Date: _____

FAX

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

To: Devorah
Fax:

From: Cindy

Number of Pages (excluding cover):

Subject:

Voice Numbers:

Health Division (Front Office)	202/395-4922
Health & Human Services Unit	202/395-4925
Health Programs & Services Branch	202/395-4926
Health Financing Branch	202/395-4930

Fax Numbers:

Health Division (Front Office)	202/395-3910
Health Division (Room 7001)	202/395-7840
Health Division (Room 7002)	202/395-5648

From: Clarke Cagey
To: AWedgeworth, MFlore, TSachs, DGreenberg, TPratt, B...
Date: 5/25/99 12:16pm
Subject: Call with Ray Hanley at 2:00 Thursday 5/27

Hello everyone. As many of you know, last week we faxed to the State of Arkansas a list of interim criteria to be used when States seek approval of 1915(b) waivers that mandatorily enroll special needs children. The most current version of the interim criteria is attached. There will doubtlessly be further refinements to the document, but this is what we will be using in the case of Arkansas, where timing of the second 90-day clock forced us to get the information to Ray last week.

At that time, Ray was promised that we would provide assistance with any questions he may have regarding the criteria. We have scheduled a time on Thursday at 2:00. There are five lines available – dial (410) 786-3100. Access code is 103035. For Baltimore-based people, pls. gather in Anne Wedgeworth's office.

Thanks very much.
Clarke
(410) 786-7700

FAX COVER SHEET

TO: Lillian Lyons

FAX NUMBER: 202-395-5648

FROM:

MARGARET CANO, ACCOUNTANT

DIVISION OF MEDICAID & STATE OPERATIONS

REGION VI DALLAS, TEXAS

TELEPHONE: (214) 767-6394

FAX: (214) 767-0322

DATE: 5/25/99 ~~04/20/99~~

THIS FAX CONTAINS 7 **PAGES**
(INCLUDING THE COVER PAGE)

Arkansas Department of Human Services

Division of Medical Services

Donaghey Plaza South
P.O. Box 1437
Little Rock, Arkansas 72203-1437
Telephone (501) 682-8292 TDD (501) 682-8789 FAX (501) 682-1197

MEMORANDUM

May 21, 1999

To: Sally Richardson, Director, HCFA Center for Medicaid and State Operations

From: Ray Hanley, Director, Division of Medical Services, Arkansas DHS

Re: Mental Health Waiver

Sally, per conversations with you, Trish, and Mike Fiore, I am sending the correspondence advising you we are, under protest, requesting that you "stop the clock" on the waiver application for which the second 90 period otherwise expires this weekend.

As discussed HCFA lacks the authority to stop the clock as this is the second 90 day period and your choices are otherwise to deny the application or to approve it. As you are aware we were given verbal approval by HCFA central office staff some three weeks ago on this waiver and were merely awaiting the promised letter of confirmation.

HCFA decided this week to decline approval based on the fact that we failed to address all questions, ie related to "special needs" children. As we all know, we did indeed answer all questions posed some 90 days ago. The questions not answered, pertaining to "special needs" were only raised yesterday. These questions deal with provisions that HCFA has been aware of since the passage of the BBA almost two years ago. It is a breach of good faith to have raised these only this week in voiding the verbal approval previously given.

All that said for the record, I respect the fact you are following orders and it is in the best interest of all to do whatever it takes to get this waiver approved and the enhanced services in place. We are having the criteria Mike faxed me reviewed by Options, our contractor. Hopefully we will be able to secure the delayed approval next week based on our response to this late issue.

Arkansas Department of Human Services

Division of Medical Services

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Little Rock, Arkansas 72203-1437
Telephone (501) 682-8292 TDD (501) 682-6789 FAX (501) 682-1197

May 21, 1999

Wayne Smith, Director
Division of Integrated Health Systems
Disabled and Elderly Health Programs Group
Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, Maryland 21244-1850

SUBJ: Benefit Arkansas - 1915 (b) Waiver Request

Dear Mr. Smith:

The purpose of this letter is to request withdrawal of the State's letters dated February 11, 1999, February 25, 1999 and March 31, 1999 responding to your August 6, 1998 letter requesting additional/clarifying information on Arkansas' mental health waiver request entitled, "Benefit Arkansas: The Behavioral Health Care Program of the Arkansas Department of Human Services".

Arkansas will be resubmitting the additional/clarifying information to HCFA.

Attached to this letter is a memorandum to Sally Richardson regarding this waiver.

Thank you for your assistance in this matter. If you have any questions, please contact me at (501) 682-8292 or Teresa Hursey at (501) 682-1473.

Sincerely,

Ray Hanley
Director

Attachment - Memorandum to Sally Richardson

cc: Andrew R. Perez, Associate Regional Administrator, Regional Office VI
John Selig, Director, Arkansas Division of Mental Health Services
Teresa Hursey, Assistant Director, Arkansas Division of Medical Services
Anne Wells, Assistant Director, Arkansas Division of Mental Health Services

Interim Review Criteria for Children with Special Needs
May 21, 1999

When addressing these criteria, please provide the following information by each appropriate subset of children with special needs:

- The State's responsibilities in managed care programs enrolling children with special needs.
- The State's requirements for MCOs/PHPs enrolling children with special health care needs.
- How the State monitors its own actions and that of its contracting MCOs and PHPs.
- For foster-care children only, the provisions which address the broader, unique issues occurring because of out-of-home, out-of-geographic area placement.

