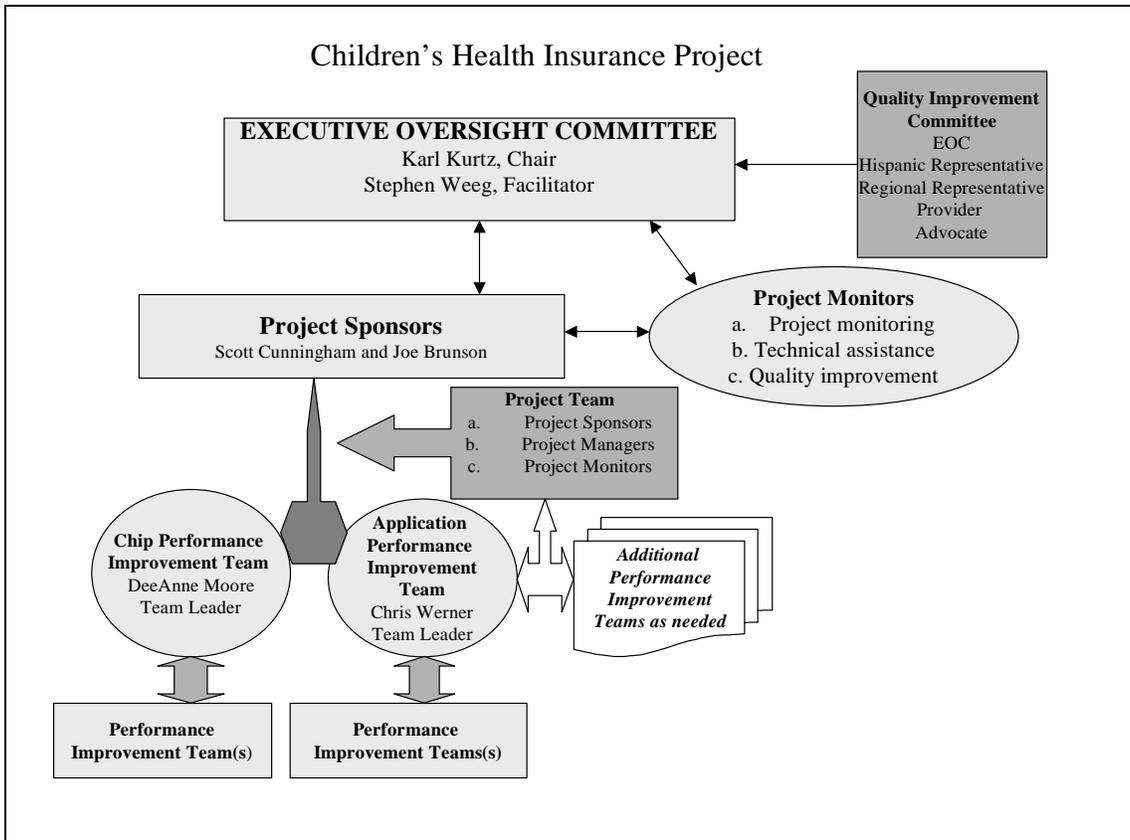
The Idaho Department of Health and Welfare (DHW) is an umbrella human services organization. DHW has direct responsibility for child protection, child abuse prevention, health, Medicaid, family cash and other subsidy income supports, developmental services, and mental health and substance abuse services. DHW staff includes line personnel in each of these areas who have daily contact with children and families as well as regular contact with community leaders.

DHW recognizes that it would not be possible to reach this large number of potential enrollees through a single Division. Rather DHW envisions CHIP as an ongoing sustainable outreach, insurance enrollment and service provision process.

The large size of the project requires a coordinated effort across DHW divisions and the development of a strong partnership with Regional Field Offices and other stakeholders to achieve this goal. DHW has established the sustainable structure that insures coordination of activities at both the state level and regional levels. This structure is described in more detail below.

State Level Coordination

In order to insure ongoing coordination of activities throughout the DHW, an executive oversight committee responsible for overall project direction and quality improvement activities has been established. Specific project tasks are the responsibility of project teams with appropriate representation from throughout the Department and other affected stakeholders. The table on the page 9 presents the Department Organization for CHIP. The Enrollment Performance Improvement Team, led by staff from the Welfare Division, is responsible for designing and implementing all enrollment changes. The CHIP Performance Improvement Team led by staff from the Medicaid Division is responsible for designing and implementing the Outreach and Education portions of the access pathways.



