

**Indiana's Child Health insurance Program Phase II
Title XXI State Plan Amendment
Questions and Comments**

SECTION 2. GENERAL BACKGROUND AND DESCRIPTION OF STATE APPROACH TO CHILD HEALTH COVERAGE

Section 2.2.1

1. The amendment indicates that Maternal and Child Health (MCH) clinics participate as Hoosier Healthwise enrollment centers. Are the four school-based health clinics funded by the MCH program included as enrollment centers? If so, do enrollment strategies at the school-based health clinics differ from those of other MCH clinics?

Section 2.3

2. The amendment mentions that the Department of Education (DOE) includes a check-off box on its school lunch application to allow families to indicate interest in learning more about the Hoosier Healthwise program. Do all local school districts utilize this approach? How is the DOE information transferred to the Division of Family and Children (DFC)? How quickly does this information get transferred?

SECTION 4. ELIGIBILITY STANDARDS AND METHODOLOGY

Section 4.1.8

3. Section 8.2.1 indicates that eligibility begins on the first day of the month in which the application was submitted, however Section 8.5 indicates that eligibility begins on the first day of the month in which the application was authorized. Is the applicant retroactively eligible for CHIP Phase II from the first day of the month in which the application was submitted to the DFC or the first day of the month in which the application was authorized?

Section 4.1.9

4. The amendment states that the CHIP program is permitted to adjust eligibility requirements based upon available resources. Please clarify how eligibility requirements would change if resources become insufficient.

Section 4.3

5. We issued guidance ("Dear State Health Official" letter of September 10) that clarifies that a Social Security Number (SSN) must be supplied only by applicants for and recipients of Medicaid benefits. In all other cases, including non-applicant parents of children applying for Medicaid and children applying for a separate State CHIP program, States are prohibited from making the provision of an SSN a condition of eligibility. This rule also applies to other members of the household whose

income might be used in making the child's eligibility determination. Please clarify whether the SSN is required or optional on your application.

Section 4.4.4

6. The Department of Health and Human Services issued a policy prohibiting cost sharing for American Indian/Alaska Native (AI/AN) children. Section 2102(b)(3)(D) of the Social Security Act requires the State Plan to include a description of the procedures used to ensure the provision of child health assistance to targeted low-income children of AVAN families. The special access provisions for AI/AN children in Title XXI recognize the unique relationship between the Federal government and the Tribal governments in the delivery of health care services to AVAN children. Because cost sharing poses a unique financial barrier to care for AVAN, States that impose cost sharing on AVAN children are not in compliance with the access provision of section 2102(b)(3)(D). Therefore, we will no longer approve amendments to State plans that would impose cost sharing on AVAN children. Please revise your amendment to comply with this policy.

SECTION 5. OUTREACH AND COORDINATION

7. Are school-based and school-linked clinics part of the CHIP Phase II delivery system? If so, please describe school involvement in outreach and enrollment activities.

Section 5.1

8. Please elaborate on out-station activities. Has the number of out-station sites increased since Phase I was implemented? If so, where have additional out-stations been established?

9. Are there other languages spoken by significant numbers of enrollees in addition to English and Spanish? If so, please describe how outreach will be provided for those populations and for persons who are hearing impaired.

SECTION 7. QUALITY AND APPROPRIATENESS OF CARE

Section 7.1

10. The amendment mentions that the State is contracting with an evaluation consultant who will develop performance criteria. Please describe how this criteria will be applied to the measures in Section 9.

Section 7.2

11. Please describe primary medical provider (PMP) targeted recruitment efforts to ensure that enrollees are able to access services in under-served areas.

SECTION 8. COST SHARING AND PAYMENT

Section 8.2.1

12. The amendment mentions that if a family does not sign/agree to the cost-sharing requirements under CHIP Phase II, the child will be considered only for Medicaid and will not be considered for CHIP Phase I. Since CHIP Phase II are children in families with incomes between 150% and 200% of the Federal Poverty Level (FPL), please explain how these children could then be eligible for Medicaid or CHIP Phase I which serves children in families with incomes below 150% FPL?

