

**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.



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

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

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

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

1.1.3. **XX** 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))

The State assures that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. 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. The 2003 Idaho Legislature provided for the new CHIP B program and directed an implementation date of July 1, 2004.

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)

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

1.4 **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: 7/1/04

Implementation date: 7/1/04

**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.

Idaho's population was 1,293,953 in 2000 and estimated for 2001 at 1,321,006 (2.1% increase). Idaho's population grew 28.5% from 1990 to 2000.

**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). In 2000, the percentage of whites was 95.9% The racial composition of the remainder of Idaho's population is as follows:

	African American	Native American	Asian/Pacific Islander	Other	Total % Population
1997	.5%	1.3%	1.1%	.1%	3%
2000	.4%	1.4%	1.0%	1.3%	4.1%

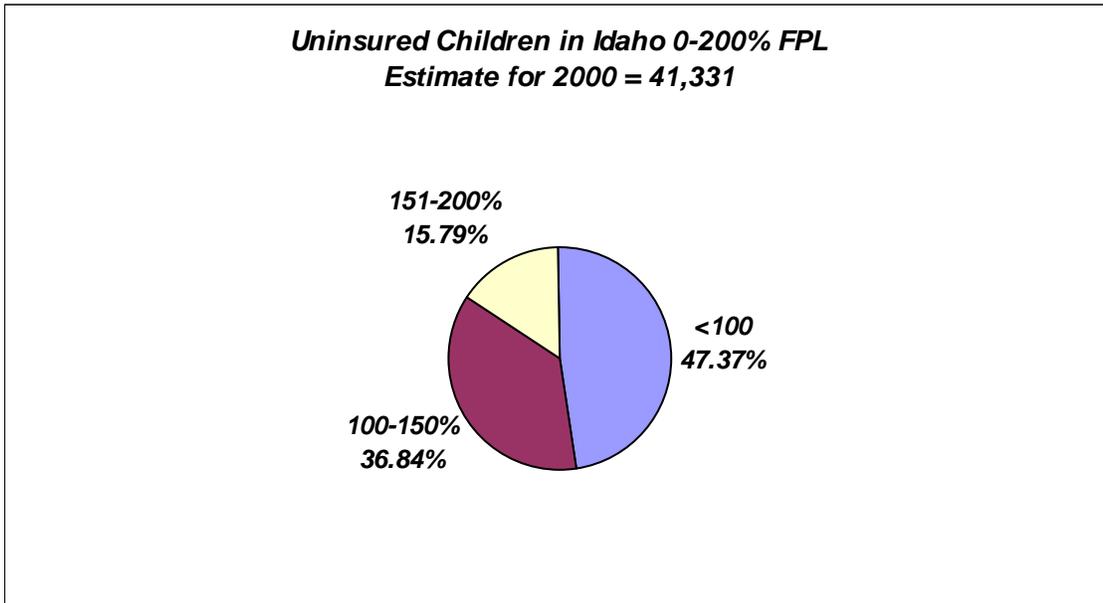
Ethnic Demographics: Idaho's largest ethnic minority, representing 7.1% of the state's total population, is of Hispanic heritage. This percentage rose to 7.9% in 2000. Southwest and south central Idaho especially have large concentrations of people with Hispanic heritage. Up to 15% of these two region's 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:** Original estimates of the number of children in Idaho and the number of uninsured children were 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 was 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**

<b>FPL</b>	<b>Children</b>	<b>Children w/o insurance</b>	<b>% w/o insurance</b>	<b>Children w/o insurance cumulative</b>	
<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	
<b>Total</b>	<b>399,167</b>	<b>59,821</b>	<b>15%</b>		

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 estimated that there were 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.

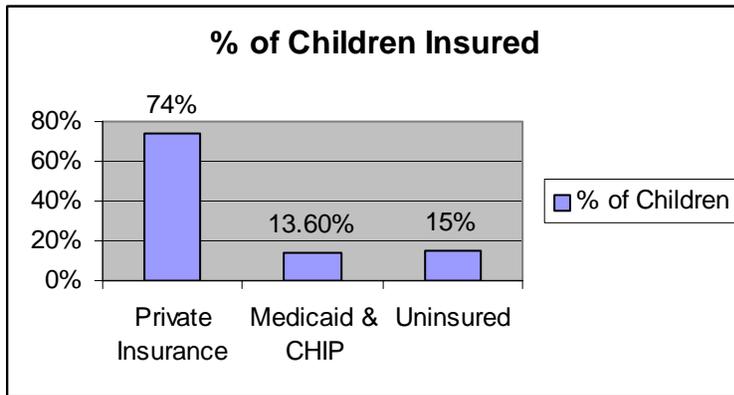


In addition to the estimates on the number of uninsured children in Idaho, the Department of Health and Welfare has data on actual enrollment of children in Title XIX and Title XXI programs from July, 1996 to September, 2003. Those figures indicate that a total of 54,172 children were enrolled in these 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
MEDICAID/CHIP ENROLLEES (9/03)	112,678	10,954	123,632
ENROLLMENT INCREASE SINCE 9/97	75,665	10,954	86,619

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 was 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 further enhanced the opportunity to enroll uninsured children. Significant partnerships were established 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 presented its recommendations to the 2000 Legislature. Its goal was to identify financial, business, legislative, and taxation strategies that would make it more feasible to provide coverage to uninsured individuals.