DHW is in the process of establishing a CHIP Resource Network. This network, to be established in FFY 2000, will be linked by email and the Web to insure that all participants have the latest information on CHIP. The Resource Network is broadly based and includes both DHW staff and stakeholders:

Internal Stakeholders

- Office of Public Participation
- State WIC program
- Governor's Office
- Idaho CareLine
- Division Administrators and appropriate staff
- County Welfare Staff
- Self-reliance Specialists
- Out-stationed Eligibility Workers
- Regional Directors

External Stakeholders

- Pediatric/Family Health Care Providers
- Idaho Hospital Association
- Immunize-by-Two Coalition
- Idaho Perinatal Project
- Community/Migrant Health Centers
- Director of the Idaho Robert Wood Johnson Covering Kids project and staff
- The Idaho Robert Wood Johnson Covering Kids Coalition
- Culturally diverse and under-served populations
- State schools
- State Head Start program
- Parish nursing coordinator
- Pharmaceutical companies
- County Welfare
- Salvation Army

Following a continuous quality improvement model, DHW has also established a Quality Improvement Committee composed of the Executive Oversight Committee and representatives of the medical community, advocacy groups, public health and Head Start. The purpose of the Committee is to monitor the Department's performance in implementing Children's Health Insurance and to provide guidance in areas where performance can be improved.

Innovations in Application Assistance and Enrollment

DHW also has implemented a number of initiatives designed to be customer friendly and provide potential enrollees with application assistance and thus enhanced enrollment. The activities below reflect only those activities undertaken by the DHW with DHW resources. Activities involving enrollment but based on public/private partnerships are contained in 2.2.2. These initiatives include but are not limited to:

- Idaho CareLine—an 800 number providing referral assistance to DHW customers throughout Idaho. The Idaho CareLine has a direct link to CHIP assistance. CHIP makes up the largest segment of callers on a regular basis. 888 KIDS NOW connects directly to the Idaho CareLine
- Benefits for Working Families—a brochure outlining the services available throughout DHW to families
- Provisions of Spanish Speaking DHW staff in all regions—Idaho's largest minority group are Hispanics. DHW has made an effort to ensure that all materials are in Spanish and that Spanish Speaking staffs are available in the local offices
- Provision of customer satisfaction forms in all offices as well as follow-up on customer satisfaction after a final determination has been made.
- Provision of mail/fax in applications—the redesigned application allows potential CHIP enrollees to submit their application by mail or fax. Eligibility workers can make a CHIP eligibility determination without a personal visit. When information is missing, self-reliance workers are to contact potentially eligible families by telephone.
- Contracting for out-stationed eligibility workers—DHW has contracted with the Idaho Primary Care Association to make out-stationed eligibility workers available at Federally Qualified Health Centers (FQHC). These workers focus on providing both application assistance and outreach. All out-stationed eligibility workers are bilingual.
- Expanded enrollment assistance through alternative public sites--DHW is in the process of working with the public health agencies throughout the state to establish a process in which applicants for public health services such as Maternal and Child Health Block Grant, Title V, and WIC will receive immediate assistance in applying for CHIP.
- Coordinated outreach and enrollment activities with the Idaho Department of Education and school lunch and child care food programs.
- Coordinated outreach activities with the Idaho Hospital Association as described in Section 2.2.2.

Changes in Policy Designed to Increase Enrollment

As part of its efforts to significantly increase enrollment of eligible children, DHW under the direction of Karl Kurtz undertook a fast-track redesign of the Application for Assistance. The redesigned form is four pages long and is used for all benefit programs in the Self-Reliance Program (Health Coverage, Cash Assistance, Food Stamps, Child Care, Telephone Service and Nursing Home). As part of the forms redesign process, DHW implemented a number of new policies designed to improve enrollment. These policies are as follows:

- Establishment of a 12-month continuous eligibility period for children.
- Redesign of Application from case-centered to person-centered.
- Self-declaration of income and assets for health coverage for families and children.
- Annualize income for enrollment. This policy was adopted to assist seasonal or temporary workers. In some cases, the bulk of a workers' income may be earned during a time-span of three to four months.
- Elimination of the requirement for proof of citizenship from non-applicants.

