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March 29, 2013

Judith Cash
Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
Division of State Children's Health Insurance
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Cash:

My staff has been working closely with CMS staff to develop amendments for our 1115 Demonstration waivers. Idaho currently has both child and adult participants enrolled in premium assistance programs. Idaho currently covers these participants under both Title XIX and Title XXI authorities.

Idaho's Title XXI waiver, known as "Idaho Children's Access Card Demonstration", expires on September 30, 2013. The State proposes to provide a bridge to coverage for these participants into 2014. To facilitate this bridge, Idaho submits two amendments for both the Title XIX waiver, known as "Non-pregnant, Childless Adults Demonstration" and the Title XXI waiver.

The State looks forward to continuing its work with CMS as we develop our transition plan for our premium assistance populations. Thank you for your continued assistance. Should you have any questions, please contact Ms. Cindy Brock, Alternative Care Coordinator, Division of Medicaid at (208) 364-1983, or by e-mail at brockc@dhw.idaho.gov.

Sincerely,

PAUL J. LEARY
Administrator

PJL/rs

Enclosure

c: Carol Peverly, CMS Region X
Janice Adams, CMS Region X
Dr. Kelly Heilman, CMS CO
Tom Couch, CMS Region X
Angela Corbin, CMS CO

Amendment Request for Idaho's Title XXI Demonstration

Title XXI Children's Access Card Demonstration Waiver Approved Period: September 1, 2010 – September 30, 2013

I. SUMMARY

Idaho has supported an approved premium subsidy program since 2004. The programs have experienced significant evolution since their implementation. The Children's Access Card implemented as a statewide section 1115 Demonstration in 2004. The adult subsidy program, Access to Health Insurance, was added under an amendment in 2005. The objective of the programs has historically been to make health insurance more affordable by providing premium subsidy to families and individuals with incomes at or below 185 percent of the Federal Poverty Level (FPL). The programs were originally funded by a premium tax implemented by the State and Title XXI funding from the Federal Government.

The programs target small businesses (2-50 employees) that do not offer a health benefit plan. The State provides up to \$100 per month in assistance per enrolled employee, spouse or child. The assistance is paid to offset each participant's share of the employer-sponsored health insurance premium, with a maximum of \$500 per month per family. In July 2006, the program was amended to require a 50 percent employer contribution toward the cost of the health benefit plan.

The passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), required the State to remove the non-pregnant childless adults from Title XXI funding no later than December 31, 2009. In response, Idaho submitted an amendment request to the Centers for Medicare and Medicaid Services (CMS) to move the eligible non-pregnant childless adults into a section 1115 Demonstration under Title XIX funding. CMS approved Idaho's request and the premium assistance to Non Pregnant, Childless Adults Demonstration was implemented for the period of January 1, 2010, through September 30, 2014.

The Title XXI waiver was most recently renewed for the period of September 1, 2010 through September 30, 2013. After September 30th, coverage will end for the adults receiving title XXI premium assistance. The children whose families are receiving title XXI premium assistance will be forced to move to direct CHIP coverage for this time period and then face an additional transition of coverage (on January 1, 2014 under the full implementation of the Affordable Care Act) to either direct coverage under Title XIX, Title XXI or through premium assistance under the Health Insurance Exchange. The state requests an extension of this waiver for the period of October 1, 2013 – December 31, 2013 for these children in order to minimize disruption in coverage for these families.

Demonstration participants ages 6-18 with family incomes between 100 – 133% of FPL will be eligible for direct coverage under Title XIX in January 2014 under the eligibility changes mandated by the Affordable Care Act.

Families with children ages 0-18 with incomes above 133% of FPL will have the choice to enroll their children in subsidized (family or individual) coverage through the health insurance exchange or elect direct coverage for their children under Title XXI.

Allowing these families to maintain the same form of coverage during the bridge period will allow for a single and relatively uncomplicated transition to exchange or expansion coverage, rather than multiple transitions with high potential for negative impacts on their health care.

II. BUDGET NEUTRALITY

This change will result in cost savings since the maximum amount paid for monthly premiums is \$100, as compared to a per member per month amount of approximately \$150 for direct coverage.

