



DEPARTMENT OF HUMAN RESOURCES
DIVISION OF HEALTH CARE FINANCING AND POLICY

May 12, 1998

Richard Fenton, Deputy Director
Division of Integrated Health Systems
Health Care Financing Administration
Mail Stop C3-20-07
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Attn: Ms Sherrie Fried, Project Officer

Re: Responses to HCFA'S Title XXI State Plan Questions

Dear Mr. Fenton:

Thank you for your letter of April 28, 1998, requesting additional information and clarification regarding Nevada's proposal for the State Children's Health Insurance Program under Title XXI of the Social Security Act. We appreciate having the opportunity to respond to each of your concerns.

Upon review of your seventeen concerns and/or comments, we respectfully submit our responses as follows:

Section 1. General Description and Purpose of the State Child Health Plan

1. Please describe the status of the authorizing legislation for this plan. Senate Bill (SB) 470 authorizes the use of Medicaid account surpluses only for children under age 13. Does the State need additional authorizing legislation for the 13 through 18 age group? Please certify that the State will not seek to draw Title XXI funding until authorizing legislation is enacted and the program is implemented in accordance with the approved plan.

Response: The State of Nevada assures that it has authorizing legislation to implement its Title XXI state children's health insurance program. Senate Bill (SB) 470 which was approved by the 1997 Legislature, was a "generic" enabling

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legislation to address outreach and marketing for Medicaid and “any other” federal health insurance program.

During the November 5, 1997 meeting of the Interim Legislative Committee on Health Care, the committee endorsed the creation of a children’s health care program covering as many children as possible (birth to 18), reaching full coverage, if possible, of all eligible children based on federal funding and supported necessary administrative costs of Nevada’s Division of Health Care Financing and Policy (DHCFP) in order to proceed with the creation of the program. It was the opinion of Nevada Legislative Counsel Bureau, Legal Division, that Nevada could use the money in its Intergovernmental Transfer Account to cover children other than those under age 13, so an age of birth to 18 would be allowed under the current legislation.

During the November 24, 1997 meeting of the Interim Finance Committee, the committee approved transfer of funds from the intergovernmental transfer account to provide for administrative costs for the children’s program. At its May 6, 1998 meeting, it appropriated full funding for this program in order to provide coverage for all eligible (birth to 18) children. These actions were approved in accordance with Legislative Counsel Bureau’s legal opinion.

2. Please provide an assurance that the Title XXI State Plan will be conducted in compliance with all civil rights requirements. This assurance is necessary for all programs involving continuing Federal financial assistance.

Response: The State of Nevada assures that its Title XXI state children’s health insurance program will comply with all civil rights requirements.

Section 3. General Contents of State Child Health Plan

3. Section 3.1: Please clarify if dental care is carved in or out of Managed Care Organizations (MCOs)? On pages 9-10, dental care is not mentioned as part of the discussion of provider networks, yet the Nevada Check Up information sheet for the patient says that dental is part of MCO’s package of benefits.

Response: The Nevada Check Up program will cover certain specified dental services, including preventive, diagnostic, palliative and restorative care. The exact package is still being negotiated.

The dental services will be provided under an insurance model, but may or may not be part of the primary HMO package. To the extent that they are provided by a separate entity, the dental standards would apply only to the separate entity.

Section 4. Eligibility Standards and Methodology

4. Section 4.3: Nevada Check Up proposes to obtain the Social Security number (SSN) of the parents of the applicant. We understand that our model application does include these questions, and we plan to revise the forms to request the SSN if it is available. However, the SSN cannot be required for the applicant or family members as a condition of eligibility. This is based on the Privacy Act which states that disclosure of the SSN can only be required when its disclosure is required under Federal law.

Response: The SSN block as shown on the Nevada Check Up application is not a condition of eligibility. When we revise the application during Phase II of our marketing and outreach, we will put the following statement in the SSN block: "SSN Not Required",.

