

CENTERS FOR MEDICARE & MEDICAID SERVICES SPECIAL TERMS AND CONDITIONS
(STCs)

NUMBER: No. 21-W-00018/10 & No. 11-W-00187/10

TITLE: Idaho Children's Access Card Demonstration

AWARDEE: Idaho Department of Health and Welfare

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Idaho Access Card program, a title XXI section 1115 Demonstration. The parties to this agreement are the State of Idaho and the Centers for Medicare and Medicaid Services (CMS). This demonstration is approved for a 3 year period, from September 1, 2010, through August 31, 2013.

The STCs have been arranged into the following subject areas: Program Description and Objectives, General Program Requirements, General Reporting Requirements, Legislation, Eligibility and Enrollment, Benefits, Cost Sharing, Program Design, Monitoring, Evaluation of the Demonstration, and Schedule of Deliverables. Appendices include, General Financial Requirements Under title XXI, General Financial Requirements under Title XXI (for Demonstration Population 1), and Monitoring Budget Neutrality for the Demonstration.

Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the Centers for Medicare & Medicaid Services' (CMS) Central Office Project Officer and the Associate Regional Administrator at the addresses shown on the award letter.

The State agrees it will comply with all applicable Federal statutes relating to nondiscrimination. These include, but are not limited to: the Americans with Disabilities Act, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

II. PROGRAM HISTORY

- **Initial Waiver Application Submitted:** February 27, 2004
- **Phase I: *Children's Access Card* Approved:** November 4, 2004

- **Children's Access Card Implemented:** November 4, 2004
- **First Waiver Amendment Submitted:** December 8, 2004
Phase II: Access to Health Insurance
- **First Waiver Amendment Approved:** June 21, 2005
Phase II: Access to Health Insurance
- **First Waiver Amendment Implemented:** June 21, 2005
Phase II: Access to Health Insurance
- **Second Waiver Amendment Submitted:** July 11, 2006
While retaining the 50 percent employee contribution towards the premium for employees, this amendment removed the employer contribution requirement for dependent spouses.
- **Second Waiver Amendment Approved:** November 6, 2006
- **Second Waiver Amendment Implemented:** December 1, 2006
- **First Waiver Extension Request Submitted:** August 4, 2009
Under this renewal, premium assistance is provided for CHIP children and uninsured parents of children who are eligible for Medicaid, or CHIP, with family incomes up to and including 185 percent of the FPL. It also removes the authority for pregnant women and childless adults to be covered under this demonstration.

III. BACKGROUND AND OBJECTIVES

Idaho's provides coverage for children ages 6 through 18 years with family incomes above 100 up to and including 133 percent of the Federal poverty level (FPL) who are eligible for Idaho's title XXI Medicaid expansion and not eligible under the Medicaid State plan as of March 31, 1997. In addition, children from birth through 18 years with family incomes above 133 up to and including 185 percent of the FPL are eligible for Idaho's title XXI Separate Child Health Program. Both of these populations are part of this demonstration.

The objective of Idaho's title XXI Section 1115 demonstration is to make health insurance more affordable by providing premium assistance to families with CHIP children with incomes at or below 185 percent of the FPL. Premium assistance is provided under the *Children's Access Card* either through individual health plan coverage or through employer sponsored insurance (ESI) provided by employers. In addition, children may receive premium assistance as part of family coverage under the *Access to Health Insurance Program* through small business employers.

Children's Access Card

The *Children's Access Card*, approved and implemented on November 4, 2004, provides premium assistance to title XXI funded children for private health insurance coverage that is available either through private health insurance carriers in the individual market or through ESI.

The benefits and cost sharing for children under the *Children's Access Card* vary by plan. Large business employers, those with more than 50 employees, are not regulated by the State and there is no minimum benefit level. The State is required to provide information to families regarding where children may receive well-baby and well-child services in the event these services are not covered under the ESI plan. Immunizations are provided to all children in the State free of charge regardless of whether these services are included or excluded from an ESI plan.

Health plan benefits provided by a small business employer are regulated by the State and must include: preventive services (including well-baby and well-child care), maternity services, inpatient and outpatient hospital services, physicians' medical and surgical services, hospice care, ambulance services, durable medical equipment, psychiatric and substance abuse services, and pharmacy.

Benefits and cost sharing for children receiving premium assistance through the individual health insurance market also vary by type of plan, but benefits are regulated by the State and include a minimum level of services as follows: well-baby and well child services, inpatient/outpatient hospital and physician clinic, and surgical services.

Access to Health Insurance Program

The *Access to Health Insurance Program*, implemented as an amendment to the demonstration in July of 2005, currently allows the State to provide premium assistance to Title XXI eligible children and their parents if one of the adults is employed by a participating small business.

In order for participants to qualify for premium assistance under this program, adults must have access to health care coverage through small businesses that meet the following conditions: 1) be a small business comprised of two to 50 employees; 2) not currently offering or participating in providing coverage to employees through any insurance plan; 3) contribute at least 50 percent of the cost of the insurance premium of the employee; and 4) register their intent to participate with the State. There are approximately 119 small employers participating in the *Access to Health Insurance Program*.