III. STATE'S PROPOSED CHANGES TO THE STANDARD TERMS AND CONDITIONS

The State proposes to amend the Title XXI Standard Terms and Conditions as follows:

1. Remove Demonstration Population 3 (adult population), effective October 1, 2013.
2. Extend Title XXI Coverage for Populations 1 and 2 through December 31, 2013.
3. Update Reporting Requirements to exclude adult population measurements.

Please see proposed revisions, attached.

Amendment Request for Idaho's 1115 Demonstration

Title XIX Non-Pregnant, Childless Adult Waiver

Approved Period: January 1, 2010 – September 30, 2014

I. SUMMARY

Idaho has supported an approved premium subsidy program since 2004. The programs have experienced significant evolution since their implementation. The Children's Access Card implemented as a statewide section 1115 Demonstration in 2004. The adult subsidy program, Access to Health Insurance, was added under an amendment in 2005. The objective of the programs has historically been to make health insurance more affordable by providing premium subsidy to families and individuals with incomes at or below 185 percent of the Federal Poverty Level (FPL). The programs were originally funded by a premium tax implemented by the State and Title XXI funding from the Federal Government.

The programs target small businesses (2-50 employees) that do not offer a health benefit plan. The State provides up to \$100 per month in assistance per enrolled employee, spouse or child. The assistance is paid to offset each participant's share of the employer-sponsored health insurance premium, with a maximum of \$500 per month per family. In July 2006, the program was amended to require a 50 percent employer contribution toward the cost of the health benefit plan.

The passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), required the State to remove the non-pregnant childless adults from Title XXI funding no later than December 31, 2009. In response, Idaho submitted an amendment request to the Centers for Medicare and Medicaid Services (CMS) to move the eligible non-pregnant childless adults into a section 1115 Demonstration under Title XIX funding. CMS approved Idaho's request and the premium assistance to Non Pregnant, Childless Adults Demonstration was implemented for the period of January 1, 2010, through September 30, 2014. The Title XXI waiver was most recently renewed for the period of September 1, 2010, through September 30, 2013.

After September 30, 2013, coverage will end for the adults receiving title XXI premium assistance. Idaho is requesting CMS approval to transition these adults to title XIX coverage for the period of October 1, 2013, through December 31, 2013. This will allow these beneficiaries to maintain coverage until they are able to access premium subsidy support through the health insurance exchange in January 2014.

II. BUDGET NEUTRALITY

This change will result in cost savings since the maximum amount paid for monthly premiums is \$100, as compared to a per member per month amount of approximately \$700 for direct title XIX coverage for adults under Idaho's basic benchmark plan. The state has completed the attached budget neutrality spreadsheet supplied by CMS.

III. STATE'S PROPOSED CHANGES TO THE STANDARD TERMS AND CONDITIONS

The State proposes to amend the Title XIX Standard Terms and Conditions to include former Access Card Parents as outlined below:

1. Program Description, Objectives and Eligibility Criteria to include criteria for this new demonstration population as follows:

Add population called "Premium Assistance to Access Card Parents". This population to consist of: Adults, ages 19-64 currently enrolled in Idaho's Title XIX section 1115 Children's Access Card Demonstration as of September 30, 2013.

- Have income between 133 – 185% of FPL
- Have a child (children) eligible for Medicaid or CHIP
- U.S. citizens/legal residents
- Residents of Idaho
- Not otherwise eligible for coverage through the State Plan
- Not eligible for Medicare or Veterans benefits
- Employed by a small business (2-50 employees) or are the spouse of an employee in a small business
- Only covered under Medicaid through the section 1115 Demonstration

There is no resource limit for this demonstration population.

2. The State proposes to update the benefit definition to include the following description:

The sole benefit provided to Premium Assistance to Access Card Parents, formerly covered under the Title XXI Demonstration, is assistance in paying the employee's share and/or employee's spouse's share of the monthly premium cost of qualifying employer-sponsored insurance (ESI) plans, for the period of October 1, 2013 – December 31, 2013

3. The State proposes to freeze enrollment beginning October 1, 2013.

4. The State proposes an update to Reporting Requirements as follows:

The monthly, quarterly and annual enrollment reporting requirements to include the addition of a new demonstration population called: "Premium Assistance to Access Card Parents". Please see proposed revisions, attached.

