



DEPARTMENT OF HUMAN RESOURCES
DIVISION OF HEALTH CARE FINANCING AND POLICY

July 27, 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

Dear Mr. Fenton,

Thank you for your response of June 19, 1998, to our proposal for treating potentially Medicaid eligible children. It is truly unfortunate that your interpretation of the State Children's Health Insurance Program will result in some very low-income children in Nevada staying uninsured and further limits our States flexibility in addressing this issue. It is particularly distressing that Nevada's attempts to dramatically broaden coverage to low-income children in an administratively simple and efficient manner have been thwarted, and that as a result, Nevada's process for enrolling children will be far more complex and bureaucratic, which will in and of itself stop some families from applying.

The Nevada ✓ Check Up application has been revised to add a question on assets. All applicants who appear to meet Medicaid eligibility criteria will be required to fill out a Medicaid application. They may provisionally enroll in Nevada ✓ Check Up, but they will be reviewed after one month to ensure they have filed the Medicaid application. Failure to do so will result in disenrollment from Nevada ✓ Check Up. Sections 4.4.1 and 4.4.2 have been revised to incorporate these changes.

As a result of these changes, Nevada has determined that the administrative cost of a totally separate program may not be feasible, particularly given the overall 10% cap.

Accordingly, Nevada ✓ Check Up will be modified so that coverage under Nevada ✓ Check Up will mirror that of Nevada Medicaid's managed care program. Services not provided through the managed care contract that are Medicaid covered services will be provided through a fee-for-service wraparound. These services include dental services, non-emergency transportation, and school based rehabilitative services. In areas of the state where there are no managed care companies providing services to Medicaid children on a capitated basis, all Nevada ✓ Check Up services will be provided on a fee-for-service basis.

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In addition, co-payments for specified services as originally contemplated under Nevada ✓
Check Up will be dropped.

Due to the scope of the changes, Nevada is submitting revised sections 4.4.1, 4.4.2, 5.2, 6, and 8
to our State Plan for your review. All new language has been italicized for your aid in reviewing
these changes.

You have also raised a question regarding hospital district funding. Based on a subsequent
discussion with Jim Frizzera of your agency, I believe that this issue has been resolved. The
salient points are:

1. A hospital district is a separate unit of government, established by counties in accordance
with Nevada Revised Statutes (NRS) 450.550-450.750, a copy of which is attached.
2. Hospital districts generally have the same boundaries as the county, or in some cases, a
distinct sub-part of the county that the hospital district serves.
3. The hospital district levies taxes on real and personal property in accordance with NRS
450.660. These taxes are generally applied and as such would not constitute health care
related taxes under federal rules.
4. There is only one hospital in each hospital district within the state. The only private
hospitals in the state are in Clark County and Washoe County, which do not have hospital
districts. (In June of 1998, Elko County converted its public hospital to a private
hospital. Accordingly, the hospital district is being dissolved.)

I sincerely appreciate the efforts of you and other HCFA staff in providing guidance and
constructive comment on the Nevada ✓ Check Up program. I am confident that this response
will resolve all outstanding issues you have raised.

Sincerely,

Christopher Thompson, Administrator
Division of Health Care Financing and Policy

Attachment

CT/lmd

4.4. Describe the procedures that assure:

4.4.1. Through intake and follow up screening, that only targeted low-income children are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) (Revised)

Families who apply will be asked about insurance coverage for each child. If a child is currently covered, or was covered at any time since *April 1, 1998*, by private (creditable) insurance, the child will be ineligible for Nevada ✓ Check Up. Children will be eligible to apply only after six months without creditable insurance. The six month waiting period does not apply to children coming off of Medicaid, and may be waived for families who lose insurance for circumstances outside of their control (e.g., employer drops dependant health care coverage). Random verification of income and children's health insurance status through contact with employers and other means will be done.

Information in the application packet includes Medicaid eligibility criteria and how to apply for Medicaid **as** well as information on differences between Medicaid and Nevada ✓ Check Up. In particular, Medicaid has **no** cost sharing while Nevada ✓ Check Up *has quarterly premiums*. When the application is submitted, reported income *and assets* will be screened and any family that *appears to meet the income and assets test will be sent a Medicaid application. See 4.4.2.*

4.4.2. 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. (Section 2102)(b)(3)(B)) (Revised)

In order to assure that Medicaid eligible children are enrolled in Medicaid, Nevada will take the following steps:

- 1) *For families who apply with ~~the current application (which does not include any question on assets)~~, if ~~their income is below the income requirements for Medicaid or f their income is no more than 25% above the Medicaid income requirement (to account for work expense disregards allowed in the Medicaid eligibility determination)~~, ~~then~~ Nevada ✓ Check Up application will be considered to be a Medicaid application as well unless the family has applied for and been denied Medicaid eligibility in the past twelve months. The date ~~of~~ application will be the ~~approval date of the Title XXI State Plan~~ or the date received by the State of Nevada, whichever is later.*

These families will be sent an enrollment form for Nevada ✓ Check Up along with a full Medicaid application. The enrollment form will include an additional question designed to screen individuals who have assets above the Medicaid allowable level.