Benefits provided by a small business employer are regulated by the State under the *Access to Health Insurance Program*, and must include: preventive services (including well-baby and well-child care), maternity services, inpatient and outpatient hospital services, physicians' medical and surgical services, hospice care, ambulance services, durable medical equipment, psychiatric and substance abuse services, and pharmacy.

Children receiving coverage through their parents under the *Access to Health Insurance* program are subject to the cost sharing requirements of the ESI plan.

Informed Choice

Families must be informed that children can choose to receive coverage through premium assistance or direct coverage under the CHIP state plan. Enrollment into a premium assistance option must be voluntary and based on informed choice regarding the implications of choosing premium assistance, including the possibility of reduced benefits and increased cost sharing.

Period of Uninsurance

Children in both premium assistance and direct coverage are subject to a six month period of uninsurance. 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. Applicants who have dropped insurance with the intent to qualify for State assistance within 6 months of their application will be denied.

Premium assistance Cap for both the *Children’s Access Card* and *Access to Health Insurance*

The premium assistance amount is up to \$100 per participant per month with a maximum of \$200 for the parents and a maximum of \$300 for all children (three or more children) for a total maximum of \$500 in one family regardless of type of program. The reimbursement covers the cost (or a portion of the cost) directly attributable to adding the individual to a private insurance policy. Premium assistance payments are currently paid directly to the insurance carrier.

IV. GENERAL PROGRAM REQUIREMENTS

1. Definitions. For purposes of the STCs, the following definitions apply.

- a. **“Income”:** Income limits are expressed in terms of gross income, excluding sources of income that cannot be counted pursuant to other statutes.
- b. **“Private Health Insurance Coverage”:** This term refers to both group health plan coverage and health insurance coverage as defined in section 2791 of the Public Health Service Act.
- c. **“Informed Choice:”** The State must ensure that at the point of application that Demonstration Populations 1 and 2 are informed in writing of the differences in benefits and cost sharing under direct state plan coverage versus receiving premium assistance coverage through ESI, or individual health plans. The State must provide adequate and timely information to ensure that all families can make an “informed choice,” between direct coverage, and premium assistance.

The State shall establish a process for permitting the parents of Demonstration Populations 1, 2 and 3, receiving premium assistance to disenroll the child from the ESI coverage and enroll the child in, and receive child health assistance under, the State child health plan, effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child.

- d. **“Demonstration Population 1”:** Children ages 6 through 18 years with family incomes above 100 percent of the FPL and through 133 percent of the FPL who meet the eligibility standards for Idaho’s title XXI Medicaid Expansion and would not be not eligible under the Medicaid State plan as of March 31, 1997, but who elect not to enroll in Medicaid and instead elect to enroll under the demonstration for premium assistance. *(These children will have the option of choosing direct coverage under the Medicaid State plan or premium assistance under the Access Card demonstration.)*
- e. **“Demonstration Population 2”:** Children from birth through 18 years with family incomes above 133 percent of the FPL and through 185 percent of the FPL who meet

the eligibility standards for Idaho's title XXI Separate Child Health Program but elect not to enroll under the separate child health plan but instead elect to enroll under the demonstration for premium assistance. *(These children will have the option of choosing direct coverage under the State plan or premium assistance under the Access Card demonstration.)*

- f. Demonstration Population 3:** Uninsured parents of children who are eligible for Medicaid or CHIP, who are themselves ineligible for Medicare or Medicaid, with family incomes above the section 1931 low-income families group up to and including 185 percent of the FPL. *(These parents do not have the option of direct coverage.)* Note: Under CHIPRA and at the State's request, this population has been automatically extended through September 30, 2011. If the State wants to extend coverage to parents beyond September 30, 2011, the State will need to notify CMS prior to the September 30, 2011 expiration date of coverage for this population. The CHIPRA also provides States with the option in fiscal years 2012 and 2013 to continue covering parents with title XXI funds if they achieve outreach and benchmarks related to performance in providing coverage to children.
- 2. Adequacy of Infrastructure.** The State shall ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing; and reporting on financial and other issues.
- 3. Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, when any program changes to the Demonstration, including (but not limited to) those referenced in STC 6, are proposed by the State. In States with Federally recognized Indian tribes, Indian health programs, and / or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and / or renewal of this Demonstration. In the event that the State conducts additional consultation activities consistent with these requirements prior to the implementation of the demonstration, documentation of these activities must be provided to CMS.
- 4. Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of STC IV(6).