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:

Idaho has been actively involved in creating an array of public/private partnership to increase enrollment of children in health insurance programs. These activities include the following:

- Provision of Application Assistance in areas of high utilization by potential enrollees
 - DHW has contracted with the Idaho Primary Care Association to provide additional application assistance to potential eligible in locations where participants have a high likelihood for being eligible for assistance, such as Migrant Center and Community Health Centers.
 - DHW is in the process of working with the Idaho Hospital Association so that hospital admitting units, billing offices and emergency rooms are able to provide application assistance.

Model Application Template for the State Children's Health Insurance Program

- Work with Mountain States Group, a private non-profit corporation, in developing and implementing a successful proposal for funding through The Robert Wood Johnson Foundation Covering Kids Initiative to increase enrollment of uninsured children in health insurance programs.
 - DHW staff worked with Mountain States Group staff on the initial application for Covering Kids funding from The Robert Wood Johnson Foundation.
 - DHW staff participates on the Covering Kids Coalitions at the statewide level and in the project's two pilot communities.
 - DHW staff is working with the Mountains States Group to match certain Robert Wood Johnson Foundation funds with Medicaid funds in order to enhance the funding available to this project for outreach activities.
 - DHW's CHIP Outreach Coordinator and the Covering Kids Director meet regularly to coordinate outreach efforts.
 - DHW staff have engaged in joint outreach efforts with Covering Kids staff at the state and regional levels.
 - The Covering Kids Director serves on the DHW CHIP Quality Improvement Committee.

- 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 Idaho Department of Health and Welfare (DHW) began enrolling children in Idaho Children's Health Insurance Program (CHIP) in October 1997. The Health Care Financing Agency (HCFA) approved the state plan in June 1998, as a Medicaid expansion program. At the program approval time, eligibility for the program included children 0-19 years of age with no credible health insurance coverage and with a family income below 160% of the Federal poverty limit. The Idaho Legislature changed the income eligibility to 150%, effective July 1998.

When the federal government developed the CHIP program (Title XXI), CHIP terminology referred to a categorical health insurance program for children whose family's income was above traditional Medicaid eligibility (Title XIX) and below the eligibility cap established by each state's legislature (in Idaho's case 150% of poverty).

As part of the process of developing a comprehensive program to insure Idaho's low income children and based on Idaho and national experience, it has become clear that a comprehensive effort to enroll Idaho's uninsured children in CHIP will also impact the Medicaid program. Thus, DHW leadership has determined that CHIP in Idaho will be the name used to refer to a comprehensive approach to providing health insurance, to all potentially eligible children below 150% of poverty. This approach includes both Title XIX (Medicaid) and Title XXI (Federal CHIP) children. The Idaho CHIP program is designed to ensure that the category of federal funding is invisible to the enrollee, but trackable for executive policymaking and legislative purposes. As described in Section 2.2.1 every effort has been made to create an administrative structure for CHIP that enhances enrollment of children in health insurance.

Through the single application process, all children are first reviewed for Title XIX eligibility. Those that are found eligible are enrolled in Title XIX. Those who are ineligible for Title XIX and meet the income standards for Title XXI are considered for Title XXI enrollment. The application requests information from the applicant to determine if s/he has other creditable health coverage.

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

XX 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))

- 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))

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

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

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

- 4.1.1. ~ Geographic area served by the Plan:
- 4.1.2. ~ Age:
- 4.1.3. ~ Income:
- 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:
- 4.1.8. ~ Duration of eligibility:
- 4.1.9. ~ Other standards (identify and describe):

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)

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))

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))

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))

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.

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.

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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))

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)

Idaho views outreach to families of children likely to be eligible for assistance as a two-pronged process of outreach/education. These activities are defined as follows:

Outreach: Activities targeted toward informing and motivating potentially eligible families to apply for health care coverage.

Education: The process of giving individuals and organizations who come into contact with low-income children information on health care coverage options.

Outreach and education activities are those administrative procedures and program features that inform and recruit children and their families into potential enrollment. Outreach activities are associated with a set of complex procedures in which families interact with state and local government agencies, advocacy groups, and other organization involved in outreach (Halfon, et al, Milbank Quarterly, 1999, p. 189). In other words, Idaho does not view quality outreach as synonymous with public relations. General media activities are an important component of a quality outreach plan but media is certainly not the only component and depending on the population to be reached may not be the most effective component.

