

8-23-98

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



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STATE OF MONTANA

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HELENA, MONTANA 59620-2951

August 26, 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:

Attached is further clarification of Montana's response to the questions raised by the Health Care Financing Administration which we received on July 29, 1998. These questions and our response further clarify the Title XXI state plan which Montana originally submitted on April 10, 1998.

I have submitted an electronic copy of this response to Rick Fenton, Dee Raisl, and you. Yesterday, I faxed a copy of the attachment (the agreement between the Insurance Commissioner and Conseo) to the 8/18/98 letter. If you do not receive the FAX, 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
Nancy Ellery
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Further Clarification of Response to HCFA Questions and Comments
Montana's Title XXI State Plan
August 26, 1998

Section 4.3

1. Section 4.3, the enrollment process. Please provide further details on the time frame for forwarding the CHIP application to the County Public Assistance Office. (A paraphrase of verbal questions asked by Diona Kristian, HCFA Central Office, and Dee Raisl, HCFA Region VII CHIP Coordinator, during a phone conference 8/25/98 with Mary Dalton, Montana CHIP Coordinator.)

CHIP eligibility will be determined within five working days of receipt of a complete application. On the 5th working day, the family will be notified that they are eligible or ineligible for the CHIP program. As described in the 8/18/98 state response, if families who appear to be Medicaid eligible give us permission to forward the information on the CHIP application, we will enter the demographic information on the first page of our regular Medicaid application and forward it to the appropriate county office. This will occur on the 5th working day as well.

Section 8.2

2. Section 8.2, the enrollment fee. Please provide further clarification of your 8/18/98 response at item (D) under co-payment. How will families be notified when they reach the \$200 co-payment cap? If a family pays more than the \$200 co-payment cap, how will they be reimbursed for amounts paid in excess of \$200? How will families be notified of their right to receive recoupment of any co-payment made in excess of the \$200 cap? (A paraphrase of verbal questions asked by Diona Kristian, HCFA Central Office, and Dee Raisl, HCFA Region VII CHIP Coordinator, during a phone conference 8/25/98 with Mary Dalton, Montana CHIP Coordinator.)

Families will receive an explanation of benefits each time a claim is paid on their behalf from their insurance carrier. Among other things, the amount of co-payment paid year

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to date will appear on this explanation. When the total \$200 co-payment amount has been reached, the explanation of benefit will indicate that the family has met their obligation. This explanation of benefits can then be used by the family to show any subsequent medical providers that they are no longer subject to co-payment.

In the event that a family is charged more than the \$200 co-payment cap, the family will be required to track and submit to the state documented receipts of the co-payment amounts that they have paid. The state will reimburse them for the amount equal to their excess payment.

Families will be notified of how they can recoup any excess co-payment that they have paid through the CHIP outreach and educational material.

Families with income less than 100% of poverty will be sent a letter at the time of eligibility determination from the state (phase I) or its eligibility broker (phase II) stating that they are exempt from co-payment requirements. This information will be transmitted to the insurance carriers who will reflect that the family has no co-payment obligation on the explanation of benefits statements as well.

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