As part of the Demonstration extension request, the State must provide documentation of compliance with the public notice requirements outlined in STC IV(3), as well as include the following supporting documentation:

- a. **Demonstration Summary and Objectives:** The State must provide a narrative summary of the Demonstration project; reiterate the objectives set forth at the time the Demonstration was proposed, and provide evidence of how these objectives have been met, as well as provide any future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of each change and desired outcomes must be included.
 - b. **Special Terms and Conditions:** The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time. Consistent with Federal law, CMS reserves the right to deny approval for a requested extension based on non-compliance with these STCs, including, but not limited to, failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein.
 - c. **Waiver and Expenditure Authorities:** The State must provide a list, along with a programmatic description, of the waivers and expenditure authorities that are being requested in the extension.
 - d. **Quality:** The State must provide summaries of External Quality Review Organization reports, managed care organization, and State quality assurance monitoring, and any other documentation of the quality of care provided under the Demonstration.
 - e. **Compliance with the Allotment Neutrality Cap:** The State must provide financial data (as set forth in the current STCs) demonstrating the State's projected allotment neutrality status for the requested period of the extension. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made.
 - f. **Draft report with Evaluation Status and Findings:** The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.
- 5. Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in STC IV(6), a phase-out plan will not be shorter than 6 months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP will be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

6. **Enrollment Limitation during the Last 6 Months.** If the demonstration has not been extended, no new enrollment of individuals eligible solely on the basis of the demonstration is permitted during the last 6 months of the demonstration.
7. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration, the State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the demonstration.
8. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate this project in whole or in part at any time before the date of expiration, if and whenever it determines that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights under 42 CFR 430, Grants to States for Medical Assistance Programs, to challenge CMS' finding that the State materially failed to comply. CMS reserves the right to deny pending demonstration requests or withdraw demonstrations at any time if it determines that granting or continuing the demonstrations would no longer be in the public interest. Subsequent to the release of this approval letter and STCs, CMS does not anticipate changes to the Idaho Medicaid or CHIP plan, in terms of reduced coverage groups or reduced benefits, as a means of providing savings to cover individuals under the demonstration. Such changes could affect the continuation of the demonstration. If the project is terminated or any relevant demonstrations withdrawn, CMS will be liable only for normal close-out costs.
9. **State Right to Terminate or Suspend.** The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State must promptly notify CMS in writing of the reasons for the suspension or termination, together with the effective date. If the project is terminated or any relevant demonstrations suspended by the State, CMS will be liable only for normal close-out costs.
10. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.
11. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

V. GENERAL REPORTING REQUIREMENTS

1. **Quarterly Progress Reports.** Idaho will submit quarterly progress reports, which are due 60 days after the end of each quarter. The format for the report will be agreed upon by CMS and the State. These reports must include information on operational and policy issues appropriate to the State's program design. The report must include information on the progress of the evaluation component. It must also include information on any issues which arise in conjunction with the premium assistance portion of the program for CHIP eligibles, including, but not limited to, access to services not covered in the enrollee's plan, transfers to direct State plan coverage due to affordability issues and for any other reasons. The report must also include proposals for addressing any problems identified in each report.

The State will also include a separate section to report on progress on evaluation and a separate section to report progress toward agreed-upon goals for reducing the rate of uninsurance. From data that are readily available, the State will monitor the private insurance market (e.g., changes in employer contribution levels (if possible, among employers with low-income populations), trends in sources of insurance, and other related information in order to provide a context for interpreting progress toward reducing uninsurance. The State will also monitor the number of participants that enroll in group health plans versus individual coverage. Quarterly reports, at a minimum, shall include the following information:

- a. The current number of children and parents enrolled by program type (individual, small business group health plans, large employer group health plans),
 - b. Current number of employers participating in *Access to Health Insurance*,
 - c. Current number of individual plans under the *Children's Access Card*,
 - d. Current number of employers under the *Children's Access Card*,
 - e. The number of children disenrolled from premium assistance and converting to direct coverage under the Medicaid or CHIP state plan.
 - f. The number of children disenrolled from direct coverage under the Medicaid or CHIP state plan and enrolling in premium assistance.
 - g. Number of inquiries the State has received as to where children, may receive well-baby and well-child services and information on the follow-up actions the State completed to respond to these requests,
 - h. Number of inquiries the State has received as to where children, enrolled in the demonstration, may receive immunizations and information on the follow-up actions the State completed to respond to these requests,
 - i. Number of families provided information as to where children may receive services,
 - j. Number and copies of informed choice notifications sent to families of children currently receiving premium assistance informing them they may choose direct coverage at any time,
 - k. Progress with milestones in the approved program evaluation plan, program evaluation implementation, and deliverables including current updates on items XIII(d) and (e).
 - l. Progress with STC XV - Evaluation Of The Demonstration
2. **Quarterly and Monthly Enrollment Reports.** Each quarter, the State will provide CMS with an enrollment report by demonstration population showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter. In addition, the State will provide monthly enrollment data as specified by CMS.
 3. **Monitoring Calls.** CMS and the State will hold monthly monitoring calls to discuss issues associated with the implementation and operation of the demonstration, including but not limited to the data provided by the State in their quarterly and annual reports. The State will identify at least one item for discussion each month.
 4. **Annual Reports.** The State must submit a draft annual report documenting accomplishments, including project status, including a budget update; quantitative and any case-study findings; policy and administrative difficulties; and progress on conducting the demonstration evaluation, including results of data collection and analysis of data to test

the research hypotheses no later than 6 months after the end of its operational year. Within 30 days of receipt of comments from CMS, the State shall submit a final annual report.