State Responsibilities for Managed Care Programs Enrolling Children with Special Needs

- **Definition of Children with Special Needs**

  The State has a definition of children with special needs that includes at least these five subsets :

  1. Blind/Disabled Children and Related Populations (eligible for SSI under title XVI);
  2. Eligible under section 1902(e)(3) of the Social Security Act;
  3. In foster care or other out-of-home placement;
  4. Receiving foster care or adoption assistance; or
  5. Receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, as is defined by the State in terms of either program participant or special health care needs.

- **Identification**

  – The State identifies and/or requires MCOs/PHPs to identify children with special needs. The State collects, or requires MCOs/PHPs to collect specific data on children with special needs. The State explains the processes it has for identifying each of the special needs groups described above.

- **Enrollment/Disenrollment**

The State performs functions in the enrollment/disenrollment process for children with special needs, including:

-- Outreach activities to reach potential children with special needs and their families, providers, and other interested parties regarding the managed care program.

-- Enrollment selection counselors have information and training to assist special populations and children with special health care needs in selecting appropriate MCO/PHPs and providers based on their medical needs.

-- Auto-assignment process assigns children with special health care needs to an MCO/PHP that includes their current provider or to an MCO/PHP that is capable of serving their particular needs.

-- A child with special needs can disenroll and re-enroll in another MCO/PHP for good cause.

-- If an MCO/PHP requests to disenroll or transfer enrollment of an enrollee to another plan, the reasons for reassignment are not discriminatory in any way -- including adverse change in an enrollee's health status and non-compliant behavior for individuals with mental health and substance abuse diagnoses -- against the enrollee.

- **Provider Capacity**

-- The State ensures that the MCOs/PHPs in a geographic area have sufficient experienced providers to serve the enrolled children with special needs (e.g., providers experienced in serving foster care children, children with mental health care needs, children with HIV/AIDS, etc.).

-- The State monitors experienced providers capacity.

- **Specialists**

-- The State has set capacity standards for specialists.

-- The State monitors access to specialists.

-- The State has provisions in MCOs'/PHPs' contracts which allow children with special needs who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as PCPs or be allowed direct access to specialists for the needed care.

-- The State requires particular specialist types to be included in the MCO/PHP network. If specialists types are not involved in the MCO/PHP network, arrangements are made for enrollees to access these services (for waiver covered services only).

- **Coordination**

-- The State requires an assessment of each child's needs and implementation of a treatment plan based on that assessment.

-- The State has required the MCOs/PHPs to provide case management services to children with special needs.

-- The State has developed and implemented a process to collaborate and coordinate with agencies and advocates which serve special needs children and their families.

-- The State has a process for coordination with other systems of care (for example, Medicare, HRSA Title V grants, Ryan White CARE Act, SAMHSA Mental Health and Substance Abuse Block Grant Funds) or State/local funding sources.

-- The State requires the MCO/PHP to coordinate health care services for special needs children with: providers of mental health, substance abuse, local health department, transportation, home and community based waiver, developmental disabilities, and Title V services.

- **Quality of Care**

-- The State has some specific performance measures for children with special needs (for example, CAHPS for children with special needs, HEDIS measures stratified by special needs children, etc.).

-- The State has specific performance improvement projects that address issues for children with special health care needs.

- **BBA Safeguards**

-- To the extent appropriate, the State has adequately addressed Balanced Budget Act (BBA) guidance that HCFA has issued to date.

- **Payment Methodology**

-- The State develops a payment methodology that accounts for special needs populations enrolled in capitated managed care.

- **Plan Monitoring**

  -- The State has in place a process for monitoring children with special needs enrolled in MCOs/PHPs for access to services, quality of care, coordination of care, and enrollee satisfaction.

  -- The State has standards or efforts in place regarding MCOs'/PHPs' compliance with ADA access requirements for enrollees with physical disabilities.

  -- The State defines medical necessity for MCOs/PHPs and the State monitors the MCOs/PHPs to assure that it is applied by the MCOs/PHPs in their service authorizations.

DRAFT -- DRAFT -- DRAFT
Policy Regarding the Children of State Employees and CHIP

Issue

- The State of Kentucky wants to ensure that the children of their low-income state employees are eligible for the Children's Health Insurance Program (CHIP). The Department of Health and Human Services (HHS) had previously informed the State that this is not possible under current policy. However, HHS has reconsidered this policy and has now developed a different approach.

Previous Policy

- Under Section 2110(b)(2)(B), a child "eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State" is excluded from participation in the CHIP program.