5. Section 4.4.1: The process described in section 4.4.1. of the State plan does not meet the statutory requirements for Medicaid screening under section 2102(b)(3). These requirements mandate a screening process that identifies, at a minimum, all children who are potentially eligible for Medicaid under the State Plan as poverty-level children. In States which have not accelerated the phase-in of the poverty level children's group to cover children up to 19, the process must also identify, for children at ages not covered under the State's poverty-level group, all children potentially eligible under the optional categorically needy eligibility group described at 42 CFR 435.222, Individuals Under Age 21 who Meet the AFDC Income and Resource Requirements. While the State may initially use a gross income screen which compares total family income against the applicable Medicaid standard, it must have a second income determination screen for those children whose incomes are higher than the gross test to further assess the child's eligibility for Medicaid. The initial gross income screen would eliminate from the eligibility process, children whose gross family income was low enough that Medicaid eligibility would be almost certain. A second screen, in which a full income determination was made, would detect children whose gross family incomes exceeded the initial screening standard but who were nevertheless Medicaid-eligible when applicable income disregards were applied. Absent this second step, the State would not be meeting its responsibility to ensure that children eligible for Medicaid are enrolled for such assistance as required by section 2102(b)(3).

Response: I respectfully disagree with the assertion that the screening process under section 2102(b)(3) requires identification of potentially eligible Medicaid children. Rather, the screening process must determine if **an** applicant is a

targeted low-income child, and that if in performing the screening, it is determined that the child is eligible for Medicaid, he must be enrolled in Medicaid. (A more complete analysis of the law is attached.)

As this relates to Nevada, the income test is applied for Nevada Check Up but there is no screen for assets. Nevada's Medicaid program includes an assets test, and therefore a child would not be "found through the screening [for targeted low-income children] to be eligible" for Medicaid.

A minor exception relates to children receiving supplemental security income (SSI). For those children, the application will be forwarded to the Welfare Division (who performs the Medicaid eligibility function). Once the child's SSI status is verified, the Nevada Check Up application will be treated as a Medicaid application. If any further demographic information is necessary, the application will be pended until the information is submitted. Once all necessary information is supplied, the child would be enrolled in Medicaid

6. Section 4.4.2: Please describe how the State will ensure that children who are determined to be potentially Medicaid eligible will be enrolled in the Medicaid program (rather than simply referred to the Welfare Division Office). Also, if after the child is referred to Welfare Division Office, s/he is found to be ineligible for Medicaid, how will the child be enrolled Nevada Check Up?

Response: For the SSI children whose applications are forwarded to the Welfare Division, Nevada Check Up staff will ensure that they are enrolled in Medicaid by reviewing the monthly Medicaid eligibility rolls. If the child is not enrolled after one month, there will be a follow up with the Welfare Division. If the child is not enrolled after two months, additional information has been requested but not received, there will be direct follow-up with the family.

7. Section 4.4.4: Tribal outreach is dependent on Head Start which would not completely capture potential CHIP enrollees. In fact, eligibility for Head Start is more comparable to Medicaid. Are there other efforts to ensure tribal participation in CHIP? How will the State assure access to services for targeted low-income children who are Native Americans?

Response: Staff of Nevada Check Up have been working with the 27 Indian Tribal Council members, Executive Director of the Indian Tribal counsel, and the Nevada Indian Commissioner in getting the application packet and posters to all the 27 Indian reservations. In addition, the Indian Health Clinics and Indian Hospitals have been informed about the program and supplied with application packets. The tribal council chairmen are playing a vital role in supporting

Nevada's CHIP program. Staff is working very closely with the Native American community to enroll their 1,800 children who could possibly qualify for Nevada Check Up. In the Request for Contract, the Contractor must offer a contract to the Indian Health Clinics and Indian Hospitals to provide services to Nevada Check Up children who access said health care providers.

Section 5. Outreach and Coordination

8. Section 5.2: Describe how Nevada Check Up will ensure coordination with the services provided by other health, social service and education programs, (e.g. Baby Your Baby, FQHCs, Head Start, Special Children's Clinics, WIC and Title V programs as required by Section 2102(c)(2).