5. **Final Report.** No later than 3 months after the end of the demonstration, a draft final report must be submitted to CMS for comments. CMS' comments shall be taken into consideration by the State for incorporation into the final report. The final report is due no later than 90 days after the receipt of CMS' comments.
6. **Evaluation Report.** The State will inform CMS of the status of the State's evaluation in the quarterly, annual, and final reports using the timeframes specified above in this section.

VI. LEGISLATION

1. **Changes in the Enforcement of Laws, Regulations, and Policy Statements.** All requirements of the Medicaid and CHIP programs expressed in laws, regulations, and policy Statements, not expressly waived or identified as not applicable in the award letter of which these STCs are a part, will apply to the demonstration.
2. **Changes in Medicaid/CHIP Law.** The State must, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid and CHIP programs.

VII. ELIGIBILITY AND ENROLLMENT

1. **Screening for Medicaid.** Applicants for the demonstration will be screened for Medicaid eligibility. Demonstration applicants eligible for Medicaid will be enrolled in Medicaid and receive the full Medicaid benefit package unless the family opts to place the child in premium assistance for demonstration populations 1 or 2.
2. **Enrollment in Premium Assistance.**
 - a. **Eligibility:** CMS has given approval through this demonstration for children eligible for Idaho's title XXI funded program (Medicaid expansion and Separate child health program) and not eligible under the Medicaid State plan as of March 31, 1997 to receive premium assistance for coverage provided through the individual market or ESI.
 - b. **Informed Choice and Opt Out:** No premium assistance shall be provided to Population 1 or 2 unless the individual (or the individual's parent) voluntarily elects to receive such premium assistance. The State may not require such an election as a condition of receipt of medical or child health assistance. The State must ensure that children in the demonstration (Populations 1 and 2) are informed at the point of application of the differences between the benefits and cost sharing requirements under premium assistance relative to direct coverage. The State must also provide adequate and timely information to ensure that families understand that they can make an informed choice and that a parent of a child receiving premium assistance can disenroll the child from the employer sponsored coverage

and enroll the child in, the Medicaid or CHIP State plan, effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child.

c. **Notice of Availability:** The State will include on any application or enrollment form for child health assistance a notice of the availability of premium assistance subsidies for the enrollment of children in employer sponsored coverage. The State will also provide, as part of the application and enrollment process under the State child health plan, information describing the availability of such subsidies and how to elect to obtain such premium assistance; and the State must ensure through the initial application process and at other intervals, that parents are fully informed of the choices for receiving child health assistance under the State child health plan or through the receipt of premium assistance subsidies.

d. **Voluntary Participation of Employers:**

i. **Employer:** Participation by an employer in a premium assistance program offered by the State shall be voluntary.

e. **Submission of Informing Materials:**

i. **Informed Choice and the Ability for Families to Opt-out of Premium Assistance:**

- A. During the duration of this demonstration, the State must provide materials to families regarding informed choice and the ability to opt-out of premium assistance. The State must also receive approval from CMS prior to making any changes to such printed materials. . Printed materials include but are not limited to: information sheets provided to families at time of application, and letters to families at initial application and every six months thereafter.. Any future changes to information and materials under items (VII)(2)(e)(i)(A) and (B) must be submitted to CMS 30 days prior to implementation. CMS must re review these materials within 30 days of submission by the State
- B. These materials must be made available in print and on the State's website.
 1. Specifically, materials must be designed to help families determine the differences between benefits and cost sharing in a premium assistance program (regardless of whether it is large or small employer group health plan or individual health plan) relative to direct coverage provided through the State Plan.
 2. The State must update the Access to Health Insurance website with the CMS approved language specified under STC

(VII)(e)(i)(A) within 15 days after the approval of the renewal of this demonstration.

3. The State will add a Premium Assistance/Child Access Card component to its website with the agreed upon language specified under STC (VII)(e)(i)(A) within 15 days after the approval of the renewal of this demonstration.

- C. The State will notify families of the differences between premium assistance and direct coverage under the CHIP State plan, as well as the ability for a family to opt out of premium assistance every six months beginning in October 2010.

ii. **Well-Baby and Well-Child Services:**

- A. During the duration of this demonstration, the State must provide materials to families regarding how their children can access and receive well-baby and well-child services in the event these services are not covered in the ESI or individual market health plans in which they are enrolled. The State must also receive approval from CMS prior to making any changes to such printed materials. Printed materials include but are not limited to: information sheets provided to families at time of application, and letters to families at initial application and every six months thereafter. Any future changes to information and materials under items (VII)(2)(e)(i)(A) and (B) must be submitted to CMS 30 days prior to implementation. CMS must review these materials within 30 days of submission by the State
- B. These materials must be made available in print and on the State's website.
 1. The State will update the Access to Health Insurance web site with the agreed upon language specified under STC (VII)(e)(ii)(A) within 15 days after the approval of the renewal of this demonstration.
 2. The State will post the agreed upon language specified under STC (VII)(e)(ii)(A) on the Premium Assistance/Child Access Card web site (STC (VII)(e)(i)(B)(2)) with the agreed upon within 15 days after the approval of the renewal of this demonstration.
- C. The State will notify families of where children may receive well-baby and well-child services in the event these services are not covered in the ESI or individual market health plans in which they are enrolled every six months beginning in October `2010.