~~The Nevada ✓ Check Up application has been redesigned to include a single assets question to screen out families who do not meet the Medicaid assets requirement. If the question is not answered, the application will be treated as if the applicant meets the Medicaid assets screen.~~

- 2) ~~If a family has children which appear on the basis of the initial screen to be potentially eligible for Medicaid submits the enrollment form and premium payment, those children would be provisionally enrolled in Nevada ✓ Check Up.~~
- 3) Any family sent a Medicaid application will have two weeks (ten working days) to return the completed application. If the application is not returned, the family will be sent a notice of denial for Medicaid, but the notice will allow an additional two weeks (ten working days) to provide all necessary information to have ~~the application reinstated.~~
- 4) Nevada **J** Check Up staff will review all potentially Medicaid eligible children after one month to determine if the family has filed a Medicaid application. If no application has been filed, the family will be sent a notice of pending disenrollment **from** Nevada ✓ Check Up. The family will be given 10 days to appeal. If an appeal is filed, the children will be maintained in Nevada Check Up pending the outcome of the appeal. If no appeal is filed the children will be disenrolled at the start of the following month.
- 5) Once a Medicaid eligibility determination has been made, the family will be notified. If the children are approved for Medicaid and have previously enrolled in Nevada **J** Check Up, the Medicaid program will reimburse Nevada ✓ Check Up for the cost of the premiums paid. In this manner, the federal match rate for such expenses will be the lower Medicaid rate. The family will also be refunded any premiums they paid. If the children are denied eligibility for Medicaid and have not enrolled in Nevada **J** Check Up, they will be sent another enrollment form for Nevada **J** Check Up.
- 6) Medicaid enrollees will be compared monthly with the Nevada **J** Check Up enrollees to ensure that a child is not enrolled in both programs.
- 7) Nevada **J** Check Up will maintain statistics on families applying for the program who meet the income guidelines of Medicaid, including whether they apply for Medicaid, and the disposition of the applications.

5.2 Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2)) (Revised)

Nevada ✓ Check Up will be closely coordinated with the Medicaid program. When families apply, a match will be performed through the data system interface to determine if a child is in Medicaid. Based on the income reported, if a child may qualify for Medicaid, further information will be sent to the family regarding application for Medicaid. Because Nevada ✓ Check Up has an enrollment fee and premiums, there will be an economic incentive for the family to make a Medicaid application for said child(ren). Families who first apply for Medicaid and are determined ineligible will be referred to Nevada ✓ Check Up.

Ongoing on a monthly basis, eligibility roles will be reviewed to ensure that children who have subsequently enrolled in Medicaid are disenrolled from Nevada ✓ Check Up. Additionally, children being disenrolled from Medicaid will be given an opportunity to enroll in Nevada ✓ Check Up without a waiting period.

Services will be provided through HMOs who are contracted with the Medicaid program. Families will be required to select an HMO to provide services for their children, but if there is no available HMO in the area the children may receive services from any Medicaid provider. Also to the extent that services are not provided through an HMO (e.g., dental services, non-emergency transportation), they may access them through any Medicaid provider.

Evaluation, oversight, and reporting by HMOs will be coordinated with Medicaid. As the HMOs will be the same, children moving between programs will be able to maintain their primary care physician, which will improve continuity of care.

Outreach efforts for Medicaid and Nevada ✓ Check Up will be closely coordinated. Demographic data and the surveys on insurance status of children will be used for both programs. Finally, Nevada ✓ Check Up will build on the relationship between Medicaid and other social service organizations (see 2.2.1) in informing eligible individuals about available services.

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

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.)

- 6.1.1. Benchmark coverage; (Section 2103(a)(1))
- 6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)
- 6.1.1.2. State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.1.3. HMO or MCO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.2. Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). See instructions.
- 6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.
- 6.1.4. Secretary-Approved Coverage. (Section 2103(a)(4))
Nevada has opted to offer Medicaid services as provided under Nevada's Title XIX State Plan.