Response: During the initial statewide marketing and outreach phase for Nevada Check Up, Baby Your Baby, Head Start, Special Children's Clinics, WIC and Title V programs have been supplied with the application packets. The Nevada Check Up Marketing and Outreach Coordinator has met with the program administrators of each of these programs to educate them about the program as well as instruct them on the eligibility requirements. In order to keep these entities supplied with applications, Nevada Check Up has devised and distributed the request form to use when requesting more applications and posters.

WIC encourages all of their clients to apply to Nevada Check Up because they are under 200 percent of federal poverty level. The other cited entities are in the process of adding information about Nevada Check Up to their informational brochure and/or other outreach material. In addition, other social service agencies, such as, Clark County Social Services, upon review of their social service case files, is identifying families whose household income might qualify for the Nevada Check Up program and sending them a letter along with the application packet.

On the Nevada Check Up application, there is a section that asks the applicant how did s/he hear about the program. This information is being tracked through the application system to determine during Phase II whether or not certain entities need to be contacted for more assistance in making referrals to Nevada Check Up.

Section 7. Quality and Appropriateness of Care

9. Section 7.2: How will the State assure quality and access in fee-for-service areas?

Response: Nevada has seventeen counties of which all but one, White Pine County, has at least one managed care provider, a licensed health maintenance

organization. In order to ensure maximum coverage and choice for Nevada Check Up members, DHCFP will consider accommodations for under served rural areas. Large rural areas without licensed health maintenance organizations may not have the same types of requirements established for other areas. Our current state laws contain provisions that allow eased access standards for under-served rural areas. Access for Nevada Check Up will be at least as good as current rural areas have to health care.

In order to accommodate the Nevada Check Up members in rural areas where there is not a sufficient network of providers available to assist the contractors in providing services in said rural areas, the contractor will be allowed to implement/follow one of the following arrangements:

- 1) In rural counties that have no more than one managed care organization, the Contractor will have to offer a contract to essential community providers at a rate comparable to a similar provider in the urban area. Essential community providers include a rural health clinic, Indian Health clinic or facility or public hospital. Under such an arrangement, access standards for primary care could be eased to allow for the lack of available providers in the geographic area, but in no event to a level below that available to other people in the community.
- 2) If no essential community provider exists, the Contractor could request a waiver from access and capacity standards, but in no event to a level below that available to other people in the community.
- 3) A contractor acting as an indemnity insurer, paying all medical claims covered under the benefits package at Medicaid rates. Under such an arrangement, contractor could not impose prior authorization controls other than for determination of whether a particular service is covered under the benefits package. The contractor would be at risk.
- 4) A contractor acting as a third party administrator. Under such an arrangement, contractor would provide the same function as in 3), but would be paid a fee for administering the claims. The state would be responsible for the cost of such claims, and as such would be the risk bearing entity.

Section 8. Cost Sharing Payment

10. Section 5.2. In the table of income and enrollment fee/premiums, please add a column illustrating the percentage of Federal Poverty Level (FPL) under which

the income category falls. This information is needed to determine whether cost sharing at and below 150% of the FPL meets the requirements of section 1916(b)(1). It appears that some children under 150% of the FPL potentially could pay enrollment fees and quarterly premiums in excess of the maximum monthly charge that is permissible under section 2103(e)(3). In those cases, please be aware that the family must be given the option to pay the enrollment fee and quarterly premiums on a monthly basis in payments that do not exceed the monthly maximums.

Response: The following chart illustrates the percentage of Federal Poverty Level (FPL) per income category and the enrollment fee and premiums for each:

The table below shows the income levels for Nevada Check Up, and show the percentage of FPL as requested. Based on this comment, Nevada will change its cost sharing as follows:

- a) Enrollment fees will be equal to the quarterly premiums. For families under 150% of poverty, the amount will be \$10 (this represents a \$10 reduction in the annual cost). For families between 150%-175%, the amount will be \$25 (\$100 per year, the same total annual cost). For families between 175%-200%, the amounts remain at \$50 (\$200 per year).
- b) For families under 150% of poverty who have a maximum monthly charge under \$10, they will be given the choice of paying the maximum monthly charge each month, or the \$10 quarterly fee. For families with a maximum monthly fee of \$3 or less, premiums and enrollment fees will be waived.