- HHS has previously interpreted "eligible for health benefits coverage under a State health benefits plan" to include only situations in which the State or public employer makes available a subsidy to cover part or all of the cost of coverage for a dependent child in the family. A subsidy is present when the State contribution for health benefits coverage could exceed the minimum amount necessary for coverage of the employee alone and when that subsidy is available to pay part or all of the cost of health benefits coverage for the family.

- For many counties in Kentucky, there is at least some subsidy available for families that can be used to pay the cost for family health benefits coverage under the State's HMO Option B. Under the previous policy, these children would not be eligible for CHIP. The subsidy may, in some counties, be low. Previously, the size of the subsidy did not matter; these children would be ineligible for CHIP.

Policy Clarification

- In order to address this issue, HHS would propose a regulation more clearly defining the phrase "eligible for health benefits coverage under a State Health benefits plan."

- For the purposes of the regulatory definition, a child in such a family who otherwise meets the criteria under Section 2110(b)(2)(B), but who only has available a nominal amount of funds for the purchase of health benefits coverage, would not be considered eligible for health benefits coverage under a State health benefits plan.

- Since a child in such a family would not be eligible for health benefits coverage under a State health benefits plan, the child would not fall into the exclusion given at Section 2110(b)(2)(B).

- Since the level of funding available to purchase, "health benefits coverage under a State Health benefits plan" varies by county, children in some counties might be eligible for CHIP, while children in other counties might be ineligible.

Definition of Nominal

- In order to determine whether or not the State makes available a nominal subsidy to a child "eligible for health benefits coverage under a State health benefits plan," HHS will consider the difference between: 1) the defined contribution available to a pay for health benefits coverage for an individual State employee, and 2) the dollars needed to purchase the lowest cost individual health benefits coverage available for the individual State employee.

- The difference between these two numbers must be less than or equal to $7 ($10) per month in order to be considered nominal. (There is still an open question as to whether a dollar figure should be used or whether we should consider the $10 to be the numerator or the cost of the "family coverage" plan offered by lowest cost individual health plan. In the case of a percentage, a nominal level would be considered to be 3%. In either case, only 17 counties would qualify.)

Maintenance of Effort Date

- It is critical that HCFA's policies not encourage States to reduce their contribution of funds to the insurance of the State employees.

- Therefore, the amount of the State-provided subsidy will be determined as of a date certain (not to be made public, but the date will be the date of publication of the CHIP Notice of Public Rule Making (NPRM)). In the event that more than a nominal subsidy is available on that date certain, then the individuals in that county may not participate in the CHIP program regardless of the subsidy level thereafter.

- For the future, if the subsidy level in a county exceeds a nominal level, the children in that county will no longer be eligible to participate in the CHIP program. A subsequent reduction in the subsidy will not reopen eligibility for participation in the CHIP program.

Process for Approval of this Policy in Kentucky

- In order for Kentucky to be eligible to receive CHIP funds to provide coverage to the children of State employees in one or more of its counties, the State would need to file a CHIP amendment with sufficient information to demonstrate that since the date of the NPRM publication Kentucky has provided no more than a nominal subsidy toward the coverage of employees' children in each such county and that coverage will be provided in compliance with all other requirements of the CHIP program.

- After Kentucky submits a complete amendment, HHS will review the application as quickly to determine if all the legal requirements have been achieved. By statute, the Department has 90 days to review and disapprove CHIP plans and amendments, but this time frame can be considerably shorter.

- To ensure an expedited review, HHS will provide any technical assistance necessary, both prior to the submission of the amendment and during the review.

- The critical information needed for the application is material the State already has. The application would need to include: 1) the funds available to the employee for the purchase of health benefits coverage, and 2) the cost of purchasing all available health benefits coverage options for the individual and the family in each county.

- The NPRM process will not slow HHS' ability to approve Kentucky's amendment nor will it slow Kentucky's ability to draw down matching federal funds under this policy.

Tentative Time Line

The following represents a time line that could be followed for the approval of Kentucky's CHIP amendment regarding the children of State employees.

- **Late April** -- HHS provides technical assistance to Kentucky on their amendment.
- **May 1** -- Kentucky submits amendment.
- **Mid-May to Mid-June** -- HHS and Kentucky work together to develop the amendment and answer relevant questions.
- **Late June** -- If the requirements are met, HHS would approve Kentucky's amendment. Upon approval, Kentucky is eligible to draw down Federal funds under this policy.
- **Mid-July** -- HHS publishes a NPRM on this issue as part of the comprehensive CHIP regulation.
- **Mid-July 2000** -- Following the public comment period, HHS publishes final CHIP regulation.

Analysis of Maximum Subsidy Available Per County

Number of Counties	Subsidy Available in Dollars	Percentage of Family Coverage Paid For by the Subsidy
17	$6.62	2.2%
6	$15.78	5.7%
1	$26.90	10.2%
25	$28.44	10.9%
54	$31.40	12.2%
14	$54.30	24.3%

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(Information on all counties not available)

Analysis of Health Coverage Plans Available to Kentucky's Public Employees

Monthly Premium of Purchasing Health Benefits Coverage for 1999

Kentucky provides $203 to each State employee for the purchase of health benefits coverage.