- f. In the case of title XXI-eligible children; families are to be informed that all age-appropriate immunizations are available in the event these services are not covered in the employer-sponsored plan or private health plan in which they are enrolled.

- g. The State shall provide information as to where children may receive immunization services in the event these services are not covered in the employer-sponsored plan or individual health plan in which they are enrolled.

- h. **Immunizations under the Children’s Access Card and Access to Health Insurance Program:**

Immunizations are provided to all children in the State free of charge regardless of whether these services are included or excluded from an individual or ESI plan. The State provides an information sheet to all families with children applying for premium assistance and informs them that they can receive State-supplied free vaccines from participating physicians, local health districts, hospitals and community health centers. Providers may charge a small fee for providing the vaccine, but no child can be denied vaccinations due to an inability to pay.

Childhood immunizations are provided at no cost to the child if the service is not covered by the health plan. Idaho participates in the Vaccines for Children (VFC) Program through CDC as a Universal Purchase (UP) state, and is required to comply with all rules and regulations established by the VFC program. All children 0 through 18 years of age in Idaho are eligible for free vaccine through the Idaho immunization program regardless of income or insurance coverage. If a child is currently enrolled in an ESI plan that does not offer vaccine and immunization coverage, the child can receive services through the family’s physician or through one of the State’s District Health departments to receive the vaccine(s). Vaccines administered to non-VFC children are purchased entirely with State funds. UP rules prohibit providers from billing and/or claiming for the cost of the vaccine(s) under the VFC program. In the event the State chooses to opt-out of UP status, the State will be required to establish a payment mechanism describing State policies and procedures to be used by providers for vaccine reimbursement.

- i. The State must establish and maintain procedures for all individuals receiving premium assistance subsidies under this demonstration (which may be done through rulemaking) that will:
 - 1. Prior to implementing direct payment to demonstration-enrolled individuals for the premium assistance payment, the State must submit, for CMS’s prior approval, a plan that addresses how the State will:
 - a. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled and receiving health benefit coverage through a qualifying plan and the individual’s/family’s share of the premium and a quality control plan for cross checking the verification system (e.g., if the information is obtained from the insurance carrier then crosscheck with the employee or employer). This plan may also include requesting information directly from participants in the form of pay stubs showing withholding for health insurance;

- b. Require clients to notify the Idaho Department of Health & Welfare within 10 days if they change their plan, there is a change in the amount of their premium, or their health care benefit is terminated;
- c. Ensure that the total amount of premium assistance subsidies provided to demonstration-enrolled individuals (parents for enrolled children) does not exceed the amount of the employee’s financial obligation toward their coverage; and
- d. Provide for recovery of payments made for months in which the demonstration-enrolled individuals (parents for enrolled children) did not receive coverage through a qualifying health benefit plan. The Federal share must be returned within the timeframes established in statute and regulations.
- e. The State will only reimburse demonstration-enrolled individuals (parents for enrolled children) directly when an employer makes such a request in writing on the basis of their wish not to engage in accounting for the premium assistance.

3. Enrollment Limits. Enrollment in the *Access to Health Insurance* program (for parents and childless adults (funded with title XIX funds under a separate demonstration) is capped at a total of 1,000 participants. Once the enrollment cap is met for adults, the State will maintain a waiting list. There is no enrollment cap for children.

VIII. BENEFITS

Premium Assistance: For optional categories of children who choose to receive coverage through premium assistance, as well as for the optional parents, who are enrolled in premium assistance, CMS is approving the benefit package available through the private or employer-sponsored insurance company as the benefit package to be delivered. (See discussion in STC VII.2. regarding immunizations and well-baby and well-child services.) Under section 2103(c)(1)(D) of the Act, the State must provide well-baby and well-child care, including age-appropriate immunizations.

Children’s Access Card

a. Premium Assistance/ESI

The benefit requirements for children through the *Children’s Access Card* vary by individual ESI plan. Large business employers, those with more than 50 employees, are not regulated by the State and there is no minimum benefit level. Idaho, however, is required under these STCs to provide information to families regarding where children may receive well-baby and well-child services in the event these services are not covered under the ESI plan.

b. Individual Market Plans

Benefit packages for children receiving premium assistance through the individual health insurance market also vary by type of plan, but are regulated by the State and include a

minimum level of services as follows: well-baby and well-child services, inpatient/outpatient hospital, physician, clinic, and surgical services.

Access to Health Insurance Program

Benefits provided by a small business employer are regulated by the State and must include: preventive services (including well-baby and well-child care), maternity services, inpatient and outpatient hospital services, physicians' medical and surgical services, hospice care, ambulance services, durable medical equipment, psychiatric and substance abuse services, and pharmacy.

Immunizations under both the Children's Access Card and Access to Health Insurance Program

Immunizations are provided to all children in the State free of charge regardless of whether these services are included or excluded from an ESI plan. The State provides an information sheet to all families with children applying for premium assistance and informs them that they can receive State-supplied free vaccines from participating physicians, local health districts, hospitals and community health centers. Providers may charge a small fee for giving the vaccine, but no child can be denied vaccinations due to an inability to pay.