13. If the account is held in suspense until the premium is paid, will services rendered during the retroactive period be reimbursed? Or is coverage simply not effective until the first payment is received and the Indiana Client Eligibility System (ICES) changes the status from suspended to enrolled? When does the State's payment to the managed care organization begin?

Section 8.5

14. How will the "shoebox" method of monitoring cost-sharing expenses be communicated to families?

SECTION 9. STRATEGIC OBJECTIVES AND PERFORMANCE GOALS FOR THE PLAN ADMINISTRATION

Section 9.1.3

15. Please describe how consumer satisfaction will be monitored, and specify which consumer satisfaction tool will be used to measure enrollee satisfaction.

Section 9.1.5

16. Per the amendment, performance goals would ensure that at least 60% of two-year-olds enrolled in CHIP Phase II would receive immunizations and that 60% of enrollees would receive recommended preventive care. Does the State have any baseline data for comparison purposes? If so, what are the baseline rates for these performance goals?

Section 9.3.7

17. The State indicated in Section 9.1.5 that it will monitor "recommended preventive services", yet tracking of well child and adolescent well care using HEDIS measures is not checked in Section 9.3.7. If the State is not using the HEDIS measures, how will the State monitor preventive well care visits?

Section 9.10

18. There are errors in the budget for Federal Fiscal Years (FFYs) 2000 and 2001. "Total Program Costs" should equal the sum of "Net Benefit Costs" and "Total Administration Costs." Please recalculate Total Program Costs, then recalculate the Federal and State shares for these two years.

19. Please explain why the Per Member Per Month (PMPM) is expected to decrease from FFY 1999 to FFY 2001.

20. Please explain how "Managed Care" costs were calculated, as $(PMPM * \text{Number of Eligibles} * 12)$ does not equal Managed-Care costs.
21. Please provide budget estimates and cost projections for FFY 2002.

SECTION 2. GENERAL BACKGROUND AND DESCRIPTION OF STATE APPROACH TO CHILD HEALTH COVERAGE

Section 2.2.1

1. The four school-based health clinics are very involved in outreach but, for various reasons, they do not serve as enrollment sites. These reasons include concerns about opening the school to non-students if the clinic were to become an enrollment site and small populations of low-income families. Information regarding the school-based clinics' role in outreach is described in the response to Question 7.

Section 2.3

2. The check-off box has been added to all of the school lunch program application forms. Each school district has entered into a memorandum of agreement with the local Division of Family and Children (DFC) office which addresses the manner in which information about interested families will be transferred to the DFC office. The amount of time it takes for the information to be transferred to the DFC varies, according to the size of the school district. Most school districts communicate such information within thirty to sixty days.

SECTION 4. ELIGIBILITY STANDARDS AND METHODOLOGY

Section 4.1.8

3. Eligibility will begin the first day of the month that the application was received by the enrollment center or the DFC.

Section 4.1.9

4. The CHIP program will monitor CHIP enrollment and keep the Governor's Office, the State Budget Agency and the General Assembly apprised. If enrollment were to be restricted due to insufficient resources, a waiting list for CHIP Phase II applicants would be instituted and children would be enrolled in the program in the order that their application was received. Since children in families with incomes up to 150 percent of federal poverty level (FPL) are enrolled in the Phase I Medicaid expansion, they would not be subject to a waiting list, if such a situation were to **arise**. As such, children in families with lower incomes would be given special protection and preference if a waiting list ever had to be instituted.

Section 4.3

5. Indiana is using the same application for Medicaid and CHIP. However, while Social Security numbers are required for Medicaid, they are not required for the CHIP program. Thus, CHIP eligibility will not be denied if a Social Security number is not included on the application.

Section 4.4.4

6. Targeted low-income children who are American Indians or Alaskan Natives as defined in the Indian Health Care Improvement Act, 25 USC 1603(c), are not subject to any cost-sharing. Indiana will put into place a manual system override procedure to ensure that American Indian and Alaskan Natives do not pay any cost sharing.

SECTION 5. OUTREACH AND COORDINATION

7. The schools, including the school based clinics, play an important role in the Phase II delivery system. School-based clinics are instrumental in distributing brochures and applications, and in making referrals to the Hoosier Healthwise program. Outreach strategies vary depending upon the school corporation. Common outreach practices involving schools include: training school nurses and counselors about family-level outreach, eligibility staff attending school events that parents attend, check off boxes on school lunch applications, and distribution of promotional materials.

