

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES
HEALTH POLICY & SERVICES DIVISION



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July 7, 1998

Diona Kristian, Title XXI Project Officer
Division of Integrated Health Systems
Health Care Financing Administration
Mail Stop C3-18-26
7500 Security Boulevard
Baltimore, Maryland, 21244-1850

Dear Ms. *Diona* Kristian:

Enclosed is Montana's response to the questions raised by the Health Care Financing Administration which we received on June 2, 1998. These questions and our response further clarify the Title XXI state plan which Montana originally submitted on April 10, 1998.

As we discussed today, we understand that you will respond in the very near future to the following questions: 1) What inflationary factor will be applied if a state wishes to use a deductible as part of the cost sharing? 2) When and how will the number of Native American children who are eligible for the CHIP program be reflected in Montana's allotment? 3) When and under what circumstances is an inmate in a public institution eligible for CHIP-covered services? Further detail for these questions can be found in the 6/18/98 "draft" response to your questions.

I would like to thank you and the many others from both the Central and Regional Office who participated in numerous phone calls with us. Your collective assistance was invaluable. I have **submitted** an electronic copy of this response to Rick Fenton, Dee Raisl, and you. if you do not receive the electronic version, or if you have further questions about our response, please feel free to contact me directly at (406) 444-4144 or through the Internet at mdalton@mt.gov.

Sincerely,

Mary E. Dalton, CHIP Coordinator

Enclosure

cc: Richard Fenton - Central Office
Dee Raisl - Region VIII
Spencer Ericson - Region VIII
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7.1

med/qacover

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Response to HCFA Questions and Comments
Montana's Child Health Insurance Plan - Title XXI State Plan
July 7, 1998

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

1. The state has not made clear in all aspects of its application what will occur in phase one and what will occur in phase **two**. Please provide further information on the **two** phases, particularly relating to the outreach strategies in Section 5. It is our understanding that we are approving only Phase **1**. Please confirm our understanding and provide clarification of the two phases.

The state of Montana has submitted a state plan which outlines how we intend to implement our Children's Health Insurance Plan (CHIP) program. In most instances, Montana will be able to apply the same policies and procedures to comply with both the start-up in phase I and the more fully developed program we will implement with legislative approval in phase II. For this reason, the plan does not differentiate between the two "phases" in most sections. The exceptions are: **A)** Section 1 where we describe the overall program; **B)** Section 4.3 where we describe that while the state or its contractor will perform the initial eligibility determinations for the small program we are implementing during phase I, we will be contracting with an eligibility broker to perform this function once the program is fully implemented; and **C)** Section 5.1 where the outreach functions in phase I are not as extensive as the outreach we will perform when we fully implement the program in phase II.

We are asking for approval of the entire state plan, both phase I and phase II. **As** we state in the introduction, we will amend the plan only if the legislature makes extensive changes.

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

Montana assures that it will conduct its CHIP program in compliance with all applicable civil rights requirements.

Section 2. General Background and Description of State Approach to Child Health Coverage

Section 2.1

- 3. Please provide more detailed data as required by Section 2102(a)(1) including income and other relevant factors such as age, race and ethnicity and geographic location.**

Montana has very little data on the insurance status of its children. No studies have been conducted in the state on this issue. The only information available to us is from the US Census Bureau. We cannot independently validate the census estimates. For this reason, we propose to conduct a survey using the Behavioral Risk Factor Surveillance System (BRFSS) to further define our baseline. We are providing these very preliminary estimates at your request. We are unable to present data broken by race, ethnicity, or geographic location.

Category	# of children per Census Information for CY97	# Estimated to be Uninsured for CY97
At 100% FPL		
Age Under 5	13,509	3,148
Age 5-11	18,667	4,349
Age 12-17	14,847	3,459
<u>Age18</u>	<u>3,538</u>	<u>925</u>
Total	50,561	11,881
At 150% FPL		
Age Under 5	21,295	3,769
Age 5-11	31,106	5,505
Age 12-17	24,712	4,373
<u>Age18</u>	<u>5,234</u>	<u>1,039</u>
Total	82,347	14,686
At 200% FPL		
Age Under 5	29,956	4,742
Age 5-11	44,921	7,111
Age 12-17	35,328	5,592
<u>Age18</u>	<u>6,701</u>	<u>1,190</u>
Total	116,906	18,635

All Children		
Age Under 5	55,660	5,598
Age 5-11	90,359	9,614
Age 12-17	86,732	10,176
<u>Age18</u>	<u>12,252</u>	<u>1,612</u>
Total	245,003	27,000

*Data is cumulative for each age group and total.