## UPDATED INFORMATION FOR 2004

The 2003 Idaho Legislature passed legislation to create the CHIP B program.. The CHIP B will cover children living in families whose gross annual income is 150% through 185% of FPG. The benefit package is reduced from the full Medicaid benefit package that is currently offered to CHIP-A children in Idaho's Medicaid-expansion program. Additionally, some cost-sharing will be imposed on participants. The program will start on July 1, 2004.

Data from the 2002 Current Population Survey (CPS) indicated that 144,000 or 39.7% of Idaho's children (18 years of age or less) live below 185% of the FPG. This is consistent with the percentage of Idaho children participating in the Free or Reduced Lunch program (school year 2004/5) which is offered to families up to 185% of the FPG. The 2003 CPS (Table HI10) indicates that the rate of uninsurance for Idaho children under age 19 and living below 200% of FPG is 8.4%. Simple calculation indicates that the number of uninsured children who would be eligible for any CHIP or Medicaid program is approximately 12,100. We believe this number is understated as the CPS information was gathered during the national economic decline. It is probable that the CPS data is further understated due to the inherent problems with sample size and elicited responses from those surveyed.

- 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 and SCHIP, 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 envisions CHIP as an ongoing sustainable outreach, insurance enrollment and service provision process. The nature of the program 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 ensures coordination of activities at both the state level and regional levels. This structure is described in more detail below.

### **State Level Coordination**

To better ensure ongoing coordination of activities throughout the DHW, an executive oversight committee responsible for overall program direction and quality improvement activities was established to implement new SCHIP programs. Specific project tasks are the responsibility of project teams with appropriate representation from throughout the Department and other affected stakeholders. DHW staff participate as member representatives on the statewide Covering Kids and Families in Idaho Coalition. Representatives from this Coalition, as well as, the State Planning Grant are collaborating with the DHW in program development and implementation.

The legislation passed in 2003 to create the new SCHIP programs also provided for a CHIP B Advisory Board to be created. This Board is comprised of eight representatives of the various stakeholders, including two parents of potentially eligible children. This Board is responsible for providing direction to the DHW in program development.

### **Stakeholders**

- Governor's Office
- Idaho CareLine
- Division Administrators and appropriate staff
- Self-reliance Specialists
- Out-stationed Eligibility Workers
- Regional Directors
- Legislators
- Idaho State Planning Grant
- Health care providers
- Idaho Hospital Association
- Community/Migrant Health Centers (Idaho Migrant Council)
- Covering Kids and Families in Idaho Coalition
- Culturally diverse and under-served populations

- State schools- Free and Reduced Lunch Program, school nurses, etc
- State Head Start program
- Idaho Citizen's Action Network (ICAN)
- WIC program
- District Health Departments
- Idaho Pediatric Association
- March of Dimes
- Idaho Food Bank
- Idaho Primary Care Association
- Indian Health Services and Tribal Governments

Following a continuous quality improvement model, DHW has collaborated with the Covering Kids and Families Coalition in identifying and implementing strategies regarding outreach and administrative simplification. Many Coalition member organizations provide application assistance and have hot-linked their web-sites to the State's CHIP website to ensure the most reliable information is provided to Idaho citizen's. To visit the State's CHIP website, go to [www.idahohealth.org](http://www.idahohealth.org) and click on CHIP.

### **Innovations in Application Assistance and Enrollment**

DHW has implemented a number of initiatives designed to be customer friendly and provide potential enrollees with application assistance and thus enhanced enrollment. 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 mail/fax in applications—the redesigned application allows potential CHIP enrollees to submit their application by mail or fax. Self-reliance specialists make CHIP eligibility determinations without a personal visit. When information is missing, self-reliance specialists 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 application 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 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. Efforts in this area will be increased as part of the new programs implementation. Idaho's Back-to-School campaign has demonstrated success in reaching uninsured children.
- 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 three pilot communities.
- DHW's CHIP Director and the Covering Kids Project Manager meet regularly to coordinate outreach efforts.
- DHW staff have engaged in joint outreach efforts with Covering Kids staff at the state and regional levels.

### **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 (in 1999) 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. DHW adopted to assist seasonal or temporary workers. In some cases, the bulk of a workers' income is earned during a time-span of three to four months.
- Elimination of the requirement for proof of citizenship from non-applicants.

In 2000, simplification of the redetermination process was implemented. This involves checking all available interfaces and databases for current pertinent information prior to contacting the participant. If the family cannot be reached by phone, a renewal form is sent. The form instructs the family to review the information entered by their worker on the form, provide any updated information, sign and return the form or call and report that there are no changes.