Childhood immunizations are provided at no cost to the child if the service is not covered by the health plan. Idaho participates in the Vaccines for Children (VFC) Program through CDC as a Universal Purchase state. All children 0 through 18 years of age in Idaho are eligible for free vaccine through the Idaho Immunization program regardless of income or insurance coverage. If the child's private plan does not cover vaccines, the child can go to his/her regular physician or to one of the State's District Health departments to receive the vaccine. Vaccines given to non-VFC children are purchased entirely with State funds.

IX. COST SHARING

Children's Access Card

Children, including American Indian and Alaska Native (AI/AN) children, who receive premium assistance through the *Children's Access Card* demonstration, are subject to cost sharing requirements as set by their individual plan and are not subject to the 5 percent out-of-pocket maximum.

Access to Health Insurance Program

Children and parents receiving coverage under the *Access to Health Insurance* program are subject to the cost sharing requirements of the private group plan chosen by the employer and are not subject to the title XXI 5 percent out-of-pocket maximum. Cost sharing imposed by small business employers that currently participate in the program range from \$0 (e.g., preventive care for children) up to \$500 (e.g., inpatient services), dependent upon the plan and type of service.

X. EMPLOYER PARTICIPATION

All employers participating in the *Access to Health Insurance* program (small business group) must contribute at least 50 percent of the premium for participating employees. There is no minimum employer contribution in the *Children's Access Card* program, regardless of whether it is a small or large business group.

XI. PROGRAM DESIGN

1. Concurrent Operation

The State's title XIX and title XXI State plans, as approved, will continue to operate concurrently with this section 1115 demonstration.

2. Maintenance of Coverage and Enrollment Standards for Children

- a. The State shall not close enrollment, institute waiting lists, decrease benefits, increase cost sharing above 5 percent of the family income, or decrease eligibility standards with respect to the children covered under its title XXI State plan while the demonstration is in effect.
- b. The State shall, throughout the course of the demonstration, include a review of enrollment data to provide evidence that children are not denied enrollment and continue to show that it has implemented procedures to enroll and retain eligible children for CHIP.
- c. The State will establish a monitoring process to ensure that expenditures for the demonstration do not exceed available title XXI funding (i.e., the title XXI allotment or reallocated funds) and the appropriate State match. (Note: This does not affect the State's ability to revert to the use of title XIX funds for Demonstration Populations 1 and 2 in case the title XXI funding is exhausted.) The State will use title XXI funds to cover services for the CHIP and demonstration populations in the following priority order:

- 1) Children eligible under the title XXI State plan
- 2) Demonstration Population 1
- 3) Demonstration Population 2
- 4) Demonstration Population 3

If the State determines that available State or title XXI funding will be exhausted, available title XXI funding will first be used to cover costs associated with the title XXI State plan population and Demonstration Population 1.

The State may also, for any of the demonstration populations under title XIX or XXI eligible for coverage only by virtue of the demonstration:

- Lower the Federal poverty level used to determine eligibility, and/or
- Suspend eligibility determination and/or intake into the program, or
- Discontinue coverage.

Before taking any of the above actions related to the priority system, Idaho will provide 60-day notice to CMS.

XII. MONITORING

The State must monitor changes in employer contribution levels or the degree of substitution of coverage and be prepared to make changes to its premium assistance program in response to substantial decreases in contribution levels or data showing significant substitution of coverage.

XIII. EVALUATION OF THE DEMONSTRATION

1. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 60 days after the approval of the demonstration. At a minimum, the draft design must include the following:
 - a. **Goals and Objectives:** A discussion of the goals and objectives set forth in Section III of these STCs, as well as the specific hypotheses that are being tested;
 - b. **Outcome Measures:** A discussion of the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval;
 - c. **Data Sources and Sampling Methodology:** A discussion of the data sources and sampling methodology for assessing these outcomes; **Effects of Demonstration:** A detailed analysis that describes how the effects of the demonstration must be isolated from other initiatives occurring in the State;
 - d. **Comparison of Benefits and Cost Sharing:** A discussion and analysis of how benefit and cost sharing provisions provided under this demonstration compare to the benefits and cost sharing allowed under the approved title XXI State child health plan and title XIX Medicaid State plan;
 - e. **Cost Effectiveness Test:** A discussion and analysis of whether the purchase of individual and employer sponsored coverage under this demonstration proves to be cost-effective relative to the CHIP or Medicaid State plan costs. Specifically, the State must compare the demonstration costs to the individual or aggregate amount of expenditures under the approved title XXI State child health plan or title XIX Medicaid State plan, including administrative expenditures, that the State would have made to provide comparable coverage of the targeted low-income child involved or the family involved (as applicable);
 - f. **Surveys:** A discussion of how the State plans to conduct an annual survey of demonstration enrollees to determine the outcomes for those enrollees which have made inquiries to the State regarding where children may receive immunizations when otherwise not provided by the ESI or individual health plan, and
 - g. The draft design must identify whether the State will directly conduct the evaluation, or select an outside contractor for the evaluation.
2. **Interim Evaluation Reports.** In the event the State requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.
3. **Final Evaluation Design and Implementation.** CMS will provide comments on the draft evaluation design within 60 days of receipt, and the State will submit a final design within 60 days after receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports.