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

CHIP Parents	2008	2009	2010	2011	2012	5-YEARS
TOTAL EXPENDITURES	\$ 305,200	\$ 381,500	\$ 331,518	\$ 291,648	\$ 289,668	\$ 1,599,534
ELIGIBLE MEMBER						
MONTHS	3,954	5,250	4,246	3,534	3,432	
PMPM COST	\$ 77.19	\$ 72.67	\$ 78.08	\$ 82.53	\$ 84.40	
TREND RATES	ANNUAL CHANGE					5-YEAR AVERAGE
TOTAL EXPENDITURE		25.00%	-13.10%	-12.03%	-0.68%	-1.30%
ELIGIBLE MEMBER		32.78%	-19.12%	-16.77%	-2.89%	-3.48%
MONTHS						
PMPM COST		-5.86%	7.45%	5.70%	2.27%	2.26%

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATION

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	2013 3 months	TOTAL WOW
CHIP Parents						
Eligible Member Months	-3.5%	0	3,432	-3.5%	828.14	
PMPM Cost	2.3%	0	\$ 84.40	2.3%	\$ 86.31	
Total Expenditure					\$ 71,477	\$ 71,477

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP		DY 00	DEMO TREND RATE	2013 (3 months)	TOTAL WW
CHIP Parents					
Eligible Member Months		3,432	-3.5%	828	
PMPM Cost	\$	84.40		\$ 84.40	
Total Expenditure				\$ 69,895	\$ 69,895

Budget Neutrality Summary

Without-Waiver Total Expenditures

	2013 (3 months)	TOTAL
<u>Medicaid Populations</u>		
CHIP Parents	\$ 71,477	\$ 71,477
TOTAL	\$ 71,477	\$ 71,477

With-Waiver Total Expenditures

	2013 (3 months)	TOTAL
<u>Medicaid Populations</u>		
CHIP Parents	\$ 69,895	\$ 69,895
TOTAL	\$ 69,895	\$ 69,895
VARIANCE	\$ 1,582	\$ 1,582

Population Status Drop-Down
Medicaid
Expansion

IV.a - Title XIX Standard Terms and Conditions, Page 4

II. Program Description and Objectives

The Idaho Medicaid ~~Non-Pregnant Childless~~ Adult ~~and Child~~ Waiver (Idaho ~~Adult~~ Access Card Demonstration) is a statewide section 1115 Demonstration to make health insurance more affordable by providing premium subsidy to individuals with incomes at or below 185 percent of the Federal Poverty Limits (FPL). This program is targeted at small businesses (2-50 employees that do not offer a health benefit plan).

The Idaho program for ~~children was implemented~~ in 2004 and an amendment to add adults ~~was approved~~ ~~implemented~~ in July of 2005. ~~The program was partially funded by Title XXI funds. The program and~~ provides up to \$100 per month per enrolled ~~adult participant~~ (for a qualifying employee, ~~or the spouse or child~~ of the employee) toward the individual's share of the employer-sponsored health insurance premium. In July 2006, the program was amended to require a 50 percent employer contribution toward the cost of the health benefit plan.

~~The passage of the Children's Health Insurance Program Reauthorization Act of 2009, (CHIPRA), required the State to remove entitled Access to Health Insurance, required the State to remove the childless adults from Title XXI funding no later than December 31, 2009. In response, the State submitted a proposal to the Centers for Medicare and Medicaid Services (CMS) to move the eligible non-pregnant childless adults into a section 1115 Demonstration under Title XIX. CMS approved the Idaho's Premium Assistance to Childless Adults Demonstration under section 1115(a) of the Act. This essentially left Idaho with two waivers, one under Title XXI (approved January 1, 2010 through September 30, 2013) and the other under Title XIX (approved for the period of January 1, 2010, through September 30, 2014)~~

~~CHIPRA provided no funding for extending the Title XXI waiver through December 31, 2013. So, the State could not seek to extend under Title XXI authority. The full implementation of the Patient Protection and Affordable Care Act of 2010 (PPACA) (occurring on January 1, 2014) will provide premium subsidy through Idaho's health insurance exchange, the State provided a proposal to amend their XIX waiver and add the Title XXI population for the period of October 1, 2013 through January 1, 2014 to bridge the coverage gap for the participants of the Title XXI waiver.~~

The following Special Terms and Conditions, and the approved Costs Not Otherwise Matchable apply to the Demonstration.