- 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 does not currently have any public-private health insurance programs.

- 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))

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). In 2003, legislation was enacted to create a separate child health program and extend the eligibility threshold to 185% of poverty with reduced benefits and participant cost-sharing.

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 became clear that a comprehensive effort to enroll Idaho's uninsured children in CHIP also impacts the Medicaid program. In 1999, DHW leadership decided to name its comprehensive approach to providing health insurance to all potentially eligible children below 150% of poverty Idaho CHIP. This approach includes both Title XIX (Medicaid) and Title XXI (Federal CHIP) children. The current Idaho CHIP program is designed to ensure that the category of federal funding is invisible to the enrollee, but can be tracked 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.

With implementation of the separate CHIP program, Idaho will be reevaluating best practices to ensure the most "client friendly" processes are utilized.

Through the single application process, all children are first reviewed for Title XIX eligibility. Those who 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. The application will be supplemented with additional information needed to make accurate eligibility determinations for the new programs.

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

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

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

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

- 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))

CHIP B employs utilization controls from the Title XIX program, including prior approval controls, peer reviews, claims processing edits, post-audit and review procedures. Primary care providers are charged with making referrals for medically necessary specialty services.

Health services providers will be provided a handbook describing the benefit package including limitations. Participants are issued an identification card delineating the applicable benefit package. The card is used to determine covered services and service limitations.

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

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

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

- 4.1.1. **XX** Geographic area served by the Plan: State of Idaho
- 4.1.2. **XX** Age: birth to 19<sup>th</sup> birthday
- 4.1.3. **XX** Income: over 150% through 185% FPL.
- 4.1.4. **XX** Resources (including any standards relating to spend downs and disposition of resources): \$5000 countable resources using the same criteria as Title XIX
- 4.1.5. **XX** Residency (so long as residency requirement is not based on length of time in state) :The child must be a resident of the State of Idaho.
- 4.1.6. **XX** Disability Status (so long as any standard relating to disability status does not restrict eligibility): No child will be denied eligibility based on disability status. If the child receives SSI, the child will be denied coverage based on their eligibility for Medicaid, not for reasons of disability status.
- 4.1.7. **XX** Access to or coverage under other health coverage:  
A child will be ineligible for CHIP B for the following reasons:
- if it is determined the child is covered by creditable health insurance at the time of application
  - if the child has been voluntarily dropped from creditable coverage in the 6 months preceding application with the intention of qualifying for public coverage
  - if the child is eligible for Medicaid or CHIP A benefits.
  - if the child is eligible to receive health insurance benefits under Idaho's state employee benefit plan.
- 4.1.8. **XX** Duration of eligibility:  
The duration of eligibility will be for 12 months unless terminated for one of the reasons described below. Eligibility is determined at least every 12 months. Eligibility is terminated if;
1. The child loses his or her Idaho residency,
  2. The child attains 19 years of age
  3. The child becomes eligible for and is enrolled in Medicaid or CHIP A,
  4. The child's parent or adult who is legally responsible for the

child's health care makes a written request to terminate coverage

5. The application is found to have inaccurate information which effected an incorrect eligibility determination
6. The child dies

4.1.9. **XX** Other standards (identify and describe):

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

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

4.2.1. **XX** These standards do not discriminate on the basis of diagnosis.

4.2.2. **XX** 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. **XX** 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)

A combined application is used for all Idaho CHIP programs. Through a single application, children are reviewed for eligibility under all programs and placed in the appropriate program. The application can be mailed to the Department. Face-to-face interviews are not required. All eligibility determinations will be made within the 45 days following receipt of the application.

An annualized gross income figure is used to determine eligibility.. There are no earned income disregards. A \$5000 resource limit applies. The number of persons in

the family determines the applicable income standard.

If the monthly income figure is above 150% and less than or equal to 185% FPL, the child is eligible for CHIP B. Only those applications received during an open enrollment period will be considered for CHIP B participation. Due to the enrollment cap on CHIP B, children found to be eligible for CHIP B when no program slots are available will be denied participation in the program.

All applicants are notified in writing regarding the outcome of their eligibility and enrollment status.

A child determined eligible for Idaho CHIP programs will be eligible for 12 months. In 2000, simplification of the redetermination process was implemented. This involves checking all available interfaces and databases for current pertinent information prior to contacting the participant by phone. If the renewal is not completed at this point, a renewal form is sent to the family at least 45 days before their health coverage will end. The form instructs the family to review the information entered by their worker on the form, provide any updated information, sign and return the form or call and report that there are no changes.

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

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

Enrollment in CHIP B is limited by State funding. If the plan's enrollment reaches levels that indicate that costs for those currently enrolled are approaching the limit, the State will stop enrollment into CHIP B until enrollment levels are reduced or funding becomes available. The cap on enrollment for CHIP B will be determined annually.

