

Family and Children's Health Programs Group, Center for Medicaid and State Operations

Mr. Chad Westover
Administrator
Children's Health Insurance Program
Utah Department of Health
P.O. Box 144102
Salt Lake City, UT 84114-4102

Dear Mr. Westover,

Thank you for your State Children's Health Insurance Program (SCHIP) state plan amendment submitted on November 14, 2002. 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, we find it necessary to seek further information. Our major concerns relate to the following areas.

- Section 4.4.1, related to the State's screening procedures used at intake and follow-up eligibility determination. Please describe the procedures used to assure that children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (*including access to a state health benefits plan*) are furnished child health assistance under the State child health plan.
- Section 9.10, related to the State's one-year projected budget. The state plan must include a projected budget that includes the information required by 42 CFR 457.140. Please revise the budget accordingly.
- Section 12, related to applicant and enrollee protections. Section 42 CFR 457.1120 requires that the state plan include a description of the State's review process. Please provide a description of the review processes for eligibility and enrollment matters and for health services matters.

The enclosure more fully explains this and other areas of the proposal that require additional information and clarification. CMS may have further questions in addition to the information requested at this time.

Under section 2106(c) of the Act, CMS must approve, disapprove, or request additional information on a proposed title XXI State plan amendment within 90 days. This constitutes our

notification that specified additional information is needed in order to assess fully the concerns raised in this letter. The 90-day review period has been stopped by this request and will resume as soon as the State's response to this request for additional information is received. The members of the Review Team will 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 Meredith Robertson, project officer for the Utah title XXI proposal, with a copy to CMS Region VIII Office. Meredith's Internet address is mrobertson@cms.hhs.gov. Her mailing address is:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
Division of State Children's Health Insurance
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 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 Meredith Robertson at (410) 786-6543 or Karen Shields, CMS Region VIII, at (303) 844-7082. They will provide or arrange for any technical assistance you may require in preparing your response. Your cooperation is greatly appreciated.

Sincerely,

Richard Chambers
Director

Enclosure

cc: CMS Region VII DMSO

ENCLOSURE

Please provide clarification to the following sections:

1. Section 2.2.2

Please describe the current status of the Caring Program.

2. Section 3.1

- a. Please clarify what managed care organizations are currently under contract with the DHCF.
- b. Does the State continue to require the provision of professional interpreters at no cost to clients, as indicated in the State's responses dated May 21, 1998? How does the State currently provide clients information on interpreters?
- c. Please provide additional details on the "10% set aside funds" and nontraditional services for American Indian children discussed in this section, or incorporate the State's responses dated May 21, 1998.

3. Sections 4.1.2 & 4.1.8

Please assure that the discontinuation of coverage on the last day of the month in which the child's 19th birthday occurs only applies to children in managed care. Also, please clarify that for children in fee-for-service, eligibility ends on the day after their 19th birthday.

4. Section 4.1.5

Please move the discussion of coverage for qualified aliens to section 4.1.9. Please clarify that a qualified alien, as defined in Public Law 104-193 as amended, who has been in the United States in a qualified alien status for at least five years or is not subject to the five-year bar set forth in section 403 of Public Law 104-193, is eligible for SCHIP.

5. Section 4.1.7 & 4.3

Please clarify that children within group health plans or who have health insurance coverage are not eligible for SCHIP regardless of the amount of the employer's contribution.

6. Section 4.1.9

Please specify whether the State requires a social security number for any applicant in accordance with the provisions at 42 CFR 457.340(b).

7. Section 4.4.1

Please describe the screening procedures used at intake and follow-up eligibility determination, including any *periodic redetermination* that assure that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (*including access to a state health benefits plan*) are furnished child health assistance under the State child health plan. (Sections

2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR §457.310(b) (42 CFR §457.350(a)(1)) and §457.80(c)(3)).

8. Section 8.7

Please provide a description of the consequences for an enrollee or applicant who does not pay a charge.

9. Section 9.10

Please provide a revised budget for FY 2003 to reflect changes included in this state plan amendment.

