

November 22,2000

Timothy Westmoreland
Director
Department of Health and Human Services
Health Care Financing Administration
Center for Medicaid and State Operations
Division of Integrated Health Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Vermont State Children's Health Insurance Program

Dear Mr. Westmoreland:

This letter is in regards to our June 16,2000 request for an amendment to our State Children's Health Insurance Program (SCHIP) to allow for an implementation of an increase in premiums to the households of uninsured children with family incomes between 225 and 300 percent of the Federal Poverty Level. Your office's July 25,2000 response raised concerns in certain areas. These concerns and our responses are as follows:

- Section 4.4.4, relating to cost sharing for American Indian/Alaska Native (AI/AN) children. The Department of Health and Human Services has issued a policy prohibiting cost sharing for AI/AN children. Section 2102(b)(3)(D) of the Social Security Act requires that the State plan include a description of the procedures used to ensure the provision of child health assistance to targeted low-income children of AI/AN 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 AI/AN. Because cost sharing poses a unique financial barrier to care for AI/AN, States that impose cost sharing on AI/AN children are not in compliance with the access provisions of Section 2102(b)(3)(D). Please specify how the State plans to identify AI/AN children in order to exempt them from cost sharing.

We will notify individuals upon application that membership in the designated tribes excludes families from cost sharing. This would be premiums, referred to as program fees in Vermont. If the applicants choose to disclose membership to the Department,

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the eligibility worker will record that information in the automated record. When premium-billing files are created, families that are so identified will be excluded.

- Section 8.4.5, relating to the use of cost sharing toward State matching requirements. Section 2105(c)(5) requires that no premiums or cost sharing be used toward State matching requirements. The State indicates in Section 8.4.5 of its revised plan that it will comply with this requirement. However, in the cover letter, the State asks to retain all premiums and program fees collected from SCHIP beneficiaries. Please provide an assurance that premiums will not be used toward State matching requirements.

As this is a requirement of Title XXI, we withdraw the request to retain fees. They will not be used toward State matching requirements.

- Section 9.10, relating to the budget. Section 2107(d) requires that the State plan include a description of the budget for the plan. The higher premium collections in the proposed State plan amendment will modify the budget in the approved State plan. Please submit a revised three-year budget that reflects the anticipated increase in premium collections. A budget template is attached for your use.

A revised three-year budget is attached.

At this stage we anticipate that the effective date of the fee change will be February 1, 2001.

Attached are revisions to Sections 4 and 8 and Appendix 8 of Vermont's State Children's Health Insurance Program.

We trust that this addresses your concerns. If you or your colleagues have any further questions, please contact Ann Rugg, Managed Care Senior Administrator, at annr@path.state.vt.us or 802-241-2766. We appreciate your continued assistance in the management of the Title XXI program in Vermont.

Sincerely,

Eileen I. Elliott
Commissioner

cc: Ronald Preston, Ph.D., Associate Regional Administrator, HCFA
M. Jane Kitchel, Secretary, Vermont Agency of Human Services
Paul Wallace-Brodeur, Director, Office of Vermont Health Access

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Appendix 8 Cost Sharing and Payment

8.2.: Cost Sharing

Nominal cost sharing will be required for SCHIP eligible populations just as it is currently required under the Dr. Dynasaur and Vermont Health Access Plan (VHAP) programs. The State believes that the incomes of these families is sufficient to allow them to pay out-of-pocket for many covered services, so that the added coverage will represent a substantial benefit despite the requirement for supplemental payments. The State further believes that it can reasonably assure that the cost sharing does not favor children from higher income families over lower income families and that costs will not exceed five percent (5%) of any family's income in a given year. Specific cost sharing requirements are as follows:

There are no deductibles or coinsurance for covered services. There are premium-like program fees. The following program fees will apply:

- Families above 225%, up to 300% of the FPL (SCHIP):
 - \$10 per month per household effective 10/1/98.
 - \$20 per month per household effective 1/1/99.
 - \$25 per month per household effective 7/1/99.
 - \$50 per month per household effective 2/1/01.

Non-covered services and services that are not medically necessary do not count towards the family out-of-pocket limit.

8.3.: Public Notification

Program fee payments are related to current Dr. Dynasaur payments but will be increased to reflect the higher income of the SCHIP families. Notification for past and current program fee amounts has been provided under the same public notification requirements used for public policy promulgated under Vermont's Administrative Procedures Act. Information on the specific cost sharing amounts will be included in outreach activities, as described in Appendix 5. Additionally, the State will continue to use the committees established for the VHAP/Medicaid program as sources of feedback and input on this initiative. For more information on these committees see Appendix 9.

8.5.: Annual Aggregate Cost Sharing

Vermont proposes to establish a single annual maximum for all SCHIP households with incomes 225% to 300% of the Federal Poverty Level (FPL). This maximum will be an

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amount that does not exceed 5% of the 225% FPL for a household of two. This assumes that at least one child must be in the household to qualify for Title XXI and that selecting the 225% FPL income level to set the maximum assures that no household in the income bracket will exceed the 5% mark.