Open enrollment periods for CHIP B will be held at least annually. Applications received during the open enrollment period will first be screened for Medicaid eligibility. If the applicant is not eligible for a Medicaid program, but appears to be eligible for CHIP B, further determination will be undertaken. If the applicant is found eligible for CHIP B, they will be enrolled into the program unless the enrollment cap has been reached. Applicants will be screened and enrolled in the order of receipt. Redetermination of eligibility is conducted every 12 months.

Applications received outside of an open enrollment period will be screened for proper program placement. However, if the applicant is found eligible for CHIP B, they will not be enrolled in the program.. In this case, the applicant will receive a denial notice for program participation and encouraged to reapply during the next open enrollment period. No waiting list will be maintained for CHIP B. There are no exceptions to the cap.

Program materials will contain information regarding the cap on enrollment. The public will be notified in writing of an upcoming open enrollment period via the Idaho CHIP website, notification to advocacy groups and/or news release. Prior to each open enrollment period, the Department will notify CMS in writing of the dates of the open enrollment. If the enrollment cap is met prior to the end of an open enrollment period, the Department will notify CMS in writing that a freeze in enrollment has taken place. This information will also be posted on the website.

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))

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

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

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

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

Through the single application process, all children are first reviewed for Title XIX eligibility. Those that are found eligible are enrolled in Title XIX. Those who are

ineligible for Title XIX and meet the income standards for Title XXI are considered for Title XXI enrollment. Eligibility determinations for both Medicaid and SCHIP are handled by State employees.

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

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

A six month period of uninsurance is incorporated as an eligibility requirement for CHIP B. The application requires information on when the child was last covered by health insurance. Exceptions to the period of uninsurance will be made if the applicant lost private insurance through no fault of their own (i.e. employer driven) or due to hardship.

Substitution of coverage under CHIP B is monitored using the number of creditable insurance determinations received annually. The number of eligibility denials due to having creditable insurance is also tracked and reported.

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.

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)**

Indian Health Service and tribal clinics are included as CHIP B service providers. Idaho Medicaid and Tribal representatives formally meet on a quarterly basis. Tribal representatives can request that SCHIP information be presented at any of these meetings. Additionally, regional Health Resource Coordinators work with providers and enrollees (both Medicaid and SCHIP) to resolve issues and help ensure assistance is appropriately provided.

**Section 5. Outreach (Section 2102(c))**

Describe the procedures used by the state to accomplish:

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

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)

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 work teams with representatives across DHW described in Section 2.2.
- Supporting regional efforts by supplying professionally designed promotional materials
- Provision of technical assistance to regional efforts through central office support teams
- Provision of funding through targeted community education grants.
- Use of Vista Volunteers. The State contracts with AmeriCorps VISTA to provide Vista workers 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 Healthy Connection program. Healthy Connections staff are 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

## **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. **XX** Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)
  - 6.1.4.1.
  - 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. **XX** Other (Describe) Idaho is requesting Secretary Approved coverage for the CHIP B population. Based on SCHIP Statute, Secretary approved coverage is "coverage that provides appropriate coverage for the population of targeted low-income children covered under the program". The proposed coverage is detailed in Section 6.2.

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. **XX** Inpatient services (Section 2110(a)(1))

Inpatient Hospital Benefits:

- Semi private room ; intensive and coronary care units; general nursing; drugs; oxygen; blood transfusions; laboratory; imaging service; physical, speech, occupational, heat and inhalation therapy; operating, recovery, birthing, and delivery rooms; routine and intensive care for newborns and other medically necessary benefits and prescribed supplies for treatment of injury or illness are covered.
- Coverage of postpartum care for up to forty-eight hours for vaginal delivery and ninety-six hours for caesarean section is guaranteed. Any decision to shorten the length of inpatient stay to less than these stated amounts shall be made by the attending physician and the mother.

6.2.2. **XX** Outpatient services (Section 2110(a)(2))

All benefits described in the inpatient hospital section which are provided on an outpatient basis in a hospital (including, but not limited to, observation beds and partial hospitalization benefits) or ambulatory surgical center; chemotherapy; emergency room benefits for surgery, injury or medical emergency; and other services for diagnostic or outpatient treatment of a medical condition , injury or illness are covered.

6.2.3. **XX** Physician services (Section 2110(a)(3))

Physical Benefits (including Clinic Benefits):

- Office, clinic, home, outpatient surgery center and hospital treatment for a medical condition, injury or illness by a physician, mid-level practitioner or other covered provider are covered.

- Well child, well baby and immunization services as recommended by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices are covered.
- Anesthesia services rendered by a physician-anesthesiologist (other than the attending physician or assistant) or by a nurse anesthetist are covered provided that surgical and/or hospital services are also covered.
- Medically appropriate second opinions upon physician referral or surgical consultation.

6.2.4. **XX** Surgical services (Section 2110(a)(4))

Covered as described in inpatient and outpatient hospital and physician benefit descriptions. In addition, professional services rendered by a physician, surgeon or doctor of dental surgery for treatment of a fractured jaw or other injury to sound natural teeth and gums are covered.