1998 FPL NEVADA CHECK UP ELIGIBILITY						
NUMBER OF PEOPLE IN HOUSEHOLD	150% FPL INCOME LEVEL (YEAR)	150% FPL INCOME LEVEL (MONTH)	175% FPL INCOME LEVEL (YEAR)	175% FPL INCOME LEVEL (MONTH)	200% FPL INCOME LEVEL (YEAR)	200% FPL INCOME LEVEL (MONTH)
1	\$12,075	\$1,006	\$14,088	\$1,174	\$16,100	\$1,342
2	16,275	1,356	18,988	1,582	21,700	1,808
3	20,475	1,706	23,888	1,991	27,300	2,275
4	24,675	2,056	28,788	2,399	32,900	2,742
5	28,875	2,406	33,688	2,807	38,500	3,208
6	33,075	2,756	38,588	3,216	44,100	3,675
7	37,275	3,106	43,488	3,624	49,700	4,142
8	41,475	3,456	48,388	4,032	55,300	4,608
9	45,675	3,806	53,288	4,441	60,900	5,075
10	49,875	4,156	58,188	4,849	66,500	5,542
	Add \$4,200 for each additional member	E 10 P 10 CoPay N	Add \$4,900 for each additional member	E 25 P 25 CoPay Y	Add \$5,600 for each additional member	E 50 P 50 CoPay Y

- 11. Section 8.4.2: Does the State intend to charge co-payments for families above 150% if the visit is only for dental preventive and diagnostic services? Under

section 2103(e)(3) no cost sharing may be imposed for these services, regardless of income, because such services are considered to be well-baby and well-child care.

~~Response:~~ No co-payment will be ~~charged for a diagnostic~~ or preventive service.

Section 9/ Strategic Objectives and Performance Goals for the Plan Administration

12. ~~Please~~ describe the start up and ongoing administration costs. Do these figures include outreach?

Response: Start up administrative costs are budgeted for \$622,483 for the State Fiscal Year ending June 30, 1998, the period prior to implementation. The costs are as follows:

<u>Category</u>	<u>Purpose</u>	<u>Amount</u>
Personnel	Three personnel (chief, coordinator, secretary)	\$ 91,277
Travel	In-state and out-of-state	\$ 12,928(1)
Operating	Supplies, printing, mailing, lease, advertising	\$133,147(1)
Contracts	Actuary, temps, Data, EQRO, surveys	\$189,484
Equipment	Telephones, furnishings, office equipment	27,368
Information Services	Software, hardware and telecommunications	<u>\$167,779</u>
	Total	4622,483

(1): ~~Part of the costs are for marketing and outreach which include the following: printing and mailing of the application packet and program posters; statewide in-state travel to conduct marketing and outreach sessions to public and private entities who provide services to the targeted population. Educate health care providers including essential community providers and social service entities who provide services to the low-income uninsured populations on the benefits of the program as well as train them on how to refer and/or assist potential applicants in applying to the Nevada Check Up program.~~

The ongoing administrative costs will cover overall program oversight, contract management, data, analysis and reporting, oversight of contractors, quality assurance, eligibility determination and verification, grievance review and resolution, targeted outreach, program evaluation, liaison with state and local government, and other related functions. Final budgets are still being developed for the program.

13. According to the State Plan, the expenditures defined under Section 2105(a)(2) of Title XXI (administrative and outreach expenditures) claimed for federal match are within the 10% cap. However, as stated in HCFA's State Medicaid Director letter dated December 8, 1997, the correct methodology to determine the 10% administrative cost cap is as follows:

Total expenditures for health benefits coverage ("insurance payment") divided by 9 = 10% administrative cost limit. According to this calculation, Nevada's 10% cap limit for administrative and outreach costs would be \$875,000 in FFY98. Please assure that the State will not exceed the 10% in any given year.