In addition to providing the clarification requested above, please provide responses to the following sections:

10. Section 4.4.3

Please describe the procedures that assure that the State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid.

11. Section 4.4.4.1

Please describe the methods that the State uses to monitor substitution of SCHIP coverage for private group health coverage, consistent with 42 CFR §457.805.

12. Section 4.4.5

Please describe the procedures that the State uses to assure that child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native.

13. Sections 7.2.1

Please describe the methods used, including monitoring, to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, well-adolescent care and childhood and immunizations under the plan.

14. Section 7.2.2

Please describe the methods used to assure access to emergency services.

15. Section 7.2.3

Please describe the methods used to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition.

16. Section 7.2.4

Please describe the methods used to assure that decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services.

17. Section 8.6

Please describe the procedures the State uses to ensure American Indian and Alaska Native children will be excluded from cost sharing.

18. Section 9.9.1

Please provide additional information on steps the State is taking to interact with Indian tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 125.

19. Section 10.1

Please provide assurance that the State will assess the progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of assessment.

20. Section 11.1

Please provide assurance that the services provided by the State are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound.

21. Section 11.2

Please provide assurance that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply under Title XIX: 42 CFR Part 455 Subpart B; Section 1124; Section 1126; Section 1128A; Section 1128B; and Section 1128E.

22. Section 12.1

- a. Please assure that applicants and enrollees have the opportunity for review of the following eligibility or enrollment matters in 42 CFR 457.1130(a): 1) denial of eligibility; 2) failure to make a timely determination of eligibility; and 3) suspension or termination of enrollment, including disenrollment for failure to pay cost sharing.

We note that if you are using the Medicaid fair hearing process, the State will comply with 42 CFR 457.1130(a) and will only need to respond that the Medicaid fair hearing process is used. If the Medicaid fair hearing process is used, the remaining questions pertaining to eligibility or enrollment matters are not applicable and the State does not need to respond to the questions.

- b. Please describe how reviews of eligibility or enrollment matters are conducted in an impartial manner, consistent with 457.1150(a).
- c. Please describe how the State completes reviews of eligibility or enrollment matters in a reasonable amount of time, consistent with 42 CFR 457.1160(a). Please also describe how the State considers the need for expedited review when there is an immediate need for health services.
- d. Please describe how the State provides enrollees with an opportunity for continuation of enrollment, consistent with 42 CFR 457.1170.

- e. Please describe how the State provides applicants and enrollee with timely written notice of determinations related to eligibility or enrollment matters and describe whether the information contained within such notice is consistent with 42 CFR 457.1180.
- f. Please clarify that review decisions are written, consistent with 457.1140(c).
- g. Please describe how the State ensures that applicants and enrollees are guaranteed the rights set forth in 457.1140(d)(1)(2) and (3) during the review process.

23. Section 12.2

- a. Please clarify for reviews of health services matters whether the State is using a Program Specific Review as described in 42 CFR 457.1120(a)(1) or a Statewide Standard Review as described in 42 CFR 457.1120(a)(2).
- b. If the State is using a Program Specific Review, please describe the review process for health services matters and that it complies with 42 CFR 457.1120. Please include in the description the specific details about the review process to demonstrate compliance with 42 CFR 457.1130(b), 457.1140(c) and (d), 457.1150(b), 457.1160(b), and 457.1180. We note that if you are using the Medicaid fair hearing process, the State will comply with 42 CFR 457.1120 and will only need to respond that the Medicaid fair hearing process is used.
- c. If the State is using a Statewide Standard Review, please assure that the health services matters subject to review under the state health insurance law are consistent with the intent of 42 CFR 457.1130(b).
- d. For enrollees in employer-sponsored insurance plans, please assure that the health services matters subject to review under the state health insurance law are consistent with the intent of 42 CFR 457.1130(b). Please also provide the statutory reference for the state health insurance law. If the matters subject to review under the state health insurance law are not consistent with the intent of 42 CFR 457.1130(b), please describe how the State assures that applicants and enrollees have the option to obtain health benefits coverage other than through that group health plan at initial enrollment and at each redetermination of eligibility.