Standard Terms and Conditions, Page 10

IV. ELIGIBILITY

1. Eligibility Criteria. The demonstration-eligible population consists entirely of persons who are not otherwise eligible for Medicaid through State Plan coverage. ~~and who are only covered under Medicaid through the Section 1115 Demonstration~~
2. The Idaho section 1115 Demonstration is comprised of the following Eligibility Groups:
 - a. Premium Assistance to Non-Pregnant Childless Adults is comprised of non-pregnant Childless individuals age 18 and above with countable gross family incomes at or below 185% of the FPL, who are:
 - U.S. citizens/legal residents

ATTACHMENT B

- Residents of Idaho
- not otherwise eligible for coverage through the State Plan
- Not ~~qualify~~ eligible for Medicare or Veterans benefits
- ~~do~~ Not currently participate in any insurance plan that meets the definition of a health benefit plan (as defined in State statute)
- ~~are~~ Employed by a small business (2-50 employees) or are the spouse of an employee in a small business. ~~and who are~~
- Only covered under Medicaid through the section 1115 Demonstration.

There is no resource limit for this demonstration population.

b. Premium Assistance to Access to Health Insurance Parents

Individuals age 18 and above with countable gross family incomes above the section 1931 low-income families group up to and including 185% of the FPL who:

- Have a child (children) eligible for Medicaid or CHIP:
- U.S. citizens/legal residents,
- Residents of Idaho,
- Not otherwise eligible for coverage through the State Plan
- Not eligible for Medicare or Veterans benefits
- Not currently participating in any insurance plan that meets the definition of a health benefit plan (as defined in State statute),
- Employed by a small business (2-50 employees) or are the spouse of an employee in a small business,
- Only covered under Medicaid through the section 1115 Demonstration.
- Eligible for Idaho's title XXI demonstration for the month of September 2013

There is no resource limit for this demonstration population.

3. The term "non-pregnant childless adult" has the meaning given such term by section 2107(F)
4. For the period of October 1 to January 1, 2014 of this demonstration, the State will implement a ~~re-is-an~~ freeze on enrollment for the demonstration population of Premium Assistance to Access to Health Insurance Parents, to prepare for the phase out of the waiver on January 1, 2014. ~~average annual enrollment limit of 350 for the non-pregnant childless adult populations. counts against the cap. The State may establish a limit of less than 3500 individuals, if necessary, to ensure that program expenditures do not exceed the budget neutrality annual limit. The State must notify CMS at least 630 days in advance of any changes in the enrollment limit.~~

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V. BENEFITS

1. Benefit Definition.

- a. The sole benefit provided to persons eligible as ~~Non-Pregnant Premium Assistance~~ Childless Adults is assistance in paying the employee's share of the monthly premium cost of qualifying employer-sponsored insurance (ESI) plans ~~through waiver phase-out as of January 1, 2014.~~