Section 5.1

8. Enrollment centers were authorized beginning July of **1998**, when CHIP Phase I was implemented. Since that time, **490** enrollment centers have begun taking Hoosier Healthwise applications. As of September of **1999**, over **17,000** applications have been completed at the new enrollment centers. Enrollment centers include hospitals, health clinics, mental health centers, community action agencies, Head **Start** locations, social services agencies, township trustee offices, and child care providers.
9. Indiana does not have a significant population that speaks any language other than English or Spanish. Issues regarding other languages would be handled locally, should they arise.

SECTION 7: QUALITY AND APPROPRIATENESS OF CARE

Section 7.1

10. The performance measures contained in Section 9 of the Amendment are based upon the measures used for the CHIP Phase I program. They are designed to provide continuity between data collected under the Phase I Medicaid expansion and data collected under the new Phase II program. Additional measures for the Phase II program will also be designed by the evaluation consultant. Since the measures provided in Section 9 of the Amendment provide a valuable tool in bridging the gap between the Phase I and Phase II programs, they will continue to be used even after the measures designed by the evaluation consultant are put into place.

Section 7.2

11. The State has identified fourteen counties that are being targeted for intensified pediatric provider recruitment. In addition to ongoing outreach and education activities, the Family and Social Services Administration will be collaborating with the Indiana State Department of Health to identify barriers to provider enrollment in these particular counties, and to develop possible remedies, such as increasing reimbursement rates or encouraging primary medical providers (PMPs) to increase their panel sizes.

SECTION 8. COST SHARING

Section 8.2.1

12. Children in families with incomes between 150 and 200 percent FPL are not eligible for Title XIX Medicaid or CHIP Phase I. Since the same Hoosier Healthwise application is used for children who apply for Title XIX Medicaid, the Phase I Medicaid expansion, and the Phase II program, a child applies for all three programs at the same time. When a family applies for Hoosier Healthwise, they are asked to agree to fulfill the cost-sharing requirements should it be determined that a child is eligible for CHIP Phase II. Eligibility is first considered under Title XIX, and then under the Title XXI categories. If the child is found ineligible for Medicaid and CHIP Phase I, and the family has indicated on the application form that they are willing to fulfill the Phase II cost-sharing requirements, then the child will be considered for CHIP Phase II. If the family has not agreed to fulfill the cost-sharing requirements, the child will not be considered for Phase II. This is explained in the "Rights and Responsibilities" document that accompanies the application form. If a child is found ineligible for Title XIX and Phase I, and the family did not agree to the Phase II cost-sharing requirements, the denial notice will indicate that the child was not considered for Phase II because the family did not agree to cost-sharing.

13. Once the first premium has been paid, the program will reimburse for services retroactive to the first day of the month that the application form was submitted. Payments to managed care organizations begin after the premium has been paid and the PMP has been selected. Providers will be reimbursed on a fee for service basis until the child has been linked with a PMP.
14. Families will be notified about the “shoe box” method of monitoring cost-sharing expenses through both the “Rights and Responsibilities” document that accompanies the Hoosier Healthwise application and the caseworkers. It is unlikely that a family will reach the threshold amount because premiums constitute less than one percent of gross family income and the program only requires copayments for four services.

SECTION 9. STRATEGIC OBJECTIVES AND PERFORMANCE GOALS FOR PLAN ADMINISTRATION

Section 9.1.3

15. Consumer satisfaction will be measured using the annual Hoosier Healthwise member satisfaction survey. The managed care organizations also conduct their own annual satisfaction surveys of Hoosier Healthwise members enrolled in their networks. Follow-up workplans are developed in response to the results of the surveys.