6.2.5. **XX** Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

Covered as described in sections 6.2.1- 6.2.5

6.2.6. **XX** Prescription drugs (Section 2110(a)(6))

- Coverage includes drugs prescribed by a practitioner acting within the scope of his practice. The Idaho Medicaid preferred drug list will be utilized.
- Food supplements and vitamins are not covered in the exception of prenatal vitamins and medical foods for treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exists. The need for a prescription to obtain a food supplement or vitamin shall not affect the application of this provision.

6.2.7. Over-the-counter medications (Section 2110(a)(7))

6.2.8. **XX** Laboratory and radiological services (Section 2110(a)(8))

- Coverage includes imaging and laboratory services for diagnostic and therapeutic purposes due to accident, illness or medical condition that are not described elsewhere in this section.
- X-ray, radium or radioactive isotope therapy

6.2.9. **XX** Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))

Prenatal care is covered as described for other medical conditions in this section.

Pre-pregnancy family planning services and prescribed supplies are covered including birth control contraceptives

- 6.2.10. **XX** 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))

Inpatient mental health benefits:

- Services furnished in a hospital; a residential or other 24-hour therapeutically planned structural service; or a partial hospitalization program are covered. Seven days of inpatient mental health benefits are covered per benefit year. Partial hospitalization benefits may be exchanged for inpatient days at a rate of one inpatient day for two partial treatment days. A partial hospitalization program that is operated by a hospital shall comply with the standards for a partial hospitalization program that are published by the American Association for Partial Hospitalization.
- The following specific limitations apply to coverage depending upon the child's diagnosis and the treatment setting. Federal law prohibits coverage of a child in a facility which would be termed an institute for mental disease (IMD) under Medicaid regulations (42 CFR 435.1009). A child who has applied for or been found eligible for the CHIP program prior to becoming a patient in an IMD will be covered by the CHIP program within the individual benefit limits specified in this section. However, a child who is a patient in an institution for mental disease who did not apply for the CHIP program prior to admission is not eligible for the CHIP program until he or she is discharged from the IMD.

- 6.2.11. **XX** 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))

Professional outpatient mental health services up to a maximum of twenty visits per year are covered. The visits can be furnished in a variety of community based settings or a mental hospital.

- 6.2.12. **XX** 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))

Hearing aides are not covered.

- 6.2.13. **XX** Disposable medical supplies (Section 2110(a)(13))

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- 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. **XX** 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. **XX** Dental services (Section 2110(a)(17))

Two visits per year including cleaning, x-ray, sealants, fluoride, fillings and extractions for pain or medical necessity.

- 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. **XX** Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

Ten (10) visits per year

- 6.2.23. ~ Hospice care (Section 2110(a)(23))
- 6.2.24. **XX** Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))

Vision benefits and medical eye care:

- Services for the medical treatment of diseases or injury to the eye by a licensed physician or optometrist working within the scope of his/her license are covered.
- One exam every 12 months, one pair of lenses every 12 months (except in the case of a change in prescription) and one set of frames every 12 months. Frames are limited to \$100 per frame. (If the cost of the frame is more than \$100 families will be responsible for any additional cost.)

Audiological Benefits:

- Hearing exams, including newborn hearing screening in a hospital or outpatient setting are covered. Coverage includes assessment and diagnosis.

Rehabilitation, Inpatient:

- Limited to 7 days per year.

- 6.2.25. ~ Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. **XX** Medical transportation (Section 2110(a)(26))

Limited to ground and air ambulance emergency transport

- 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. **XX** 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 for the low income children.)** (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

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

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

## Section 7. Quality and Appropriateness of Care

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

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

An annual participant survey will be implemented to monitor and assess quality and appropriateness of care. Claims data will be collected and analyzed to assess the performance measurements below.

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. XX Performance measurement (National Performance Measurements)
- Well child visits for children in the first 15 months of life
  - Well child visits in the 3rd, 4th, 5th, and 6th years of life
  - Use of appropriate medications for children with asthma
  - Comprehensive diabetes care (hemoglobin A1c tests)
  - Children's access to primary care services
- 7.1.3. ~ Information strategies
- 7.1.4. ~ Quality improvement strategies

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

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

Enrollment in Idaho's primary care case management program (Healthy Connections) is required in most areas of the state. This helps ensure that enrollees have a usual source of care. Primary care providers are required by contract to provide primary care services to their enrollees. This includes wellness care and immunizations.

Regional Health Resource Coordinators work with enrollees and providers to help ensure appropriate covered services are provided. An annual participant survey is utilized to assess access to care.

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))

Referrals are not required to access emergency services. All provider types necessary to provide covered services are included in the provider panel.

Regional Health Resource Coordinators work with enrollees and providers to help ensure appropriate covered services are provided. An annual participant survey is utilized to assess access to care.

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))

Contractually, primary care providers are required to make referrals for medically necessary specialty services. All provider types necessary to provide covered services are included in the provider panel.