- 6.2. The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a))
- 6.2.1. Inpatient services (Section 2110(a)(1))
Inpatient services includes all physician, surgical and other services delivered during a hospital stay. Inpatient services covered in full with no co-payments.
 - 6.2.2. Outpatient services (Section 2110(a)(2))
Outpatient services include outpatient surgery – covered in full with no co-payments.
 - 6.2.3. Physician services (Section 2110(a)(3))
Physician services include medical office visits with a physician, mid-level practitioner or specialist. Preventive care and immunizations covered in full.
 - 6.2.4. Surgical Services (Section 2110(a)(4))
Covered in full. See 6.2.1 for inpatient surgical services and 6.2.2 for outpatient surgical services.
 - 6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
See section 6.2.2.
 - 6.2.6. Prescription drugs (Section 2110(a)(6))
 - 6.2.7. Over-the-counter medications (Section 2110(a)(7))
 - 6.2.8. Laboratory and radiological services (Section 2110(a)(8))
 - 6.2.9. Prenatal care and pre pregnancy family services and supplies (Section 2110(a)(9))
 - 6.2.10. Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
 - 6.2.11. Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
 - 6.2.12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
 - 6.2.13. Disposable medical supplies (Section 2110(a)(13))
 - 6.2.14. Home and community-based health care services (See instructions) (Section 2110(a)(14))
 - 6.2.15. Nursing care services (See instructions) (Section 2110(a)(15))
 - 6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))

- 6.2.17. Dental services (Section 2110(a)(17))
- 6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. Case management services (Section 2110(a)(20))
- 6.2.21. Care coordination services (Section 2110(a)(21))
- 6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23. Hospice care (Section 2110(a)(23))
- 6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. Medical transportation (Section 2110(a)(26))
- 6.2.27. Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.28. Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

Generally, benefits are subject to prior authorization and/or other utilization review controls as established by the plan, except for emergency services. *Services not included in the HMO benefit packet will be provided through fee for service such as dental, non-emergency transportation. For areas not covered by an HMO a fee for service benefit will be offered with the same benefit package but without the same prior authorization and/or utilization review controls. All services not provided through HMO are subject to the prior authorization and/or other utilization review controls in use for Medicaid.*

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

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

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. YES

8.1.2. NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income:
(Section 2103(e)(1)(A))

except for income
8.2.1. Premiums: A "quarterly premium will be charged per family on gross income. *For families above 175% of the Federal Poverty Level (FPL), the premium will be \$50 per quarter (\$200 per year). For families above 150% FPL but at or below 175% FPL, the premium will be \$25 per quarter (\$100 per year). For families at or below 150% FPL, the premium will be \$10 per quarter (\$40 per year). For families who have a maximum monthly charge under federal regulations of 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 will be waived.* The premium will be due on the first day of each quarter (January 1, April 1, July 1, and October 1).

Families will be informed at the time of enrollment notification of the timing and amount of premiums, and a reminder notice will be sent approximately 3 weeks prior to the due date. Should the family fail to submit premium payment by the 10th day of the month the premium is due the health plan will be sent a listing of families who have not paid the quarterly premium. The health plan will be encouraged to contact the family by letter or phone. If payment is not received by the 45th day of the quarter, the family will be sent a notice of disenrollment to be effective the first day of the next month.

8.2.2. Deductibles: There are no deductibles.

8.2.3. Coinsurance: *No co-payments are required.*

8.2.4. Other: Enrollment fee: *N/A*

8.3 Describe how the public will be notified of this cost-sharing and any differences based on income:

The cost sharing information will be explained to potential enrollees through an informational brochure designed by DHCFP and the application packet. *Due to the changes in cost sharing, including the removal of the enrollment fee and the*

elimination of the co-payments, application packets are being revised. All applicants will be sent revised information along with their enrollment package.

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

- 8.4.1. Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))
- 8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))
- 8.4.3. No child in a family with income less than **150%** of the Federal Poverty Level will incur cost-sharing that is not permitted under **1916(b)(1)**.
Premiums will be reduced if the total payments for the plan year divided by the anticipated number of months on the program exceeds the monthly payment limit permitted. Also, if a family is disenrolled during the year, *the premiums* actually paid would be divided by the number of months actually on the program and compared to the monthly payment limit. If it exceeds the limit, a refund will be issued.
- 8.4.4. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))
- 8.4.5. No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))
- 8.4.6. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(e)(6)(A))
- 8.4.7. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, **1997**. (Section 2105(d)(1))
- 8.4.8. **No** funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105(c)(7)(B))
- 8.4.9. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105(c)(7)(A))

8.5 Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed **5** percent of such family's annual income for the year involved: (Section 2103(e)(3)(B))

The only cost sharing is a premium which is less than the 5% cap.

8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:

8.6.1. The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); **OR**

8.6.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by **HIPAA/ERISA** (Section 2109(a)(1),(2)). Please describe: _____