



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
Family and Children's Health Programs Group
Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244-1850

January 9, 1998

Douglas Porter
Deputy Director
Department of Health Services
714 P Street, Room 1640
Sacramento, California 95814

Dear Mr. Porter:

Thank you for your proposal, dated November 18, 1997, for a State Children's Health Insurance Program under Title XXI of the Social Security Act. Your commitment to providing health care coverage to uninsured children is evident in your proposal. As you are aware, your proposal has been undergoing review by the Department of Health and Human Services. In order to proceed with our review; however, additional information will be required. The enclosure explains more fully the areas that require additional information and clarification. From that listing, our major concerns relate to the following areas:

1. Section 3.1, regarding the insurance purchasing credit mechanism. We will need further explanation of this mechanism in light of our comments in the enclosure.
2. Section 4.1, regarding the continuous eligibility the plan proposes giving children whose family income increases beyond the Medi-Cal limit.
3. Section 4.3, regarding the application assistance fee.
4. Section 4.4, regarding the measures that you are taking to avoid crowd-out.
5. Section 8.2, regarding plan premiums and copayments. We would like assurances that premiums and copayments will be within the Title XXI allowable limits.
6. Section 9.10, regarding the budget for this program. We would like further clarification of the administrative costs, which exceed the 10 percent limit established by the legislation for Title XXI.

Under Section 2106(c) of the Social Security Act, HCFA must either approve, disapprove, or request additional information on a proposed Title XXI State Plan within ninety days. This

letter constitutes our notification that specified additional information is needed in order to fully assess your plan. The 90-day review period has been stopped by this request and will resume as soon as a substantive response to all of the enclosed questions is received. The members of the review team would be happy to answer any questions you may have in regard to this letter and to assist your staff in formulating a response. Please send your response, either on disk or electronically, as well as in hard copy to Kathleen Farrell, project officer for California's Title XXI proposal, with a copy to Richard Chambers, Associate Administrator for the HCFA Region IX Division of Medicaid. Ms. Farrell's Internet address is Kfarrell@HCFA.GOV. Her mailing address is:

Division of Integrated Health Systems
Health Care Financing Administration
Mail Stop C3-20-07
7500 Security Boulevard
Baltimore, Maryland 21244-1850

We appreciate the efforts of your staff and share your goal of providing health care to low income, uninsured children through Title XXI. If you have questions or concerns regarding the matters raised in this letter, your staff may contact either Ms. Farrell at (410) 786-1236 or Mr. Chambers at (415) 744-3568. They will provide or arrange for any technical assistance you may require in preparing your response. Your cooperation is greatly appreciated.

Sincerely,

Richard Fenton
Deputy Director
Family and Children's Health Program Group
Center for Medicaid and State Operations

Enclosure

cc: San Francisco Regional Office

ENCLOSURE

CALIFORNIA TITLE XXI PLAN REQUEST FOR ADDITIONAL INFORMATION

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

Section 2.3

1. Please clarify the interaction and coordination between MRMIB and the Department of Health Services in administering, monitoring, and evaluating the programs within this plan.
2. The plan notes that enrollment in the AIM program is limited to women who are not on Medical or who do not have employer-sponsored coverage, “unless such coverage has such high deductibles that MRMIB views the coverage as being tantamount to being uninsured.” Please clarify whether this is applicable to children who would be covered through their mother’s employer, since this policy would appear to allow substitution of coverage, which is not allowable under Title XXI. Are children in the AIM program offered the same set of services as children in the other insurance programs?

Section 3. General Contents of the State Child Health Plan

Section 3.1

3. This plan includes a purchasing credit mechanism that provides families with funds to purchase dependent coverage through their employer for families who have reasonably priced employer-sponsored coverage for uninsured dependents but have been unable to finance the employee share. Further explanation of this mechanism is needed. Please address the following areas:
 - Will employers apply for inclusion of their health plan for participation in **the** purchasing credit program? How will MRMIB evaluate the actuarial equivalency of each of these benefit plans?
 - e The plan states that the program will provide supplemental coverage for families using the purchasing credit if their employer-based coverage is not **95** percent actuarially equivalent to coverage offered through the purchasing pool. Clarification is requested since this appears to not be in compliance with the Title XXI requirement that the coverage has an aggregate actuarial value that is at least equivalent to one of the benchmark benefit packages. How will the supplemental coverage be administered and coordinated?
 - e Please provide additional detail regarding the availability of supplemental coverage, since this suggests that children who already have some coverage can get better coverage through CHIP. The legislation does not allow the enrollment of children in Title XXI if they already have “creditable health coverage” through a group health plan or under health insurance coverage as defined in the Public Health Service Act.
 - e What is the definition of reasonably priced?
 - Do the parents have to buy insurance for themselves separately? Is there an algorithm to determine what percentage of the total family premium is for the children’s coverage?
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- Will employers' health plans be required to change their cost sharing provisions if they are not in compliance with Title XXI?
- How will third party liability be addressed?
- How will these plans be monitored?

Section 4. Eligibility Standards and Methodology

Section 4.1.8

4. The plan proposes giving children whose family income increases beyond the Medicaid limit, one month of continued eligibility under Medi-Cal and includes this in its proposed State Plan Amendment. Clarification is requested, since the continuous eligibility provision added by the BBA applies to a determination of eligibility and not ineligibility. Therefore, under the statute, continuous eligibility would **only** be available from the time of the initial determination for up to one year and not as an add-on when someone is no longer eligible.