Regional Health Resource Coordinators work with enrollees and providers to help ensure appropriate covered services are provided. An annual participant survey is utilized to assess access to care.

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

Decisions related to prior authorization of health services will be completed in accordance with State law and/or Administrative Rule, and the medical needs of the patient. The decision will be made within 14 days of receipt all required information needed to make the decision.

**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. **XX** 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: \$15 per member per month

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))

The public will be made aware of cost-sharing requirements through:

- Program information materials (i.e. brochures, applications)
- Program notices to participants at eligibility determination and redetermination
- Public hearings held in conjunction with Administrative rules promulgation
- Publication on the State's CHIP website

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. **XX** 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. **XX** 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 **XX** 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))

Upon enrollment participants are sent a notice advising them of their cost-sharing responsibilities. This includes notice of the 5% maximum. Premiums are set at \$15 per member per month. At this rate, the 5% cap cannot be exceeded.

- 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)

Native American and Alaskan Native children will not be charged the monthly premium. The family will be required to declare tribal membership so that the cost sharing exemption can be processed.

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

If premium payments are 2 or more months in arrears at the time of renewal, the child(ren) will lose eligibility for the program and be prohibited from participation for one year. Delinquent accounts will be sent a delinquency notice periodically (i.e. 60 days, 120 days, etc). The notice includes the amount of the delinquency, their right to be considered for Medicaid eligibility and the consequence of not bringing their account current.

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

- XX** 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))
- XX** 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))
- XX** 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))
- XX** 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))

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

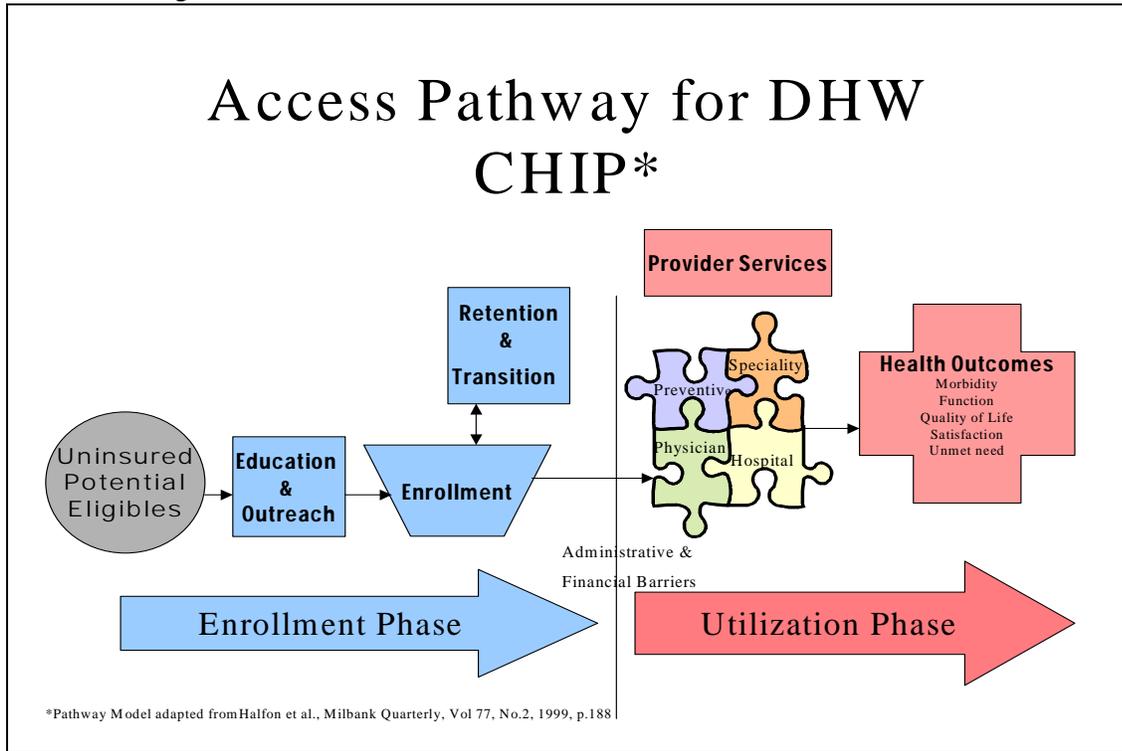
- 9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

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 and 2. Health Care Access. Figure 9.0 presents an overview of this process.

Figure 9.0



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. These are the same as reported in the SCHIP Annual Report.