**Methodology for determining the number of Montana children without health insurance. A 9/97 US Census Bureau document estimates the number of children who are uninsured at 23.3% of those 18 and under below the poverty level. Children on Medicaid are counted as insured. This is a national statistic that does not reflect individual state experiences. Each state has different eligibility requirements that are based on poverty levels. Older children were less likely to have health care coverage than younger children. 13.8% of children under 6, 14.6% of children 6-11, and 16.1% of children 12-17 were estimated to be uninsured.

Further estimates are based on US Census Bureau reports on Low Income Uninsured Children by State. In Montana, the number and percent of children under 19 years of age, at or below 200% of poverty, for 1994, 1995, and 1996 is 120,000 children or 48.1% of the population under 19 years of-age. Those estimated to be without insurance were 19,000 or 7.9% of the population under age 19. This is 15.83% (19,000/120,000) of those at or below 200% of poverty. The Children's Defense Fund estimates the number of children in Montana who are 18 years of age or younger and without health insurance to be 27,000 or 10.7% of the population of that age group.

4. Please provide further information on how the BRFSS will yield the needed information on insurance status. To what extent does Montana plan to revise the BRFSS so that it covers children without telephone coverage? When does the state anticipate the data for baseline be available?

Questions will be added to the Behavioral Risk Factor Surveillance Survey (BRFSS) to determine whether there are children in the family and whether they have creditable insurance coverage. We are examining two options for the baseline survey. We will either add the questions to the existing BRFSS in which case the data will be available by November of 1999 or perform an independent survey to establish baseline data. If we perform an independent survey, we estimate that the baseline data will be available by January 1999. We believe that the baseline will be valid using either method, because of the small number of children (957) that we are planning to enroll in the first phase of the CHIP program. Once we establish the baseline data, we will use additional questions on the BRFSS on an ongoing basis to measure our progress. We

do not intend to revise the BRFSS to include children who do not have a telephone. Approximately 94.4% of Montana households have a telephone. This high rate leads us to believe that no revision is necessary.

5. Please distinguish between the eligibility requirements for the Caring Program and the eligibility requirements for CHIP.

Montana has previously confirmed with HCFA that our Caring Program for Children is not licensed as, nor does it function as, an insurance product in Montana. The Caring Program for Children provides preventive medical, dental, and vision services. It also provides outpatient diagnostic, emergency, accident and surgical services for children up to 185% of poverty. Enrollment in the program is dependant on donations to cover health care.

Section 4. Eligibility Standards and Methodology

Section 4.1.8

6. Montana's proposal indicates that a child will be enrolled for one year, unless the child "moves from the state, is enrolled in Medicaid, is found to have other creditable coverage, or becomes financially ineligible". Section 4.3 states that children "will be guaranteed eligibility for twelve months." As these two statements seem inconsistent, please clarify how changes in income or access to other coverage will affect eligibility. If the State chooses to find children ineligible based on changes during the continuous eligibility period, how will the State require these changes to be reported?

Sections 4.1.8 and 4.3 were not meant to conflict. A child will be enrolled for one full year from the date of enrollment in the CHIP program unless the child moves from the state, is enrolled in Medicaid, is found to have other creditable coverage, or becomes financially ineligible. For the most part, conditions which would cause a child to be terminated from the CHIP program will be self-reported. The application will contain a statement asking families to notify us if any such changes occur. In the case of other creditable insurance coverage, we will also ask insurance companies to report any suspected duplication of coverage as outlined in section 4.4.1.

Section 4.1.9

7. The plan should address eligibility of children who are inmates of public

institutions or patients in institutions for mental disease.

A child who has applied for or been found eligible for the CHIP program prior to becoming a patient in an institution for mental disease (IMD) will be covered by the CHIP program within the individual service limits specified in section 6.2. The stay in the IMD would be covered subject to the aforementioned service limits. However, a child who is a patient in an institution for mental disease who did not apply for the CHIP program prior to admission may not be found eligible for the CHIP program until they are discharged from the IMD.

A child who has applied for or been found eligible for the CHIP program prior to becoming an inmate of a public institution may have all medically necessary care, including medical care rendered in the public institution, covered by the CHIP program. Services are subject to the individual service limits specified in section 6.2. If, however, a child who is an inmate in a public institution did not apply for the CHIP program prior to incarceration, the child cannot be found eligible for CHIP as long as they remain an inmate.

Section 4.3

8. 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 standards 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)**. Please provide additional information on your eligibility screening process in order to determine that the screening will adequately identify all children who are potentially eligible for Medicaid.