4. **Final Evaluation Report.** The State must submit to CMS a draft of the final evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS' comments.

XIV. TRANSITION ACTIVITIES UNDER THE PATIENT PROTECTION AFFORDABLE CARE ACT

Transition Plan. The State is required to prepare, and incrementally revise a Transition Plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible, and to ensure that coverage for children enrolled in the Demonstration will be continued through 2019. The State must submit a draft to CMS by July 1, 2012, with progress updates included in each quarterly report. The State will revise the Transition Plan as needed.

XV. SCHEDULE OF DELIVERABLES FOR DEMONSTRATION RENEWAL PERIOD

Deliverable	Date	STC
State acceptance of Demonstration Waivers, STCs, and Expenditure Authorities (approval letter) within 30 days of the date of award.	By October 30, 2010	
VII(2)(e)(i) and (ii) Informed Choice		
The State will update the Access to Health Insurance web site with the agreed upon language.	By October 16, 2010	(VII)(e)(i)(B)(2)
The State will add a Premium Assistance/Child Access Card component to its web site with the agreed upon language.	By October 16, 2010	(VII)(e)(i)(B)(3)
Before the State can publish changes to the approved documentation (VII)(2)(e)(i)(A), the State must provide to CMS copies of changes and seek approval to implement these changes 60 days prior to use.		VII(2)(e)(i)(C) and (D)
The State will update the Access to Health Insurance web site with the agreed upon language.	By October 16, 2010	(VII)(e)(ii)(B)(1)
The State will post the agreed upon language on the Premium Assistance/Child Access Card web site.	By October 16, 2010	(VII)(e)(ii)(B)(2)
Before the State can publish changes to the approved documentation under VII(2)(e)(ii)(A), the State must provide to CMS copies of changes and seek approval to implement these changes 60 days prior to use.		VII(2)(e)(ii)(C) and (D)
STC VII(2)(I) – Premium Assistance Payments		
Submit a plan for making premium assistance payments directly to individuals.	Determined by the State	VII(2)(i)
STC XII - Evaluation Of The Demonstration		
Submit Draft Design for Final Evaluation Report no later than 60 days after the approval of the demonstration	By November 30, 2010	XIII(1)
Final Evaluation Design	State will submit a final design within 60 days after receipt of CMS comments.	XIII(3)
Submit Interim Evaluation Report	By November 30, 2011	XIII(2)
Submit Draft Final Evaluation Report 3 months after expiration of the demonstration	By December 31, 2013	XIII(4)
Submit Final Evaluation Report	Within 60 days after receipt of CMS comments	XIII(4)
Deliverable	Date	STC
Monthly Deliverable		
Monthly Enrollment Report	Within 30 days after the end of each month.	V(1)
Monthly Enrollment Report	Within 30 days after the end of each month.	V(2)
Monitoring Call	As agreed upon between CMS and the State.	V(3)
Quarterly Deliverable		
Quarterly Progress Reports	Within 60 days after the end of each quarter.	V(1)

Quarterly Enrollment Reports	In Within 30 days after the end of each quarter.	V(2)
Quarterly Expenditure Reports	In compliance with section X.	Attachment A
Annual Deliverable		
Draft Annual Reports (Annual Progress Reports and Annual Expenditure Reports)	By January 30, 2011 and annually thereafter	V(4)
Draft Final Reports	December 31, 2013	V(5)
STC XIV – Transition Plan		
The State must submit a draft Transition Plan to CMS by July 1, 2012,	July 1, 2012	XIV

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

1. The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved CHIP plan and those provided through the Access Card demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide Federal Financial Participation (FFP) only for allowable Access Card demonstration expenditures that do not exceed the State's available title XXI funding.
2. In order to track title XXI expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions as outlined in section 2115 of the State Medicaid Manual (SMM) and routine CMS-64 reporting instructions as outlined in section 2500 of the SMM. Title XXI demonstration expenditures will be reported on separate Forms CMS-21 Waiver, CMS-21P Waiver, CMS-64.21U Waiver and/or CMS-64.21UP Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). A separate Form CMS-64.21U Waiver and/or CMS-64.21 UP Waiver must be completed for Demonstration Populations 1 and 2 (Premium Asst.). A separate CMS-21 Waiver and/or CMS-21P Waiver must be completed for Demonstration Populations 3 (Title XXI Separate Child Health Program Premium Asst.), and 4 (Parents)). Once the appropriate waiver form is selected for reporting expenditures, the State will be required to identify the program code and coverage (children or adults).
 - a. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.
 - b. The standard CHIP funding process will be used during the demonstration. Idaho must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the State shall provide updated estimates of expenditures for the demonstration population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