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**Table 9.1**

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
<b>Objectives related to Reducing the Number of Uninsured Children</b>		
<p><b>To increase the number of children participating in Title XIX and XXI health programs.</b></p>	<p>The targeted increase in enrollment is 8,000 children annually</p>	<p>New/Revised <input type="checkbox"/> Continuing <input checked="" type="checkbox"/></p>
		<p>Data Sources: Enrollment data from the Division of Medicaid AIM system.</p>
		<p>Methodology: Annual increase in enrollment of uninsured children in both programs compared to the previous federal fiscal year.</p> <p>The total number of new uninsured children enrolled in both programs compared to the base number of enrollees as of 9/30/99</p> <p>Numerator: Number of enrollees on 9/30/03: 112,678</p> <p>Denominator: Number of enrollees on 9/30/99: 54,824</p>
		<p>Progress Summary:: Idaho achieved it's annual target by increasing enrollment an additional 8001 children in FFY03. As of 9/30/03, Idaho has enrolled an additional 57,854 children, more than doubling the number of children covered by Title XIX &amp; Title XXI in the past 4 years.</p>
		<b>Objectives Related to SCHIP Enrollment</b>
<p><b>To increase the number of children enrolled in the Title XXI program</b></p>	<p>The targeted increase in enrollment is 2,000 children annually.</p>	<p>New/Revised <input type="checkbox"/> Continuing <input checked="" type="checkbox"/></p>
		<p>Data Sources: Enrollment data from the Division of Medicaid AIM system</p>
		<p>Methodology: Annual increase in enrollment of uninsured children compared to the previous federal fiscal year.</p> <p>The total number of children enrolled each year.</p> <p>Numerator: Number of enrollees on 9/30/03: 10,954</p> <p>Denominator: Number of enrollees on 9/30/99: 3,735</p>
		<p>Progress Summary: The number of Title XXI children decreased this year for the first time in 4 years. The number decreased by 1,022 in FFY03 resulting in an 8.5% decline. It is believed that with the downturn in the economy, children applying for assistance are qualifying for Title XIX instead of Title XXI. The statistics bear this out. As of 9/30/03, overall Idaho had increased enrollment since 1999 by 7,219 children, a 193% increase.</p>
		<b>Objectives Related to Increasing Medicaid Enrollment</b>

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(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
To increase the number of children enrolled in Title XIX health programs	The targeted increase in enrollment is 6,000 children annually	<p>New/Revised <input type="checkbox"/> Continuing <input checked="" type="checkbox"/></p> <p>Data Sources: Enrollment data from the Division of Medicaid AIM system.</p> <p>Methodology: Annual increase in enrollment of uninsured children in Title XIX programs compared to the previous federal fiscal year.</p> <p>The total number of new uninsured children enrolled in Title XIX programs compared to the base number of enrollees as of 9/30/99</p> <p>Numerator: Number of enrollees on 9/30/03: 101,724</p> <p>Denominator: Number of enrollees on 9/30/99: 51,089</p> <p>Progress Summary: The number of children enrolled in Title XIX increased by 9,023 or nearly 10% in FFY03. As of 9/30/03, Idaho had increased enrollment by 50,635 children, an increase of 99%.</p>
<b>Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)</b>		
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>New/Revised <input type="checkbox"/> Continuing <input checked="" type="checkbox"/></p> <p>Data Sources: Division of Medicaid, Healthy Connections (PCCM) Program</p> <p>Methodology: Baseline data on the number of children in the Healthy Connections is known. The data system will track new enrollees in the program</p> <p>Numerator: Number of children enrolled in HC at the end of the FFY 9/30/03: 88,415</p> <p>Denominator: Number of children enrolled in HC at the beginning of the FFY 10/1/00: 25,661</p> <p>Progress Summary: Healthy Connections enrollment increased by 37,058 children in FFY 03, a 72% increase for the year and a 244% increase over the baseline. Percent of children participating rose from 49% to 80%.</p>
<b>Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)</b>		

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(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
<p>To ensure that enrolled children receive appropriate and necessary medical care.</p>	<p>90% of enrolled children will have up-to-date, age-appropriate vaccinations.</p>	<p>New/Revised <input type="checkbox"/> Continuing <input checked="" type="checkbox"/></p>
	<p>80% of enrolled children age 12 months and younger will have received appropriate preventive care.</p>	<p>Data Sources: Division of Medicaid information system, Division of Health Immunization Registry</p>
		<p>Methodology: Claims data will be reviewed for immunization and preventive care visits. The immunization registry is being used to track immunization levels.</p> <p>Numerator: Number of children with up-to-date immunizations and preventive care visits.</p> <p>Denominator: Total number of Title XIX and XXI children.</p>
		<p>Progress Summary: No change- At this time, Idaho is examining the data collection criteria to report wellness visits. The FFY02 HCFA416 report indicates that the screening ratio for children &lt;1 year of age has dropped to 25%. However this is believed to be currently underreported. FFY03 data is not available at the time of this report. Medicaid will be addressing the issue of correct coding for wellness visits in FFY04.</p> <p>Immunizations: No change- For the first three series of shots, Idaho's rate of immunizations is in the low 90s. By the time children are ready to go to school the rate is approximately 95%. Similar to other states, rates reflect a decline in the percentage for the 2 year old age group.</p>

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.
- 9.3.5. ~ HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. **XX** Other child appropriate measurement set. List or describe the set used.