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- b. The sole benefit provided to Access to Health Insurance Parents is assistance in paying the employee's, employee's spouses or child's share of the monthly premium cost of qualifying employer-sponsored insurance (ESI) plans, for the period of October 1, 2013 - December 31, 2013.**
2. Qualifying Employer Sponsored Insurance Plans. Qualifying ESI plans are offered by a qualified employer, meet the conditions set forth in V.7 and include coverage for:
 - a. Preventive services
 - b. Maternity services
 - c. Inpatient and outpatient hospital services
 - d. Physicians' medical and surgical services
 - e. Hospice Care
 - f. Ambulance services
 - g. Durable Medical Equipment
 - h. Psychiatric and Substance Abuse Services
 - i. Pharmacy
3. Benefits furnished by qualifying ESI plans are not benefits under this Demonstration; as indicated in V.1, the only benefit under this Demonstration is premium assistance. Qualifying employer sponsored plans are not restricted from offering additional benefits, at the option of the plan, that may vary by the plan offered by the employer.
4. An eligible individual or family may enroll in any qualifying ESI plan that is offered to the individual or family by a qualified employer based on the employment of the individual or a family member.
5. Eligible individuals and families who enroll in a qualifying health benefit plan will receive premium assistance, under the following conditions:
 - a. In accord with the enrollment and implementation procedures as defined in section VI, the State will provide an eligible and enrolled **participant** ~~childless adult or childless family~~ a premium assistance subsidy.
 - b. The premium assistance is the amount of the ~~employee~~ **participant's** share of the premium for the qualified ESI plan, subject to the limits in c. and d. below.
 - c. The maximum subsidy limit is \$100 per eligible enrolled adult participant per month, with a maximum of \$200 per household for eligible childless family and a maximum of \$200 per household for Access to Health Insurance parents.**
 - d. The premium assistance subsidy must not exceed the amount of the participant's share of the premium.
 - e. The premium assistance subsidy may be paid directly to the individual/family or the insurance carrier up to the maximum amount specified in subparagraph b. above.

Standard Terms and Conditions, Page 16

- ii. Prior to moving forward with the State's concept of making payments directly to demonstration-enrolled individuals in order to reimburse them for the allowable cost of 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 individuals or family continues to be enrolled and receiving health benefit coverage through a qualified 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

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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 an **childless eligible** individual or family 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 **childless eligible** individual or family did not receive coverage through a qualified health benefit plan. The Federal share must be returned within the timeframes established in statute and regulations.
- e. The State will only reimburse individuals directly when an employer makes such a request in writing on the basis of their wish not to engage in accounting for the premium subsidy.

Standard Terms and Conditions, Page 19

IX. GENERAL REPORTING REQUIREMENTS

- 1. **General Financial Requirements.** The State must comply with all general financial requirements, including reporting requirements related to monitoring budget neutrality, set forth in Section X. The State must submit any corrected budget and/or allotment neutrality data upon request.
- 2. **Monthly Enrollment Report.** Within 20 days following the first day of each month, the State must report Demonstration enrollment figures for the month just completed to the CMS Project Officer and Regional Office contact via e-mail, using the table below. The data requested under this subparagraph is similar to the data requested for the Quarterly Report in Attachment A under Enrollment Count, except that they are compiled on a monthly basis.

Demonstration Populations (as hard coded in the CMS 64)	Point in Time Enrollment (last day of month)	Newly Enrolled Last Month	Disenrolled Last Month
Non-Pregnant, Childless Adults			
Access to Health Insurance Parents			

- 3. **Monthly Calls.** CMS will schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, **progress on evaluations**, legislative developments, and any demonstration amendments the State is considering submitting. CMS will provide updates on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS will jointly develop the agenda for the calls.
- 4. **Quarterly Progress Reports.** The State must submit ~~a~~ progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of ~~the~~ **each** quarter. The intent of ~~these~~ **this** reports is to present the State's analysis and the status of the various operational areas. ~~These~~ This **quarterly** reports must include, but ~~is~~ **are** not limited to:

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- a. An updated budget neutrality monitoring spreadsheet;
- b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: benefits, enrollment and disenrollment, grievances, quality of care, and access that is relevant to the Demonstration, pertinent legislative or litigation activity, and other operational issues;
- c. Action plans for addressing any policy, administrative, or budget issues identified;

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1. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (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 section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
2. **Standard Medicaid Funding Process.** The Standard Medicaid funding process will be used during the Demonstration. The State must estimate matchable Medicaid expenditures on the quarterly form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality agreement must be separately reported by quarter for each FFY on the form CMS-37.12 for both the medical assistance program and administrative costs. 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 with Federal funding previously made available to the State, and including the reconciling adjustment in the finalization of the grant award to the State.
3. **Extent of Title XIX FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS will provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in Section XI:
 - a. Administrative costs, including those associated with the administration of the Demonstration;
 - b. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act for ~~childless participants~~ **adults**, with dates of service during the operation of the Demonstration
4. **Sources of Non-Federal Share.** The State certifies that the source of non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds will not be used as the non-Federal share for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with title XIX of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.
 - a. CMS will review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS will be addressed within the times frames set by CMS.

each DY are the same for all ~~CHIPRA-Medicaid-childless-adult~~ waiver participants.