- c. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.
3. Idaho will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the approved title XXI separate child health program or demonstration until the next allotment becomes available.
4. Total Federal title XXI funds for the State's CHIP program (i.e., the approved title XXI State plan and this demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.
5. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total title XXI expenditures.
6. If the State exhausts the available title XXI Federal funds in a Federal fiscal year during the period of the demonstration, the State will continue to provide coverage to the approved title XXI State plan separate child health program population and the Demonstration Populations with State funds until further title XXI Federal funds become available. Title XIX Federal matching funds will be provided for Demonstration Populations 1 and 2 if the title XXI allotment is exhausted, after a budget neutrality agreement is reached.
7. If Title XXI allocations are expended and Idaho must draw down regular title XIX matching funds for Demonstration Population 1 under section 1115 waiver authority, a section 1115 budget neutrality agreement, including per-member per-month costs and trend rate shall be established for these populations in consultation with Idaho. Title XIX Federal matching funds will be provided for Demonstration Populations 1 and 2 if the title XXI allotment is exhausted, after a budget neutrality agreement is reached.
8. All Federal rules shall continue to apply during the period of the demonstration that State or title XXI Federal funds are not available. The State is not precluded from closing enrollment or instituting a waiting list with respect to the demonstration populations. Before closing enrollment or instituting a waiting list, the State will provide 60-day notice to CMS.

ATTACHMENT B

GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX DEMONSTRATION POPULATIONS 1

Note: Any reference in these Special Terms and Conditions to Budget Neutrality under Title XIX will become effective upon CMS and the State negotiating a Budget Neutrality agreement and trend rates in accordance with A.7 and B.2.b. The Project Officer will use the separately assigned title XIX waiver number when budget neutrality negotiations become necessary to claim title XIX funds.

1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide Federal Financial Participation (FFP) for allowable demonstration expenditures only.
2.
 - a. In order to track expenditures under this demonstration, Idaho will report the demonstration expenditures through the MBES/CBES, following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All expenditures will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c., as instructed in the State Medicaid manual. The term, “expenditures subject to the budget neutrality cap,” is defined in item 2.b. below.
 - b. For the purpose of this section, the term “expenditures subject to the budget neutrality cap” will include all Medicaid expenditures on behalf of Demonstration Populations 1 and 2 participants as defined in the demonstration approval letter.
 - c. At such time the State determines that it does not have sufficient title XXI funds to cover expenditures for Demonstration Population 1 and begins claiming title XIX funds for these populations, the State will complete for each demonstration year a Form CMS-64.9 Waiver and/or 64.9P Waiver reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2.b.).
 - d. If title XXI allocations are expended and the State draws down regular title XIX matching funds for Demonstration Population 1 under section 1115 authority, a section 1115 budget neutrality cap and trend rate must be established for this population in consultation with the State. CMS will consider the State’s title XXI expenditure

experience in establishing the cap. A title XIX section 1115 Waiver number must be assigned for these demonstration populations. The State must continue to report expenditures on waiver forms as specified in 2.c. above. In order to provide for a seamless continuation of section 1115 authority for this population under title XIX, Idaho should provide CMS with adequate notification if the State's projections indicate that it may exceed its title XXI allocation.

e. Administrative costs directly attributable to the demonstration are separately reported and tracked on separate Forms CMS-64.10 WAIVER and/or 64.10P WAIVER.

f. All claims for demonstration expenditures (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures.

3. a. For the purpose of calculating the budget neutrality expenditure cap referenced in Attachment A.7., the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the demonstration eligibles as defined below. These will include only member months for Demonstration Population 1 whose expenditures are matched at the regular Federal medical assistance percentage rate. This information should be provided to CMS in conjunction with the quarterly progress report referred to in subsection E of Section III. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.) Procedures for reporting eligible member/months must be defined in the Operational Protocol.

b. The term, "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member/months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member/months.

c. There will be two Medicaid eligibility groups (MEGs), or waiver names under the demonstration eligible for Medicaid under section 1905(u)(2) of the Social Security Act. These MEGs are Demonstration Population 1 (Direct Coverage) and Demonstration Population 2 (Premium Asst.).

4. The standard Medicaid funding process will be used during the demonstration. Idaho must continue to estimate total matchable Medicaid expenditures for the entire program on the quarterly Form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable/federal share) must be separately reported by quarter for each federal fiscal year on the Form CMS-37.12 for both the

Medical Assistance Program (MAP) and Administrative Costs (ADM). CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 annually with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

- 5.** CMS will provide FFP at the applicable Federal matching rate for the following:
 - a.** Administrative costs, including those associated with the administration of the demonstration.
 - b.** Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.
 - c.** Net medical assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration.

- 6.** The State will certify State/local monies used as matching funds for this demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

ATTACHMENT C

MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION DEMONSTRATION POPULATIONS 1

This attachment is to be completed upon Idaho's submission of a budget neutrality agreement, in the event that the State exhausts its available title XXI Federal funds. If this occurs, upon CMS approval of the State's proposed budget neutrality agreement, Idaho may draw down title XIX funds at the regular match rate for Demonstration Populations 1, per the terms and conditions in Attachments A and B.