The set of National Performance measures for Title XXI:

- Well child visits for children in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma

- Comprehensive diabetes care (hemoglobin A1c tests)
- Children's access to primary care services

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

- 9.3.7.1. ~ Immunizations
- 9.3.7.2. ~ Well 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))

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.

In 2002, the State Planning Grant reconvened the CHIP Task Force to review progress on recommendations. This in turn led to the enactment of legislation creating the CHIP B program in 2003.

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. The Department partners with other Covering Kids & Families in Idaho Coalition members to create ongoing public involvement in Idaho CHIP programs. A website has also been launched to help solicit public feedback and provide access to program information.

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

Idaho Medicaid and Tribal representatives formally meet on a quarterly basis. Tribal representatives can request that program information be presented at any of these meetings. The Department requests time for program updates to be presented as needed (for example, the CHIP B program was presented at the meeting prior to state plan amendment submission).

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

Public hearings will be held in conjunction with Administrative Rules promulgation required to implement the CHIP B program. These hearings will allow public comment on the entire CHIP B program.

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

Planned use of funds, including --

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

Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

Both CHIP A and CHIP B are funded with federal Title XXI dollars. State match for CHIP A is state general funds appropriations. State match for CHIP B is collected through a state-imposed premium tax on insurance policies sold within the State. A portion of these funds is dedicated to CHIP B funding via Idaho statute.

The premium tax that funds CHIP B is imposed on all entities that sell insurance (not just health insurance) in Idaho and less than 85 percent of the premium tax burden falls on health care providers. The premium tax collections from health insurance are treated the same as premium tax collections from other types of insurance. Therefore, this premium tax does not meet the definition of a "health-care related tax" as defined in 42 CFR §433.55.

**Table 9.2- Cost Projections 2003**

	<b>FFY04</b>	<b>FFY05</b>
<b>Benefit Costs</b>		
Insurance payments		
Managed Care	<b>14,651,584</b>	<b>27,155,200</b>
Per member/Per month rate @ # of eligibles		
Fee for Service	<b>3,662,896</b>	<b>6,788,800</b>
<b>Total Benefit Costs</b>	<b>18,314,480</b>	<b>33,944,000</b>
<i>(Offsetting beneficiary cost sharing payments)</i>	<b>(252,000)</b>	<b>(1,008,000)</b>
<b>Net Benefit Costs</b>	<b>\$18,062,480</b>	<b>\$32,936,000</b>
<b>Administration Costs</b>		
<b>Personnel</b>	<b>25,275</b>	<b>210,225</b>
<b>General Administration</b>	<b>74,175</b>	<b>107,250</b>
<b>Contractors/Brokers (e.g., enrollment contractors)</b>		
<b>Claims Processing</b>	<b>466,875</b>	<b>1,408,125</b>
<b>Outreach/Marketing costs</b>		
<b>Other (inflate @ 4% after FFY03)</b>	<b>906,427</b>	<b>942,684</b>
<b>Total Administration Costs</b>	<b>1,472,752</b>	<b>2,668,284</b>
<b>10% Administrative Cap (net benefit costs ÷ 9)</b>	<b>2,006,942</b>	<b>3,659,556</b>
<b>Federal Title XXI Share</b>	<b>15,495,346</b>	<b>28,280,483</b>
<b>State Share</b>	<b>4,039,886</b>	<b>7,323,801</b>
<b>TOTAL COSTS OF APPROVED SCHIP PLAN</b>	<b>\$19,535,232</b>	<b>\$35,604,284</b>
<b>Average Monthly Eligibles (Projected for 04 &amp; 05)</b>		
<b>CHIP A</b>	<b>11,030</b>	<b>14,000</b>
<b>CHIP B</b>	<b>1,400</b>	<b>5,600</b>
<b>Average PMPM Cost (Prior to Offsets)</b>		
<b>CHIP A</b>	<b>118.23</b>	<b>120.00</b>
<b>CHIP B</b>	<b>100.00</b>	<b>100.00</b>

**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))**

**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 **XX** 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. **XX** 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
  - 11.2.2. **XX** Section 1124 (relating to disclosure of ownership and related information)
  - 11.2.3. **XX** Section 1126 (relating to disclosure of information about certain convicted individuals)
  - 11.2.4. **XX** Section 1128A (relating to civil monetary penalties)
  - 11.2.5. **XX** Section 1128B (relating to criminal penalties for certain additional charges)
  - 11.2.6. **XX** 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.

Idaho CHIP will use the same Fair Hearing rights and process for CHIP B as for Idaho Medicaid. Families are informed of their rights and responsibilities upon application for coverage and via the "Notice of Decision" sent upon eligibility determination. A Fair Hearing can be requested to review any adverse decision made in determining eligibility or enrollment.

Health Services Matters

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

Upon enrollment, participants are provided instruction and contact information regarding how to file a grievance or make a complaint regarding service delivery. Idaho CHIP uses the same Fair Hearing rights and process for CHIP B as for Idaho Medicaid.

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.