- c. **FFY 2009 Base Year Expenditure.** The Base Year Expenditure will be equal to the total amount of FFP paid to the State for health care services or coverage provided to non-pregnant childless adults under the Idaho Adult Access Card Demonstration (21W-0018/10 and 11-W-187/10), as reported on CMS-21 and 21P Waiver forms submitted by the State in the four quarters of FFY 2009. A preliminary Base Year Expenditure total appears in Attachment B. A final Base Year Expenditure total will be determined by CMS following CMS receipt of the Budget Neutrality Update that the State must provide by April 1, 2010.
- d. **Adjustments to the Base Year Expenditure.** CMS reserved the right to adjust the Base Year Expenditure in the event that any future audit or examination shows that any of the expenditures included in the Base Year Expenditure total were not expenditures for health care services, health insurance premiums or premium assistance for non-pregnant childless adults participating in the Idaho Adult Access Card Demonstration (21-W-00018/10 and 11-W-187/10), or that otherwise were not approved Demonstration expenditures.
- e. **Special Calculation for FFY2010.** The FFY 2010 Expenditure Projection will be equal to the Base Year Expenditure increased by 3.7 percent, which is the percentage increase in the projected nominal per capita amount of National Health Expenditures for 2010 over 2009, as published by the Secretary in February 2009.
- f. **Annual Limit for DY 1.** To account for the fact that this Demonstration will be active for only three-quarters of FFY 2010, the Annual Limit for DY 1 will be equal to the FFY 2010 Expenditure Projection (as calculated under subparagraph (e)) multiplied by 75 percent. The Annual Limit for DY 1 will be finalized as the same time that the Base Year Expenditure is finalized.
- g. **Annual Limit for DY 2.** The Annual Limit for DY 2 will be equal to the FFY 2010 Expenditure Projection (as calculated under subparagraph (e), and prior to multiplication by three-quarters as indicated in subparagraph (f), increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for 2011 over 2010, as published by the Secretary in February 2010. The Annual Limit for DY 2 can be finalized once the Trend Factor for DY 2 is finalized.
- h. **Annual Limit for DY 3 and ~~4~~ Subsequent Years.** The Annual Limit for DY 3 ~~and DY 4~~ ~~the DYs that follow~~ will be equal to the prior year's Annual Limit, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of the DY over the year preceding that year, as published by the Secretary in the February prior to the start of the DY.
- i. **Limit for 1st Q DY 5** The Limit for DY 5 will be equivalent to one-fourth of the Base Year Expenditure for FFY 2014 and increased by the projected anticipated expenditures for the Access to Health Insurance Parents population, and increased by 2.9% as indicated by projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of the DY over year preceding that year, as published by the Secretary.

QUARTERLY REPORT FORMAT AND CONTENT

Under Section IX.4, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT:

Title Line One – Idaho Adult Access Childless Adults Card Demonstration

Title Line Two – Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 1 (January 1, 2010 – December 31, 2010)

Federal Fiscal Quarter: 01/01/2010-03/31/2010

Introduction

Information describing the goal of the Demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, The State should indicate that by "0".

Enrollment Count

Note: Enrollment counts should be person counts, not member months.

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollment (last day of quarter)	Newly Enrolled In Current Quarter	Disenrolled In Current Quarter
Non-Pregnant Childless Adults			
Access to Health Insurance Parents			

Member Month Reporting

Enter the member months for the quarter.

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Non-Pregnant Childless Adults				
Access to Health Insurance Parents				

IV. GENERAL PROGRAM REQUIREMENTS, PAGE 4

~~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.~~

V. GENERAL REPORTING REQUIREMENTS, PAGE 7

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 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 towards 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.

ATTACHMENT C

- 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 XIII(d) and (e).
- l. Progress with SCT XV – Evaluation of the Demonstration