Halfon, et al, have identified a number of critical factors leading to successful outreach. These factors are:

- Targeting
- Appropriate Message and Type for Targeted Group(s)
- Location of Outreach Activities for Targeted Group(s)
- Appropriate Media and type for Targeted Group(s)
- Cultural/Language Considerations for Targeted Groups(s)

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DHW has determined that to reach the target group families, education should be directed to the following groups:

- Schools
- Culturally Diverse Groups
- HeadStart/Child Care Providers
- Maternal Child Health Programs
- Health Care Providers
- Child Advocacy Groups

Idaho has developed a multi-dimensional approach to outreach including but not limited to:

- Building on existing regional successes through emphasis on targeted, grass-roots outreach.
- State level coordination across all DHW Divisions. The state level has an internal project work team with representatives across DHW described in Section 2.2.
- Establishment of a virtual resource network for CHIP. Membership will include all planning partners from throughout Idaho. The network will provide for ongoing dialogue and collaboration about program direction.
- Supporting regional efforts by supplying professionally designed promotional materials
- Provision of technical assistance to regional efforts through educational support teams
- Provision of funding through targeted community education grants. DHW has earmarked a minimum of \$100,000 for minority population education.
- Use of Vista Volunteers. Medicaid will provide the necessary funds to provide the match to the Americorps contribution. Vista workers will be used for CHIP community outreach and education efforts.

Regional activities are based on a regional plan. The plan is developed and implemented under the direction of the Vista Leader with the assistance of Healthy Connection Staff. The Healthy Connections staff is part of the Division of Medicaid but located in regional offices. The staff has primary responsibility for Medicaid's Primary Care Case Management Program. The planning process is intended to bring interested stakeholders to the table to share ideas and enhance coordination of outreach/education/enrollment for CHIP throughout the region. The regional plan includes at a minimum:

- Targeted groups for the region
- Message and approach for reaching each group including strategic outreach partners i.e. schools, HeadStart, WIC
- Potential partners to assist enrollees in completing applications i.e. hospitals, primary care clinics
- Potential business partners and recruitment strategy to involve these partners
- Potential staff resources

Effective Date:

20 Approval Date:

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

XX

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

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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)

- 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 pre-pregnancy 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,

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- 6.2.12. ~ 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*

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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 for the low income children.)** (Section 2105(c)(3)(A)) (42CFR 457.1010(a))
- 6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))
- 6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

Section 7. Quality and Appropriateness of Care

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

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

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

- 7.1.1. ~ Quality standards
7.1.2. ~ Performance measurement
7.1.3. ~ Information strategies
7.1.4. ~ Quality improvement strategies

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

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

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))

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))

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))

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

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

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

8.1.1. ~ YES

8.1.2. ~ **NO, skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.

(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

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))

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))

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)

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))

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

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

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

- 8.8.1. ~ No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2. ~ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5)) (42CFR 457.224) (Previously 8.4.5)
- 8.8.3. ~ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4. ~ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))
- 8.8.5. ~ No funds provided under this title or coverage funded by this title will

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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)

The state of Idaho has developed a set of strategic objectives, performance goals, and performance measures to assess the success of implementing its Medicaid Children's Health Insurance Program. These measures are designed to measure the effectiveness of both Title XIX and Title XXI Programs. The objectives, goals, and measures focus on standard indicators of success in enrollment and retention and in basic health outcomes. The measures have been developed based upon data that is readily available to the Department of Health and Welfare. Idaho has not implemented HEDIS 3.0, so information through that means is not available.

Idaho will track enrollment, retention, access, comprehensiveness, and quality of care. All performance measures will be linked to performance standards and strategic objectives.