HMO	Single		Parent Plus		Family	
	Option A	Option B	Option A	Option B	Option A	Option B
Advantage Care	$225.24	$204.48	$337.86	$306.72	$563.08	$511.20
Aetna	$168.00	$148.70	$252.00	$223.00	$420.10	$371.70
Alternative Health Delivery System	$225.92	$201.86	$338.88	$302.50	$564.82	$504.18
Bluegrass Family Health	$205.92	$171.60	$308.88	$257.40	$514.80	$429.00
CHA Health	$209.74	$187.22	$314.60	$280.82	$524.34	$468.04
HealthSource	$192.30	$168.42	$288.44	$252.64	$480.72	$421.06
Humana KPPA	$232.40	$216.12	$348.62	$324.20	$581.02	$540.34
Humana MBP	$202.94	$192.00	$304.42	$288.00	$507.36	$480.00
PacifiCare	$198.50	$180.00	$297.76	$270.00	$496.26	$450.00

POS	Single		Parent Plus		Family	
	Option A	Option B	Option A	Option B	Option A	Option B
Advantage Care	$252.64	$229.54	$378.96	$344.20	$631.58	$573.84
Aetna	$177.40	$153.10	$266.20	$229.70	$443.60	$382.90
Alternative Health Delivery System	$236.64	$210.22	$354.96	$315.32	$591.62	$525.54
Bluegrass Family Health	$226.50	$188.76	$339.76	$283.14	$566.26	$471.90
CHA Health	$219.88	$196.26	$329.82	$294.40	$549.70	$490.66
Health Source	$200.78	$176.10	$301.16	$264.14	$501.94	$440.22
Humana	$252.34	$239.64	$378.54	$359.42	$630.86	$599.06

PPO	Single		Parent Plus		Family	
	Option A	Option B	Option A	Option B	Option A	Option B
Humana	$196.46	$174.56	$294.72	$261.82	$491.18	$436.36
Anthem BC/BS Option 2000 Adv.	$228.84	$196.38	$343.26	$294.60	$572.10	$490.98

Subsidy Provided By State for 1999

* The Subsidy Level is the Raw Difference in Dollars Provided by State for the Purchase of Health Benefits Coverage ($203) and Cost of Single Coverage
* Percentages Reflect the Amount of the Premium that can Be Purchased with the Subsidy

HMO	Single		Parent Plus		Family	
	Option A	Option B	Option A	Option B	Option A	Option B
Advantage Care	($22.24)	($1.48)	-19.7%	-1.4%	-6.6%	-0.5%
Aetna	$35.00	$54.30	41.7%	73.1%	13.8%	24.3%
Alternative Health Delivery System	($22.92)	$1.34	-20.3%	1.3%	-6.8%	0.4%
Bluegrass Family Health	($2.92)	$31.40	-2.8%	36.6%	-0.9%	12.2%
CHA Health	($6.74)	$15.78	-6.4%	16.9%	-2.1%	5.7%
HealthSource	$10.70	$34.58	11.1%	41.1%	3.7%	13.7%
Humana KPPA	($29.40)	($13.12)	-25.3%	-12.1%	-8.4%	-4.0%
Humana MBP	$0.06	$11.00	0.1%	11.5%	0.0%	3.8%
PacifiCare	$4.50	$23.00	4.5%	25.6%	1.5%	8.5%

POS	Single		Parent Plus		Family	
	Option A	Option B	Option A	Option B	Option A	Option B
Advantage Care	($49.64)	($26.54)	-39.3%	-23.1%	-13.1%	-7.7%
Aetna	$25.60	$49.90	28.8%	85.1%	9.6%	21.7%
Alternative Health Delivery System	($33.64)	($7.22)	-28.4%	-6.9%	-9.5%	-2.3%
Bluegrass Family Health	($23.50)	$14.24	-20.7%	15.1%	-6.8%	6.0%
CHA Health	($16.88)	$6.74	-15.4%	6.9%	-5.1%	2.3%
Health Source	$2.22	$26.90	2.2%	30.6%	0.7%	10.2%
Humana	($49.34)	($36.64)	-39.1%	-30.6%	-13.0%	-10.2%

PPO	Single		Parent Plus		Family	
	Option A	Option B	Option A	Option B	Option A	Option B
Humana	$6.54	$28.44	6.7%	32.6%	2.2%	10.9%
Anthem BC/BS Option 2000 Adv.	($25.84)	$6.62	-22.6%	6.7%	-7.5%	2.2%

Date: 4/7

FAX

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

To: Devorah Adler
Fax:

From: Kate Kirchgunber

Number of Pages (excluding cover): 12

Subject:
weasels

Voice Numbers:

Health Division (Front Office)	202/395-4922
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Health Division (Room 7002)	202/395-5648

CENTER FOR MEDICAID AND STATE OPERATIONS

Fax Transmittal Sheet

HEALTH CARE FINANCING ADMINISTRATION
7500 SECURITY BOULEVARD
ROOM S2-26-12
BALTIMORE, MARYLAND 21244
FAX # (410) 786-3252

DATE: 4 / 1 / 99

TO: Kate Kimbrell

DEPARTMENT: OMB

PHONE: (202) 395-7815

FAX NO: (202) 395-5648

FROM: Anna Fallieras

OFFICE/
DIVISION: HCFA/CMSO/ BCP

PHONE: (410) 786-8281

COMMENTS: Kate: We are still receiving States' submissions, but this is where we are at right now.