Section 4.3

5. The plan provides that certain agencies and providers will receive a \$50 application assistance fee for assisting a family with their successful application. This \$50 application assistance fee is currently being utilized by the AIM program. Clarification is requested as to the assumptions that were used in developing this fee. How will MRMIB assure that duplicate payments are not made? Clarification is also requested regarding how the state will address the potential for conflict of interest.
6. Managed care organizations will be allowed to compete for the administrative vendor contract. The administrative vendor will conduct eligibility determinations, premium collection, payment of the assistance fee and other enrollment functions. How does the State plan on avoiding a potential conflict of interest in awarding this contract?
7. How does the State propose to make sure that if a Medicaid determination for eligibility is needed that the Medicaid State Agency makes the final determination.

Section 4.4.1

8. Clarification of the Medicaid eligibility screening process is requested. How will the State determine the specific income disregards that will be used in determining eligibility under the Healthy Families program? What assurances can the State provide that children determined eligible for Healthy Families are not eligible for Title XIX due to differences in income disregards or a different budget period for evaluating income?
9. In the Medi-Cal program, a resource disregard is being implemented. How will the State assure that the enhanced match will only be made available for children who are newly eligible because of the elimination of the resource test?

Section 4.4.3

10. ⁸ The plan indicates children will be ineligible if they have been insured within the prior three months. Although the plan notes that the State's enabling statute makes it an unfair labor practice for an employer to change coverage or change the employee share of cost for coverage to get employees to enroll in the program, how will the State avoid employees dropping their current coverage to enroll their children in CHIP? The State should also be aware that the Department of Health and Human Services is considering establishing a policy in regard to crowd out provisions and that the State would be required to comply should such policy be adopted.
11. An exception to the three month time limitation prohibiting coverage of children who have had employer-sponsored coverage is the discontinuation of health benefits to all employees by the applicant's employer. Please discuss how this exception is consistent with the State's efforts to discourage crowd-out.

Section 5. Outreach and Coordination

Section 5.1

12. What procedures will the State use in determining what languages will be designated as threshold languages? Will language thresholds be applied statewide or county wide? As Title VI of the Civil Rights Act of 1964 requires the state to provide all patients of limited English proficiency an equal opportunity to benefit from provided services, how will the State ensure that persons of limited English proficiency who are not fluent in one of the ten designated languages will receive understandable materials so that they may equally benefit from the services being provided?

Section 7. Quality and Appropriateness of Care

13. How will MRMIB identify specific quality assurance measures to include in its contracts that are appropriate for the Healthy Families target population? Please clarify how quality standards for AIM and the purchasing credit program will be implemented and monitored, since this is not addressed in the plan. Clarification is also requested regarding the quality assurance measures to be used for those services, such as mental health services (page 44) that are not under MRMIB's purview.
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Section 8. Cost Sharing and Payment.

Section 8.2.1

14. The plan provides a purchasing pool for premiums in which families selecting plans that are not designated as Family Value Packages (FVPs) will be responsible for paying the cost differential in addition to the baseline premiums. How will the State assure that premium fees for these plans will be within the Title XXI allowable limits?

Section 8.2

15. Some copayments for individual services exceed the current limits that are allowable under Title XXI for families with incomes below 150 percent of the FPL. Please clarify how the State will address this.
16. The plan notes that the amount of copayments a family will pay in a given year is limited to \$250. This limit however does not appear to be applicable for dental coverage. Please explain whether these copayments are applied to the \$250 limit and whether these copays apply only to families above 150 percent of the FPL. If the dental component functions outside of the health plan, (i.e., the dental program may be a dental HMO contracting directly with the state and not part of the managed care organization providing the health care services), how will the State advise the two entities that the maximum cost sharing has been reached by the family so the patient is not charged additional copays beyond the amount permitted? How will MRMIB monitor that the \$250 ceiling has been reached for all services? How will a family recoup monies should they accidentally be charged a copayment that puts them over the ceiling?

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

Section 9.10

17. Additional information is needed in order to understand how the budget was constructed. Please provide details and the underlying assumptions used in developing the State's budget.
 18. Proposed administrative costs for Federal fiscal year 1998 are significantly higher than the 10 percent limit established by the legislation for Title XXI. The method used by the State to determine its percentage of administrative costs to total program costs is not consistent with the instructions. Rather than dividing total program costs by a factor of 0.10 to determine the 10 percent limitation for administrative costs, the State combined both budgeted benefit and administrative costs and then divided administrative costs into the total to determine its administrative cost percentage. As a result, the current budget figures substantially understate the actual administrative cost percentage to total benefit costs. Additionally, two of the line items included in the budget as benefit costs appear to be administrative costs. These two items are: (i) payments to enrollment contractors and (ii) payments for application assistance fees. If these two items are, in fact, administrative costs, the 10 percent administrative cost limit would be exceeded in each of the three program years.
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19. Clarification is also needed on how the State will be allocating administrative costs between Title XXI and Title XIX activities. In addition, further detail is requested on how will MRMIB allocate operating costs between its Title XXI activities and those of its three existing programs.