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

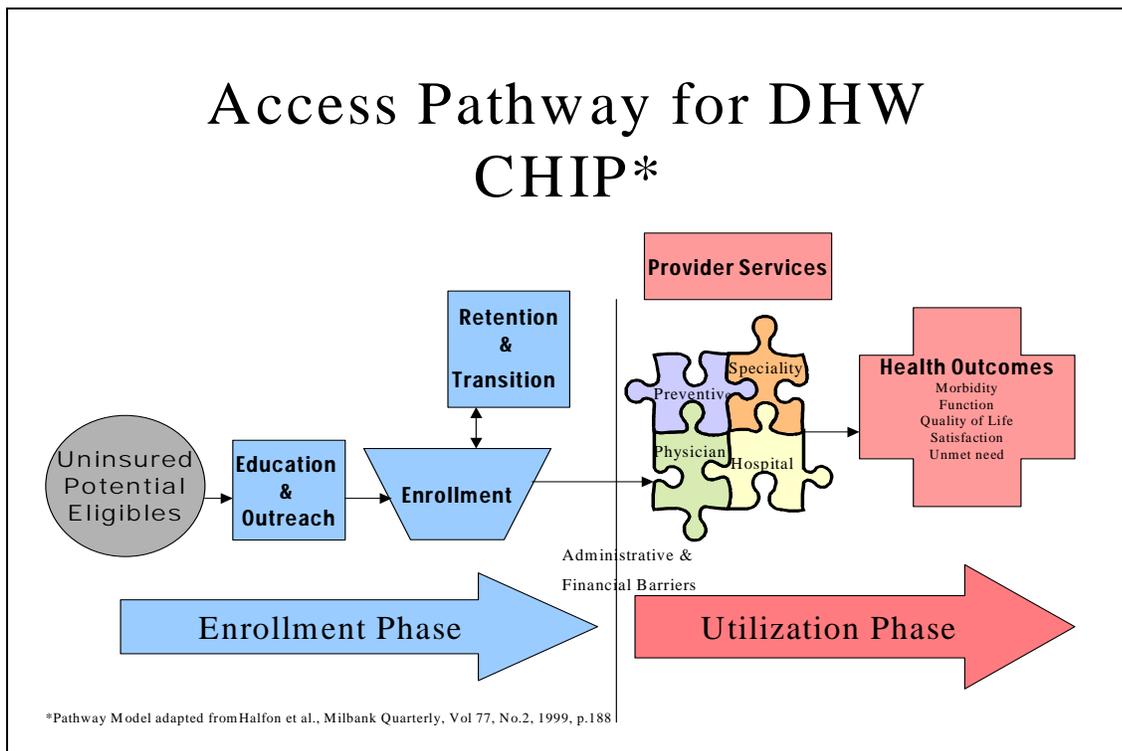
Strategic objectives are listed in Table 9.1

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

Performance goals are listed in Table 9.1

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

Idaho has approached CHIP implementation as a comprehensive process with two major components: 1. Outreach (as described throughout this proposal) and 2. Health Care Access. Figure 9.0 presents an overview of this process.



Performance measures to successfully implement this system are listed in Table 9.1

Table 9.1 provides a clear picture of the strategic objectives, performance goals, and performance measures and the data elements proposed to measure them. The strategic objectives may have more than one goal. Each goal has a performance measure and a corresponding set of measurable data elements. A baseline will be established for each measure. In most cases, the baseline will be an assessment of that measure in the Title XIX program prior to implementation of the Children’s Health Insurance Program, Title XXI.

Table 9.1

Quality Table Strategic Objectives, Performance Goals and Measures, and Data Elements			
Strategic Objectives	Performance Goals	Performance Measures	Data Elements
To enroll 35,000 uninsured children (10/99 estimate) in Title XIX and XXI health programs.	The targeted increase in the enrollment of uninsured children: FY 2000: 8,000 FY 2001: 8,000 FY 2002: 8,000 FY 2003: 8,000	Annual increase in enrollment of uninsured children in both programs compared to the previous federal fiscal year. The total number of new uninsured children enrolled in both programs compared to the base number of enrollees as of 9/30/97	Baseline child Medicaid enrollees as of 9/30/97. Annual new enrollees in both Title XXI and XIX.
To design and implement a sustainable, community-based education and outreach program.	State level and regional outreach and education plans are developed and implemented by 12/31/00. Applications and application assistance are available to target groups in a minimum of 75% of Head Start, WIC, and Migrant and Community Health sites and 90% of birthing hospitals, with a total of at least 5 sites per region, one of which is a school, by 12/31/00.	Locations other than DHW field offices having applications. Locations providing application assistance. Involvement of target groups and agencies in outreach and education activities.	Number of locations where applications and application assistance is available. Number and type of state and community partners. Outreach grant recipients and grant activities. Regional and state outreach and education plans