Response: Nevada assures that administrative costs claimed for Federal matching funds will not exceed 10% of total expenditures in any given year.

14. Please describe the underlying assumptions for the budget. How was the \$1,050 per child per year estimate derived? Premiums and enrollment fees are estimated at \$18 per child for FY98 and \$63 per child in FY99. Please provide the assumptions upon which the projections are based. For example, what percent of the caseload is estimated to be 100% to 150% FPL.

Response: The \$1,050 per child was based on an average capitated rate of \$85 per month, plus additional payments for maternity and newborn. It was based on a distribution of children by age as follows (0-1:5%, 1-6: 28%, 7-13: 40%, 14-18: 27%). Medicaid costs were used for the various age groups, with adjustments for newborn and maternity costs.

The premiums and enrollment fees were based on an estimate of 30% of families being under 150% FPL, 40% being between 150%-175% FPL, and 30% being between 175%-200% FPL. For FFY98, the calculation was based on an enrollment fee only. For FFY99, the calculation accounted for a full year's coverage, but also considered a rollover effect.

15. The State has indicated that they are using premiums and enrollment fees as part of the State revenues. Please be aware that these cannot be matched by Federal funds.

Response: The state is aware that premium and enrollment fee revenues cannot be matched by Federal funds. The funds are being used for administrative costs.

16. Please describe the source(s) of the "intergovernmental transfer account" and provide an explanation of the flow of funds with respect to this account.

Response: The source of funds for the intergovernmental transfer account is payments by counties and local hospital districts which are used for health care programs at the state level

17. Is the dedicated account that is supporting the State's share of CHIP expenditures in 1998 expected to cover 1999 **as** well?

Response: Yes.

As you are aware, the proposed date for the delivery of health care services to Nevada Check Up children is July 1, 1998. Hopefully, our responses address your concerns so that Nevada's Title XXI State Plan application is approved prior to the proposed start up date. Should you have any questions regarding our responses, please do not hesitate to contact me at ~~(702)~~ 687-3893.

Sincerely,


Christopher Thompson, Administrator
Division of Health Care Financing and Policy

CT:mo

cc: Richard Chambers, Associate Regional Administrator, Region IX
Charlotte Crawford, Director, Department of Human Resources

State Children's Health Insurance Program
Requirement for Medicaid Screen
Legal Analysis

By letter dated April 28, 1998, the Health Care Financing Administration has taken the position that a Medicaid eligibility determination is required as a screen for the State Children's Health Insurance Program. The State of Nevada disagrees with this position.

Legal Citations

(All sections refer to Title XXI of the Social Security Act
as passed in the Balanced Budget Act of 1997.)

Section 2101(a):

(a) Purpose. The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Such assistance shall be provided primarily for obtaining health benefits coverage through

- (1) obtaining coverage that meets the requirements of section 2103, or
- (2) providing benefits under the State's medicaid plan under title XIX, or a combination of both.

Section 2102(b):

(b) General Description of Eligibility Standards and Methodology.

(1) Eligibility standards.

(A) In general. The plan shall include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. Such standards may include (to the extent consistent with this title) those relating to the geographic areas to be served by the plan, age, income and resources (including any standards relating to spenddowns and disposition of resources), residency, disability status (so long as any standard relating to such status does not restrict eligibility), access to or coverage under other health coverage, and duration of eligibility. Such standards may not discriminate on the basis of diagnosis.

(B) Limitations on eligibility standards. Such eligibility standards

(i) shall, within any defined group of covered targeted low-income children, not cover such children with higher family income without covering children with a lower family income, and

(ii) may not deny eligibility based on a child having a preexisting medical condition.

(2) Methodology. The plan shall include a description of methods of establishing and continuing eligibility and enrollment.

(3) Eligibility screening; coordination with other health coverage programs. The plan shall include a description of procedures to be used to ensure

(A) through both intake and followup screening, that only targeted low-income children are furnished child health assistance under the State child health plan;

(B) that children found through the screening to be eligible for medical assistance under the State medicaid plan under title XIX are enrolled for such assistance under such plan;

(C) that the insurance provided under the State child health plan does not substitute for coverage under group health plans;

(D) the provision of child health assistance to targeted low-income children in the State who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c)); and

(E) coordination with other public and private programs providing creditable coverage for low-income children.