Section 9.1.5

16. Because baseline data regarding immunizations and preventive care for a population that has yet to receive coverage is not available, baseline data from focus studies conducted on medical records of Hoosier Healthwise members in 1996 will be used to calculate the baseline of two year olds enrolled in Phase II who receive immunizations and enrollees who receive recommended preventive care. According to that data, approximately 55 percent of two year olds enrolled in Hoosier Healthwise receive immunizations, and an average of approximately 28.2 percent of 2 year old enrollees received well child preventive services. These performance measures are intended not only to measure the percent of Phase II children who received such services, but to also to function as methods of comparing data between children in the Phase I and the Phase II programs.

Section 9.3.7

17. Currently, Indiana is using state-designed focus studies to measure the percentage of Hoosier Healthwise enrollees who receive preventive services. These focus studies were designed as measurement tools when HEDIS measures for Medicaid were still in their infancy. HEDIS measures will be used once the State begins to examine medical records of children who enroll in Hoosier Healthwise in calendar year **1999**. This review will begin in year 2000. Since HEDIS measures have evolved in a way that makes them comparable to state-designed studies, the data from the focus studies and the data from the HEDIS measures should be consistent.

Section 9.10

- 18 See response to question 21
19. It was anticipated that during the first year of CHIP Phase I benefit costs would be higher than in subsequent years as a result of pent-up demand and adverse selection. Therefore, the estimated per member per month benefit costs are higher in **FFY 1999** than in subsequent years. Similarly, it is anticipated that benefit costs will be higher during the first year of CHIP Phase II than in subsequent years due to pent-up demand and adverse selection. Thus, benefit costs should decrease during **FFY 2001** and **FFY 2002** as more healthy children enroll.
20. The managed care costs were calculated by multiplying the PMPM x 12 x number of eligibles. The errors that were made in the first budget estimates have been addressed.

21.

	FY 1999	FY 2000	FY 2001	FY 2002
BENEFIT COSTS				
Insurance Payments				
Managed Care	53,434,880	19,292,160	19,118,080	117,702,720
Per member per month @ # of eligibles	146.84 per month @ 36,000 [Phase I)	37.66 per month @ 48,000 36,000 in Phase and 12,000 beginning January 1, 2000)	29.06 per month @ 64,000 36,000 in Phase and 28,000 in Phase II)	129.06 per month @ 76,000 36,000 in Phase and 40,000 in Phase II)
Fee for Service	0	0	0	0
TOTAL BENEFIT COSTS	63,434,880	19,292,160	19,118,080	117,702,720
(Offsetting beneficiary cost sharing payments)	0	1,188,000	1,696,000	5,280,000
Net Benefit costs	64,434,880	78,104,160	35,422,080	112,422,720
ADMINISTRATION COSTS				
Personnel	130,000	385,000	400,000	420,000
General Administration	1,658,000	3,615,000	3,625,000	3,806,250
Contractors/ Brokers (enrollment centers)	600,000	1,385,000	1,285,000	1,349,250

Claims Processing	540,000	1,165,000	365,000	908,250
Outreach/ Marketing Costs	0	100,000	100,000	105,000
Other	0	1,146,000	146,000	153,300
TOTAL ADMIN COSTS	2,928,000	7,796,000	6,421,000	6,742,050
10% Admin Cost Ceiling	0	0	0	0
Federal Share (Multiplied by enhanced- FMAP rate)	48,252,450	62,896,097	74,783,373.64	87,502,690.61
State Share	18,110,430	23,004,063	27,059,706.36	31,662,079.39
TOTAL PROGRAM COSTS	66,362,880	85,900,160	101,843,080	119,164,770

Notes:

1. The estimates for beneficiary cost-sharing payments were based on **an** average of \$11 per month per beneficiary enrolled in CHIP Phase 11. Although the monthly premium amount for one child is either \$11 **or** \$16.50 depending on family income, an average of \$11 was used to calculate the cost-sharing offset because families with more than one child enrolled will **only** be required to pay an annual one-third of the cost for a second child and there will be no additional cost for more than two children.
2. Managed care includes both primary care case management and risk-based managed care. All CHIP beneficiaries will be enrolled in either primary care case management or risk-based managed care. Primary care case management providers are reimbursed on a fee-for service basis.
3. **An** enhanced FMAP rate of 73.43 percent was used to calculate the federal match for FFY 2001 and FFY 2002. This is the preliminary estimate for FFY 2001 provided by HHS.