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Quality Table Strategic Objectives, Performance Goals and Measures, and Data Elements			
Strategic Objectives	Performance Goals	Performance Measures	Data Elements
To simplify and streamline the application and enrollment process.	<p>The application will be customer friendly, 4 pages long, & only request minimum required information by 12/31/99.</p> <p>Applications can be mailed and children enrolled without a required interview by 12/31/99.</p> <p>Results of the customer surveys will be used to make adjustments as indicated by 12/31/00.</p>	<p>A shortened application is implemented.</p> <p>The % of applications processed without an interview.</p> <p>Results of customer satisfaction surveys</p>	<p>Difference in length of new and old forms.</p> <p>Total number of applications processed and number processed without interview.</p> <p>Satisfaction surveys</p>
To retain enrolled children in Title XXI and XIX programs.	Increase in mean and mode length of enrollment of at least 1 month in each of the next three fiscal years for Title XXI participants.	Average length of enrollment for children in these programs.	<p>Baseline: 6 mo. mean 2 mo. mode</p> <p>Enrollment period per child and mean and modal lengths of enrollment per fiscal year.</p>
To ensure that enrolled children have a medical home.	There will be a 10% annual increase in the number of children participating in Healthy Connections and having a primary care provider as a “medical home”.	<p>Baseline % of children participating in Healthy Connections.</p> <p>Rate of enrollment of children in Healthy Connections.</p> <p>Number and percentage of physicians participating in Healthy Connections.</p>	<p>Number of children enrolled in Healthy Connections compared to total CHIP enrollment</p> <p>Number of participating physicians compared to total possible pool.</p>

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Quality Table Strategic Objectives, Performance Goals and Measures, and Data Elements			
Strategic Objectives	Performance Goals	Performance Measures	Data Elements
To ensure that enrolled children receive appropriate and necessary medical care.	<p>90% of enrolled children will have up-to-date, age-appropriate vaccinations.</p> <p>80% of enrolled children age 12 months and younger will have received appropriate preventive care.</p>	<p>Percentage of enrolled children who have up-to-date, age-appropriate vaccinations.</p> <p>Percentage of enrolled children who have received appropriate preventive care.</p> <p>Percentage of enrolled children who access health care compared to national data.</p>	<p>EPSDT screening data</p> <p>Percentage of enrolled children who use services in Idaho and nationally</p>
To implement a quality improvement process for children’s health.	Preferred health outcomes and care management strategies for children will be identified by 12/31/00.	List of health outcomes and care management strategies adopted.	Dependent upon outcomes and strategies adopted.

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

- 9.3.1. **XX** The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. **XX** The reduction in the percentage of uninsured children.
- 9.3.3. **XX** The increase in the percentage of children with a usual source of care.
- 9.3.4. **XX** The extent to which outcome measures show progress on one or more of the health problems identified by the state.

Governor Kempthorne has established a goal of 90% immunization rate for children. Liz Trias, HCFA Region X, Health Insurance Specialist A central registry is being established to track immunization rates. Data from this registry will be used to monitor achievement of strategic objectives in this plan.

- 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:

9.3.8. ~ Performance measures for special targeted populations.

9.4. XX 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. XX 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)

The State assures it will comply with the annual assessment and evaluation required under Sections 10.1 and 10.2. The assessment will be built upon the data obtained to monitor the achievement of the strategic objectives listed in Table 9.1.

9.6. XX 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. XX 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. XX Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. XX Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations

- on payment)
- 9.8.3. XX Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. XX Section 1132 (relating to periods within which claims must be filed)
- 9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))
 - 9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR [457.125. (Section 2107(c)) (42CFR 457.120(c))

Idaho has involved key stakeholders in the design, review, and implementation of its Children's Health Insurance Program.

In 1998, then Governor Batt convened a task force charged with the responsibility to review and make recommendations on the operation of the Children's Health Insurance Program. That task force included legislators, consumers, advocates, healthcare providers, business and insurance entities, and low-income agencies. It made a series of recommendations in late 1998.

In 1999, Governor Kempthorne became Governor and asked for a review of the Task Force recommendations. The Department of Health and Welfare convened a Steering Committee to make recommendations on program implementation. That group, along with a Department CHIP Executive Oversight Committee, agreed upon a set of activities to increase outreach and enrollment and to maintain CHIP as a Medicaid expansion. The Steering Committee included representatives from the Task Force and additional community and Department representatives. Once the Steering Committee completed their recommendations, the committee work was concluded.

The Department has convened a Quality Improvement Committee comprised of Department executive staff and key community members to monitor program implementation on a quarterly basis and to make recommendations for improvement. Community members are also involved in the development and implementation of regional outreach and education plans.