TOTAL NO. OF PAGES 12 (Including Fax Sheet)

COLLECTION OF STATE BASELINE INFORMATION

3/24/99

- There are 50 States with approved plans; therefore, we expect **at least** 50 State baseline estimates of uninsured, low-income children.
- 32 of the 50 States are expected to provide HCFA with a **full** FFY 1998 annual report which includes a baseline estimate of uninsured, low-income children.
- 18 of the 50 States are required to **only** provide baseline estimates of uninsured, low-income children. Note that 4 States have not yet implemented programs (e.g., Wisconsin, New Mexico, Hawaii and Alaska, but we are still requesting a baseline estimate).
- To date, we have in the Central Office **22 of 32 State Annual Reports and 10 of 18 baseline-only estimates.** However, most, but not all of these annual reports are complete, and not all of the baselines estimates and the methodologies are clear. In addition, several of the States required to only submit a baseline estimate have submitted an Annual Report with descriptive program information.
- Of the States that have submitted baseline estimates, 14 have submitted baseline estimates using the CPS; 2 States have used some other type of survey; 6 States have used State-specific surveys; and 2 State has submitted a baseline with no methodology or source. In addition, 8 have provided verbal estimates of baseline (taken from the last RO call). Several States that have used CPS as the baseline have also incorporated other data surveys in the development of their baseline estimates (e.g., Oklahoma used CPS, a State survey, and Urban Institute Data).
- It is not clear in all of the reports what is the denominator of the baseline estimate (e.g., age of children, poverty level of children, etc.). Some States have clearly identified what they were measuring while others did not. This varies widely from State to State.
- The sources for establishing baseline estimates are varied. States have used CPS data from varying years; some have pooled the data, while others have used the survey data from one year; and some States have used additional surveys along with CPS to develop their estimates.
- We are currently in the process of reviewing additional State submissions.

Baseline "Tool"	Source/Date
1. Census' Current Population Survey (CPS)	
Alabama	1996
Arizona	1993-1995

California	1998
Colorado	1997
Delaware	3-year average (no year listed)
Illinois	1996-1996 (with EBRI survey)
Indiana	(no year listed)
Iowa	(no year listed)
Kansas	(no year listed)
New York	1996-1997
Oklahoma	1994-1996 CPS; Urban Data 1995; 1994 Oklahoma State Data
South Carolina	FFY 1998 baseline was 110,000 for uninsured children under 200% of poverty
South Dakota	(most recent data)
West Virginia	Household Income Survey with pooled 1195-1996 CPS data (by The Lewin Group)
2. Other Surveys	
Florida	1993 Rand data
Montana	CDF data
3. State Surveys	
Hawaii	1997 Hawaii Health Survey
Idaho	1997 Idaho Kids Count Data
Mississippi	State Data by Heritage Foundation
Nevada	1992 State Survey Data
Oregon	1998 Oregon Population Survey
Utah	Utah Health Status Survey
4. No Source Provided	
Connecticut	(no source for baseline provided)
Maryland	(no source for baseline provided)
5. Verbal Verification of Baseline (Need to get from State Plans)	

Alaska	
District of Columbia	
Georgia	
New Mexico	
North Dakota	

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

MEMORANDUM

TO: **Associate Regional Administrators**

FROM: **Debbie I. Chang**

RE: **Collection, Analysis and Public Release of State CHIP Annual and Quarterly Statistical Reports**

DATE: **March 24, 1999**

I am writing to provide additional guidance for the review and disposition of Children's Health Insurance Program (CHIP) Quarterly Statistical and Annual Reports. This memorandum includes instructions and an overview of the processes for the collection, initial analyses and public release of States' Annual and Statistical CHIP Reports and answers questions initiated by Regional Offices (RO).

Survey Results of the Status of State CHIP Reporting

I would like to thank the Regions for their timely response to the February survey of the status of States' January 30, 1999, submissions. These submissions were to include both FFY 1998 Annual Reports and Quarterly Statistical Reports (for all quarters in which a State had an approved program, up to and including the quarter ending December 31, 1998).

The survey identified that the *most significant reporting problems are related to Quarterly Statistical Reports* including: 1) reporting enrollment for regular Medicaid; and 2) reporting by poverty levels. In addition, the most common reasons for delayed reporting are: 1) systems incompatibility (inability to report on age, income, service delivery); 2) Y2K priorities (an inability to make changes to current systems); and 3) misunderstanding of specific HCFA reporting requirements based on implementation date (commonly cited among States that implemented in the last quarter of FFY 1998 or the first quarter of FFY 1999). Given the issues identified in this survey, States continue to need technical assistance to complete their 1998 Annual Reports and the Quarterly Statistical Reports.