The maximum will be compared to the annual program fee cost to assure that program fee cost does not exceed the maximum. This will occur at any time that the FPL is adjusted and/or program fee changes are proposed.

For example, effective February 1, 2001, the maximum is \$1,266 per year based on the 225% FPL for a household of two being \$25,320. The annual program fee cost will be \$600.

Only program fee costs will count towards the family out-of-pocket limit. Non-covered services and services that are not medically necessary will not be considered.

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

- 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 9.**

See Appendix 8 for a summary of cost sharing and payment aspects.

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))

8.2.1. Premiums: *Effective 10/1/98 - \$10 per month per household. Effective 1/1/99- \$20 per month per household. Effective 7/1/99- \$25 per month per household. Effective 2/1/01 - \$50 per month per household.*

8.2.2. Deductibles: _____

8.2.3. Coinsurance: _____

8.2.4. Other: _____

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

8.4. The state assures that it has made the following findings with respect to

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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).
- 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(c)(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))

See Appendix 8.

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

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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:

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Section 4. Eligibility Standards and Methodology. (Section 2102(b))

- 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 5.

A summary of eligibility standards is provided in Appendix 4. In general, existing Vermont methodologies for establishing Medicaid/Dr. Dynasaur/VHAP eligibility and enrolling recipients in managed care will apply to Title XXI. Related Medicaid, Dr. Dynasaur, and VHAP policy and procedures and the procedures and protocols of our benefits counseling and enrollment contractor, Maximus, are available upon request.

- 4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A))

- 4.1.1. Geographic area served by the Plan: _____
- 4.1.2. Age: _____

- 4.1.3. Income: _____

- 4.1.4. Resources (including any standards relating to spend downs and disposition of resources): _____
- 4.1.5. Residency: _____

- 4.1.6. Disability Status (so long as any standard relating to disability status does not restrict eligibility): _____

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- 4.1.7. Access to or coverage under other health coverage:_____
- 4.1.8. Duration of
eligibility:_____
- 4.1.9. Other standards (identify and
describe):_____

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4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B))

- 4.2.1. These standards do not discriminate on the basis of diagnosis.
- 4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3. These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2))

4.4. Describe the procedures that assure:

- 4.4.1. Through intake and followup screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))
- 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))
- 4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))
- 4.4.4. 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). (Section 2102)(b)(3)(D))

Vermont will notify individuals on application that membership in the designated tribes excludes families from cost sharing. If the applicants choose to disclose membership, the information will be included in the automated record. This will exclude the families from billing files.

- 4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))

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Vermont			
Revised SCHIP Budget Plan 11/00			
	Federal Fiscal Year First Year Costs	Federal Fiscal Year Second Year Costs	Federal Fiscal Year Third Year Costs
	2001	2002	2003
Benefit Costs			
Insurance payments		\$ -	\$ -
Managed care			
estimated average monthly enrollment	1,180	1,501	1,598
per member/per month rate	\$ 86.41	\$ 90.53	\$ 94.85
per member/per month rate @ # of eligibles	\$ 1,223,565.60	\$ 1,630,626.36	\$ 1,818,843.60
Fee for Service			
estimated average monthly enrollment	1,063	1,132	1,205
per member/per month rate	\$ 63.12	\$ 66.64	\$ 70.36
per member/per month rate @ # of eligibles	\$ 805,158.72	\$ 905,237.76	\$ 1,017,405.60
Total Benefit Costs	\$ 2,028,724.32	\$ 2,535,864.12	\$ 2,836,249.20
(Offsetting beneficiary cost sharing payments)*	\$ 29,473.02	\$ 51,896.43	\$ 55,247.13
Net Benefit Costs	\$ 1,999,251.30	\$ 2,483,967.69	\$ 2,781,002.07
Administration Costs			
Personnel	\$ 50,873.76	\$ 52,399.97	\$ 53,971.97
General administration	\$ 10,411.24	\$ 10,723.58	\$ 11,045.28
Contractors/Brokers (e.g., enrollment contractors)	\$ -	\$ -	\$ -
Claims Processing	\$ 104,779.84	\$ 107,923.24	\$ 111,160.93
Outreach/marketing costs	\$ -	\$ -	\$ -
Other	\$ 25,873.60	\$ 26,649.81	\$ 27,449.30
Total Administration Costs	\$ 191,938.44	\$ 197,696.59	\$ 203,627.49
10% Administrative Cost Ceiling	\$ 222,139.03	\$ 275,996.41	\$ 309,000.23
State Share	\$ 526,202.94	\$ 642,354.04	\$ 719,167.14
TOTAL PROGRAM COSTS	\$ 2,191,189.74	\$ 2,681,664.28	\$ 2,984,629.56
* Assumes 8 months of payments (Feb.-Sep.) in FFY01			