Montana does not agree with the HCFA interpretation of section 2102(b)(3). We do not believe that the Title XXI legislation itself requires a full Medicaid screen be performed prior to declaring a child eligible for CHIP. Nonetheless, in the interest of implementing the CHIP program so that we may begin providing health care to Montana's children, we will apply the income disregards in the CHIP program that we apply in the Medicaid

program. These include earned income disregards which take into account the expenditures related to employment and an obligated income disregard which applies to a legally-binding child support obligation. Please note that applying these disregards will increase the length of the CHIP application, require the family to submit more attachments and verifications, and add to the length of time it takes to process an application. Undoubtedly, with this increased requirement, many families will fail to submit all the necessary paperwork on the first try.

9. As required by Section **2102(b)(3)(B)**, the state must ensure that children who are found eligible for Medicaid through the screening process are enrolled in the Medicaid program. The plan states in Section 4.4.1 that a family who is potentially eligible for Medicaid will be offered assistance in completing the application and given a telephone number to call with further questions. Conversely, Section 4.4.2 states that the family will be assisted in completing the application and then the application will be forwarded to the appropriate county Public Assistance Office. Please clarify the steps that the state will take to assist a family in enrolling in the Medicaid program once the family has been identified as potentially eligible for Medicaid.

The CHIP program will screen applicants for Medicaid eligibility. If the family income suggests probable eligibility for Medicaid, the eligibility broker will notify the family in writing that the child cannot be insured by the Children's Health Insurance Plan because the child appears to be eligible for Medicaid. This letter will contain the toll-free number of the eligibility broker which the family may call if they have further questions. The CHIP enrollment form will have a check off box that families may mark if they wish information from the CHIP form to be forwarded to their local County Public Assistance office to be used in the Medicaid application. If the family checks this box, the CHIP information will be forwarded to the appropriate County Public Assistance Office. Whether the family agrees to forward this information or not, families will be given a reminder either by phone or in the mail of the importance of applying for Medicaid. In all instances, children who appear to be Medicaid eligible will only be enrolled in the CHIP program after they have received a denial letter from Medicaid.

10. Please describe the specific activities of the eligibility broker with regard to assisting families during the Medicaid application process. We are concerned that these activities may conflict with the Medicaid requirements that, except where authorized as part of Medicaid's outstationing requirements under 42 CFR 435.904, only State workers can assist the family in completing the applications. Additionally, please clarify who will perform the eligibility broker function; and if the brokers

include health plans, how will the State avoid a conflict of interest?

The eligibility broker will forward information from the CHIP application to the County Public Assistance Office as outlined in the response to question nine. The eligibility broker will also be responsible for reminding the family, either by phone or through the mail, of the importance of applying for Medicaid.

The eligibility broker will be a privately contracted independent entity. Health plans who contract to provide health coverage under CHIP will not be eligible to serve as the enrollment broker. The eligibility broker will determine eligibility for the CHIP program. They will not determine Medicaid eligibility.

Section 5. Outreach and Coordination

Section 5.1

11. The plan indicates that mailings will be sent to families who have left TANF, but does not include families currently on the program. This outreach mechanism may be useful in reaching both Medicaid and CHIP eligible children. Is it the intent of the State to not mail outreach material to families currently on TANF?

Montana does not intend to mail outreach material to families currently on TANF. Because of our 11 15 Welfare Reform Waiver (which is known as FAIM or Families Achieving Independence in Montana), families who are eligible for TANF are automatically also eligible for Medicaid.

Section 7. Quality and Appropriateness of Care

Section 7.1

12. Please provide further information on how the state plans on assuring quality in fee-for-service areas. How will the State monitor quality beyond complaints to the Commissioner of Insurance?

Methods specified in Sections 7.1 and 7.2 apply to both indemnity insurance plans and HMOs.

Section 8. Cost Sharing and Payment

Section 8.2

- 13. It appears that families will pay enrollment fees in excess of the maximum monthly charge that is permissible under section 2103(e)(3). In these cases, please be aware that the family must be given the option to pay the enrollment fees on a monthly basis in payments that do not exceed the monthly maximums outlined in 42 CFR 447.52. Please revise your plan to comply with 2103(e)(3).**

Montana is disappointed that we were unable to reach a mutually acceptable resolution on this issue. We firmly believe that 42 CFR 447.51(c) gives states the authority to establish an annual period of eligibility with a corresponding annual enrollment fee. It has become clear, however, that we are at an impasse on this issue with HCFA.

In lieu of the simplified premium that we first proposed, we will charge families the following annual enrollment fees. These fees were established by extending the table found at 42 CFR 447.52(b) by \$50 increments for gross family income and the premium by \$1 for each \$50 gross income increment. (Example for gross family income of \$1051 to \$1100 the corresponding premium would be \$20 for a family of 1 to 2, \$17 for a family of 3 to 4, and \$16 for a family of 5 or more.) This continued linear projection of the table complies with 42 CFR 447.52(c) which requires states to "impose an appropriately higher charge for each higher level of family income." This linear projection is necessary because the table which is given as an example in the CFR still reflects 1978 figures. The federal poverty level for a family of three in 1998 is \$1137.50 and for a family of five is \$1604.17 but the table stops at \$1000.