Current Status of FFY 1998 Annual and Quarterly Statistical Reporting

Based upon our December 4, 1998 instruction to States, FFY 1998 Annual Reports and Quarterly Statistical Reports for all quarters through December 31, 1998, were due on January 30, 1999, and there has been no change to this deadline. However, the February survey results reveal the difficulties States continue to have with the submission of these reports. The following is a status of three items: FFY 1998 Annual Reports; estimates from States required to only submit a baseline and a methodology; and Quarterly Statistical Reports.

- For FFY 1998, thirty-three States are required to submit full Annual Reports (as outlined in the 12/4 letter), and, to date, we have received at HCFA Central Office (CO) only 24. We have identified that many of the Annual Reports submitted do not include all of the requested information.

- Seventeen States are required to submit only baseline estimates of uninsured, low-income children as their FFY 1998 Annual Reports. Of these 17 required baseline estimates, we have received estimates from only 7 States, and the methodology for several of these estimates is unclear.

- Statistical data for all quarters of program operation is also required of States. Currently, 18 States have submitted some statistical data.

HCFA Central Office (CO) and Regional Offices must continue working with States to procure FFY 1998 reports.

Establishing the Processes

In order to establish processes for collecting and determining the appropriateness of incoming CHIP data, we have modeled the following approaches for Quarterly Statistical and Annual Report collection, analysis and release after the process for CHIP expenditure reporting. This will provide a streamlined and systematic process for the collection and analysis of all State CHIP reports and will assure that data accurately reflect State CHIP programs. Regions should also design internal systems for the review and analysis of States' report submissions, including the assignment of appropriate Regional staff.

HCFA CO will track regionally reviewed submissions of States' reports. Summary statistical data and Annual Reports will be publicly released in a timely manner, as we understand that States, advocacy groups and researchers are interested in obtaining data on CHIP. In response to the public interest in CHIP, we are working to further establish our internal processes for data collection, analysis and public release. However, to assure consistency in the release of data, until otherwise noted, *all requests* for information should be sent to CO to Anna Fallieras.

Quarterly Statistical Reports

States are submitting quarterly statistical data for S-CHIP, M-CHIP and regular Medicaid through HCFA's electronic reporting system. ROs should request that States continue to report aggregate data until the State has the ability to report statistical data by category (e.g., by age, income and service delivery), and provide technical assistance, as necessary. In addition, ROs should determine when States will have the ability to submit quarterly statistical data by the requested categories. If a State is either having difficulty in or unable to submit statistical data via the electronic system, ROs should collect data in hard copy from the State and forward it to Ron North at CO.

The process for FFY 1998 and subsequent is as follows, unless otherwise noted:

1. When Statistical Reports are received, ROs should conduct a desk review for completeness, recognizing any discrepancies or deficiencies in the data. This review should be conducted within 30 days upon the receipt of the reports, or as soon as possible.

2. Throughout this process, ROs should consult with Project Officers, as needed. In cases where data are either incomplete or incorrect, ROs should contact the appropriate Project Officer and continue to work with States until the data are acceptable.

3. If States must *re*submit statistical data into the system due to insufficiencies in or incorrectness of data, ROs should review subsequent submissions within an additional 15 days upon receipt of data.

4. Each spring, CO will prepare a summary report of enrollment for the previous Federal fiscal year on a State-by-State basis, and it will be publicly released through the HCFA website.

5. Questions regarding the electronic data system should directed to Ron North at (410) 786-5651, and questions regarding the content of statistical reports should be directed to Barbara Greenberg (410) 786-0435.

We will be organizing a training session on analyzing CHIP statistical data in the near future. This session will provide information on conducting quality checks on and reviewing Quarterly Statistical Reports and training on accessing the current electronic statistical data system.

Annual Reports

As noted above, we have not yet received all of the required Annual Reports from the States, and a substantial number of those that have been submitted are incomplete. Regional Offices must

continue to work with States to obtain completed FFY 1998 Annual Reports as soon as possible. An overview of what makes a FFY 1998 Annual Report complete is provided in Attachment A.

The process for FFY 1998 and subsequent years is as follows, unless otherwise noted:

1. Upon receipt of the reports, ROs must immediately forward the Annual Report to the assigned Project Officer.

2. In cases where Annual Reports have not yet been submitted or are incomplete, ROs should work with their States, in cooperation with Project Officers, to obtain accurate and complete reports. If the information is readily available, the State should submit it as soon as possible. If the report is delinquent or incomplete and the information is not readily available, a letter should be sent to the State requesting the additional information and the date in which the information will be submitted.

3. Within 30 days of the receipt of an Annual Report, the RO will review report and prepare a memorandum to the Project Officer that includes any findings, recommendations and a list of outstanding issues. To assist ROs in this process, an Annual Report checklist (included in Attachment B) should be completed and attached to the memorandum.

4. Project Officers and RO CHIP staff will determine when the Annual Report is complete. At that time the Annual Report will be considered FINAL.