The Department is committed to working with its community partners in the design, implementation, and review of this program. It has, and will continue to, solicit and receive community input from all key constituents in order to make the program succeed.

- 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).

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

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

The budget for this program in state fiscal year 1999 was \$4,436,081. The revenue for the non-Federal share, \$887,216 came from state general funds appropriated by the Idaho Legislature. The average monthly number of children enrolled in Title XXI was 3,100 at an average cost of 108.41 per month per enrollee. Through aggressive outreach the Title XXI program is enrolling more uninsured children and Idaho projects that during FFY '01, the average monthly enrollment will be 7,250 children. Using the current monthly cost per enrollee, Idaho projects that the budget for FFY '01 will be \$10,374,837. 10% of the budget is allocated to administrative costs and 90% is allocated to services.

To estimate the cost of itemized services for FFY'01, the actual costs by service category in SFY 99 were used as a basis. Then, the percentage for that category of the total cost of services was figured. That percentage was used to estimate the potential cost per service category for FFY '01.

Table 9.2 illustrates the actual and proposed budgets (as of 1999). [Table 9.3 illustrates the actual budget for FY2001.](#)

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Table 9.2

Title XXI Budget	SFY 99 Actual	% of Total	FFY 01 Projected
Average enrollees/month	3100		7250
Average cost/enrollee/month	\$108.41		\$108.41
Revenue	\$ 4,436,081.00		\$ 10,374,837.00
Administration	\$ 403,280.00		\$ 943,167.00
Services	\$ 4,032,801.00		\$ 9,431,670.00
Expenses by category			
Inpatient Hospital	\$ 810,057.00	20.09%	\$ 1,894,512.10
Inpatient Mental Health	\$ 217,265.00	5.39%	\$ 508,126.18
Physician & Surgical Services	\$ 748,216.00	18.55%	\$ 1,749,882.13
Outpatient Hospital	\$ 324,897.00	8.06%	\$ 759,849.37
Prescribed Drugs	\$ 412,102.00	10.22%	\$ 963,799.12
Dental Services	\$ 618,086.00	15.33%	\$ 1,445,541.99
Other Practitioners	\$ 185,006.00	4.59%	\$ 432,680.79
Clinic Services	\$ 314,106.00	7.79%	\$ 734,612.03
Laboratory & Radiology	\$ 112,867.00	2.80%	\$ 263,966.48
Family Planning	\$ 27,457.00	0.68%	\$ 64,214.76
Screening Services	\$ 36,474.00	0.90%	\$ 85,303.18
Home Health	\$ 9,110.00	0.23%	\$ 21,305.91
HCBS	\$ 15,189.00	0.38%	\$ 35,523.11
Medical Transportation	\$ 46,760.00	1.16%	\$ 109,359.45
Case Management	\$ 30,888.00	0.77%	\$ 72,238.98
Other Services	\$ 124,321.00	3.08%	\$ 290,754.40
Grand Total	\$ 4,032,801.00	100.00%	\$ 9,431,670.00

Model Application Template for the State Children's Health Insurance Program

Table 9.2: SCHIP Budget FY2001

	Federal Fiscal Year Costs
Enhanced FMAP rate	79.53%
Benefit Costs	\$14,696,689
Insurance payments	
Managed care	
per member/per month rate @ # of eligibles	
Fee for Service	\$14,696,689
Total Benefit Costs	\$14,696,689
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	\$14,696,689
Administration Costs	
Personnel	\$149,096
General administration	\$1,457,067
Contractors/Brokers (e.g., enrollment contractors)	
Claims Processing	
Outreach/marketing costs	\$180,024
Other	
Total Administration Costs	\$1,786,187
10% Administrative Cost Ceiling	\$1,632,965
Federal Share (multiplied by the-FMAP rate)	\$12,986,974
State Share	\$3,342,680
TOTAL PROGRAM COSTS	\$16,329,654

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

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

- 11.1 The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))
- 11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*
- 11.2.1. ~ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
 - 11.2.2. ~ Section 1124 (relating to disclosure of ownership and related information)
 - 11.2.3. ~ Section 1126 (relating to disclosure of information about certain convicted individuals)
 - 11.2.4. ~ Section 1128A (relating to civil monetary penalties)
 - 11.2.5. ~ Section 1128B (relating to criminal penalties for certain additional charges)
 - 11.2.6. ~ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

XX 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.

Health Services Matters

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

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.