<u>Familv Size</u>	<u>Gross Family Income/Month</u>	<u>% of Poverty</u>	<u>Enrollment Fee</u>
1	\$0-671	0-99%	waived
1	\$671-804	100-119%	\$11
1	\$805-891	120-132%	\$15
1	\$892-1006	133-150%	\$16
2	\$0-903	0-99%	waived
2	\$904-1084	100-119%	\$17
2	\$1085-1202	120-132%	\$20
2	\$1203-1356	133-150%	\$23
3	\$0-1137	0-99%	waived
3	\$1138-1364	100-119%	\$18
3	\$1365-1512	120-132%	\$23
3	\$1513-1706	133-150%	\$26
4	\$0-1370	0-99%	waived
4	\$1371-1644	100-119%	\$23

4	\$1 645-1822	120-132%	\$29
4	\$1823-2056	133-150%	\$32
5 or more	\$0-1603	0-99%	waived
5 or more	\$1604-1924	100-119%	\$27
5 or more	\$1925-2133	120-132%	\$33
5 or more	\$2134-2406	133-150%	\$37

14. Please clarify that the **\$3.00** copay is per emergency room visit, rather than **\$3.00** per emergency room service (i.e., an enrollee could receive several services per visit). Section **1916(b)(1)** and **2103(e)(3)** prohibits copays per service for families below 150% of FPL.

Montana will be paying a set amount per child per month for insurance coverage through either indemnity insurance plans or HMOs. This insurance premium payment will be all inclusive. We will therefore charge the \$5 per emergency room visit that is allowed per previous HCFA directives.

15. For children who are not going to be enrolled for the entire benefit year, what mechanism will the State use to ensure that the family will only pay for the portion of the year that the child is enrolled?

Because we are limiting the enrollment fee to the amount that we could charge as a monthly premium, no refund will be made.

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

Section 9.2

- 16.** Please indicate how CHIP will track coordination with Title V and the Mental Health Access programs. What will be the actual performance standard for such coordination?

The state will withdraw this performance goal as we **do** not have a reliable way to track this coordination. We will, however, give information to CHIP participants to inform them that children with special health care needs beyond what is covered by the CHIP program may be eligible for services from either the Title V Children with Special Health Care Needs program or the Mental Health Access program.

Section 9.10

17. Please confirm our understanding that the primary source of the **non-Federal** share of Title **XXI** expenditures will be derived through State general fund appropriation. Also, Section **■** of your plan mentions that private donations will be used to help fund the plan. Please provide information on the sources of these donations. This information is required to assure that the donations meet the specifications of Section **1903(w)** of the Social Security Act.

The state's share of the match is being funded by a combination of a one time intergovernmental transfer from the Commissioner of Insurance and general fund. There are no private donations being used to fund the CHIP program at this time. If any private donations are received, we will ensure that they meet the specifications of Section 1903(w) of the Social Security Act.

18. Please describe in detail the flow of funds with respect to the special revenue from the Insurance Commissioner's Office. Please provide the authority that the State is using to enable the State to use these funds for CHIP. Please include a description of the settlement arrangement between the insurance company and the Insurance Commissioner's Office.

The Insurance Commissioner and Washington National Insurance Company and Pioneer Life Insurance Company, reached an agreement whereby Washington Life agreed to donate \$210,022 to the Insurance Commissioner in settlement of a proposed action against the company. The Insurance Commissioner had charged the company with having a persistent pattern of violating state insurance law. Under the settlement agreement the company did not admit to legal violations. The settlement amount is designated as a private fund amount which falls under the purview of the Insurance Commissioner according to state statute. The agreement between these two parties stipulated that the money was to go to either the CHIP program or to public health clinics in the state serving low income individuals. The Insurance Commissioner chose to make the money available to the CHIP program through an intergovernmental transfer of funds. This was accomplished with an MOU between the Department of Public Health and Human Services and the Insurance Commissioner's office. Washington National Insurance Company and Pioneer Life Insurance Company is not a party in the MOU and will not benefit from this transfer.

19. Under Section **2105(c)(2)(A)**, enhanced federal match for administrative costs is only available for up to **10%** of total program expenditures. The State appears to be spending above the **10%** limit on administration in FY

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1998. Please recalculate costs or provide an assurance that the State will only claim federal match for up to 10% of program costs.

Montana is aware that federal match is only available for administrative costs up to 10% of the total program expenditures. The breakdown you request is found on page 50 in the table titled "Child Health Insurance Plan Summary Budget."

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