5. As there is substantial demand for States' Annual Report information, when an annual report is determined final, it will be publicly released via the HCFA website.

6. An analysis of the final data will be conducted and shared internally with CHIP RO and CO staff.

7. In addition to reviewing States' Annual Reports, ROs should also examine their States' annual submission of the *unduplicated count of children enrolled* in CHIP. If the number is acceptable and consistent with the overall program the State has designed, the RO should place a "check" in the box for "acceptable unduplicated count of children enrolled in CHIP" provided on the Annual Report checklist in Attachment B.

I appreciate your continued efforts as we work to collect and analyze States' enrollment and annual report data. If you have any comments or questions regarding the processes for data collection, analysis and public release outlined in this memorandum, please feel free to contact Anna Faillieras of my staff at (410) 786-8281.

Attachment A: When a FFY 1998 Annual Report Is Complete

We are furnishing you with the following information to assist your review of CHIP Annual Reports:

- States' FFY 1998 annual reports were due on January 30, 1999. States with ***programs that were operational*** in FFY 1998 are required to submit a full FFY 1998 annual report which includes a description of the following:

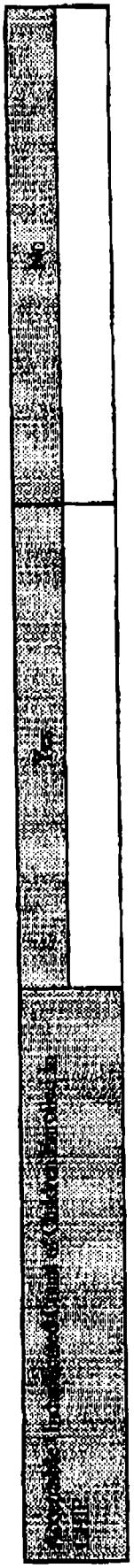
  1. a baseline estimate of low-income, uninsured children and a rationale for the methodology used to develop the baseline estimate;
  2. progress made at reducing the number of low-income, uninsured children in the State;
  3. a description of issues that a state has agreed to monitor in its State plan (e.g., outreach and crowd out), including an assessment of progress toward the State's identified strategic objectives, performance goals and performance measures;
  4. barriers to effectively implement States' plans that are associated with program design, planning and implementation and the proposed approaches to address such problems;
  5. any need for technical assistance from the Department; and
  6. other areas the State may identify as relevant.

- States with ***approved plans that did not implement*** their programs in FFY 1998 are required to only submit a baseline estimate of the number of low-income, uninsured children in their State and the methodology used to develop that estimate. States that provided a description of a baseline in their State plans have the option to reconfirm such estimates by providing to HCFA Regional Office a phone call or letter confirming the use of this estimate. If States have chosen to confirm the baseline estimate included in their State plan, ROs should check the box "baseline estimate from State plan confirmed" on the Annual Report checklist. *Regions should generally accept baseline estimates currently provided and methodology used by States unless it is identified as unreasonable. In addition, we recognize that there have been several issues raised regarding the estimation of baseline estimates, and we are working to address these issues through additional guidance.*

- States ***without an approved State plan*** are not required to submit an annual report, quarterly reports for FFY 1998 or baseline estimates of low-income, uninsured children.

ATTACHMENT B: CHIP Annual Report Element Matrix
(based on FFY 1998 request for annual reports)

Annual Report Elements	Status		Comments	Follow-up Action Items
1. Baseline estimate of number of uninsured children in the State				
1a. Baseline Estimate from State Plan Confirmed	Yes	No		
2. Progress made in reducing the number of uncovered, low-income children in the State				
3. Issues the State agreed to monitor in the State plan (i.e. outreach, crowd out)				
4. Assessment of progress toward the State's identified strategic objectives, performance goals, and performance measures				
5. Barriers impeding implementation of the State plan associated with program design, planning and implementation				
6. Proposed approaches to address implementation barriers				
7. Any need for technical assistance from the Department				
8. Other areas deemed relevant by the State				
9. Quarterly expenditure and financial/statistical reports attached				
10. Structural and/or process indicators related to crowd-out				
11. Structural and/or process indicators related to outreach				



Talking Points on Reporting
3/24/99

Implementation Overview

- The following is an overview of how many States implemented by quarter:

  -4 States implemented programs in FFY 1998, Quarter 1, FFY 1998
  -6 States implemented programs in FFY 1998, Quarter 2, FFY 1998
  -9 States implemented programs in FFY 1998, Quarter 3, FFY 1998
  -14 States implemented programs in FFY 1998, Quarter 4, FFY 1998
  -10 States implemented programs in FFY 1999, Quarter 1, FFY 1999
  -7 States have approved programs but have not yet implemented (began enrolling children)

Annual Report Submission Status

- 32 States must submit **full** Annual Reports for FFY 1999. Of these, 22 have been received in the CO.

- Of the 22 Annual Reports we have received, 19 include at least a baseline estimate of uninsured, low-income children and 13 include the baseline estimate and all but one other element requested in the December 4 letter (e.g., progress toward strategic goals, monitoring of plan (outreach, crowd-out), barriers (and approaches to addressing), need for technical assistance, other issues, etc.).