(4) Nonentitlement. Nothing in this title shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan.

Section 2105(d)(1):

(d) Maintenance of Effort.

(1) In medicaid eligibility standards. No payment may be made under subsection (a) with respect to child health assistance provided under a State child health plan if the State adopts income and resource standards and methodologies for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX that are more restrictive than those applied as of June 1, 1997.

Section 2110(b):

- (b) Targeted Low-Income Child Defined. For purposes of this title
- (1) In general. Subject to paragraph (2), the term ‘targeted low-income child’ means a child
- (A) who has been determined eligible by the State for child health assistance under the State plan;
- (B) (i) who is a low-income child, or
- (ii) is a child whose family income (as determined under the State child health plan) exceeds the medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the medicaid applicable income level; and
- (C) who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).
- (2) Children excluded. Such term does not include
- (A) a child who is an inmate of a public institution or a patient in an institution for mental diseases; or
- (B) a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member’s employment with a public agency in the State.
- (3) Special rule. A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program’s operation.
- (4) Medicaid applicable income level. The term ‘medicaid applicable income level’ means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under section 1902(l)(2) for the age of such child.

The statute cited by the Health Care Financing Administration is section 2102(b)(3). The requirement under (A) is to perform a screening to determine if an applicant meets the definition of a targeted low-income child, not a screening for Medicaid eligibility. The definition of targeted low-income child excludes children “found to be eligible for

medical assistance under Title XIX.” This language parallels section 2102(b)(3)(B) which requires states to enroll in Medicaid children found through the screening to be eligible for Medicaid.

The use of the terms “found to be eligible” and “found through the screening to be eligible” are initially cumbersome. Had the legislation intended to limit this program to children not currently eligible for Medicaid, the words “found to be” would have been omitted.

Rather the law is clear that the intention was to build on the current Medicaid programs of each state. Section 2101 states the purpose of the legislation is to expand coverage in **an** effective and efficient manner while coordinating with other sources of coverage. Section 2106 provides a maintenance of effort to assure that states don’t cut the Medicaid program to shift costs to Title XXI.

Still sections 2102(b)(3)(B) and 2110(b)(1)(C) have meaning. States are required to do a screening to determine if a child is a “low-income child.” Such a screening would require information on income of the family. For a state which has no assets test in Medicaid, that screening would, based on the income reported, allow a state to determine Medicaid eligibility. Under that circumstance, section 2102(b)(3)(B) would apply.

For Nevada, which has **an** assets test in Medicaid but not one for Title XXI, the low-income child screening is not sufficient to determine Medicaid eligibility. There is still some limited applicability in the case of **a** family who, through the low-income child screening, reports that a supplemental security income (SSI) payment is being received on behalf of a disabled child. This would establish Medicaid eligibility and the child would be enrolled in Medicaid.

HCFA has also indicated that Nevada could initially use a gross income screen, but would have to further screen for individuals below a certain income level to determine Medicaid eligibility. Such a position is directly contrary to section 2102(b)(1)(B)(i) in that it imposes an additional requirement on a lower income individual. A child in a higher income family could be enrolled without reporting assets while **a** child in a lower income family could not be enrolled if the family did not report assets.

Therefore, while initially cumbersome, the clear reading of section 2102(b)(3)(A) is that the state must have a procedure for determining if applicants meet the definition of “targeted low-income child,” and only enroll those children who meet that definition. Nevada’s program does this.

The clear reading of section 2102(b)(3)(B) is that children for whom Medicaid eligibility can be determined through the targeted low-income child screening must be enrolled in Medicaid. It does not require a separate Medicaid screen. Nevada’s program does this **as** well, although its applicability is limited because of the assets test in Medicaid.

Accordingly, Nevada’s State Plan is in compliance with the federal law and should be approved.