- We are currently in the process of reviewing additional submissions.

Baseline Submission Status

- 18 States are required to only submit a baseline estimate of uninsured, low-income children as their Annual Report for FFY 1998 (Note: 4 States have not yet implemented programs, WI, HI, AK, NM).

- To date, we have received 10 of these 18 baseline estimates of uninsured children.

- Several of the States required to only submit a baseline estimate have submitted an Annual Report with descriptive program information.

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dential nomination. Beginning in late 1997, endorsements of his reelection *by Democrats*, including Lt. Gov. Bob Bullock, were announced every few weeks. "It was like a Chinese water torture" for Democratic candidate Garry Mauro, says a Bush adviser. "Here we are now doing it again—drip, drip, drip." This time, the endorsements are by Republicans from outside Texas. In 1998, the result was that Bush had locked up the race well before Election Day. That's Bush's aim for the Republican nomination in 2000. And for Rove, who has sold his consulting business to concentrate solely on Bush's future, it's a total obsession.

Fred Barnes is executive editor of THE WEEKLY STANDARD *and co-host of* The Beltway Boys *on the Fox News Channel.*

WAG THE KIDS

by Robert Goldberg

BEFORE AL GORE became the father of the Internet, he invented a toll-free number for enrolling children in government-provided health insurance. Last month, at a press conference with the first lady, the vice president unveiled the number, which parents can call to get information on Medicaid and Kidcare, the child health-insurance entitlement that began in 1997. But Gore shouldn't wait for the phone to ring. Despite his warning in 1996 that a child health care crisis of historic proportions was threatening our children's very lives, the response to Kidcare has been underwhelming.

Back when the program was first proposed, the administration and the Children's Defense Fund claimed that 10 million children in America had no health insurance. The situation was dire, justifying an expenditure of $40 billion over five years. Children with serious illnesses were going untreated because their parents couldn't afford coverage. To drive the point home, the administration released a state-by-state breakdown of the number of kids who needed health care, and the White House vowed to sign up 5 million of them by 2000.

The 5 million target was supposed to give Gore an accomplishment to tout in his presidential run. The problem is, since Kidcare was enacted, fewer than 500,000 children have enrolled. Now the administration, desperate to reach a higher figure, has launched a $1 billion "outreach" effort to sign up more kids—whence the toll-free-number gimmick.

Chances are it won't even come close. Nancy-Ann Min DeParle, the director of the Health Care Financ-

ing Administration, which releases federal funds to states once their Kidcare plans are approved in Washington, testified recently that the program was well on its way to the 5 million goal. But Min DeParle wasn't convincing. She failed to provide Congress the total number of children enrolled to date, offering instead "unreviewed" estimates of enrollment upon full implementation of the program. And even that figure—about 2.5 million—was padded with children already enrolled in state health-insurance plans newly brought under the Kidcare umbrella.

Advocates claim it's too early to tell how well the program will work. But experience in New York, Pennsylvania, and Florida, where pre-existing state health-insurance programs for kids are now receiving Kidcare funding, is not encouraging. According to the New York *Daily News*, New York state's program has grown by barely 20,000 children since Kidcare funding kicked in, though advocates had claimed there was a large unmet need.

No wonder the administration wants to count new Medicaid enrollees toward its 5 million target. But here, too, it fudges the numbers for political purposes. Two years ago, the White House said 3 million eligible children were not signed up for Medicaid. The Health Care Financing Administration now puts the figure at 4.7 million. The Medicaid population did not increase by more than 50 percent in two years. Rather, the administration reclassified a portion of those without insurance as eligible for Medicaid.

TO SOME, IT IS INCOMPREHENSIBLE THAT ANYONE WOULD PASS UP AN ENTITLEMENT. BUT PARENTS MAY HAVE GOOD REASON NOT TO GET KIDCARE.

The hope is that it will be faster and easier to enroll kids in Medicaid than to get new Kidcare programs up and running. (Medicaid also offers a richer benefits package.) Indeed from the outset, both the Children's Defense Fund and the White House have pushed states to expand Medicaid eligibility rather than create new stand-alone programs providing private coverage. Of the 40 state plans approved so far, only 11 are entirely new, 20 are Medicaid expansions, and 9 combine new programs with Medicaid.

The current outreach effort is supposed to crank up enrollment, but that is wishful thinking. State Medicaid programs, whose funding rises with enrollment, already actively recruit participants. They use private organizations like foundations, children's advocacy groups, health care providers, and businesses to educate parents and enroll children. And their experience is chastening. Even intensive door-to-door campaigns have failed to turn up more children. Pamphlets, phone calls, and home visits by nurses have succeeded about as well as doing nothing in persuading parents to avail themselves of free well-child screenings.

The fact is, Kidcare enrollment is going nowhere. The kids this initiative seeks to help simply do not exist. The administration and its allies overstated the number of children who were uninsured and at risk. Less than 4 percent of children under 18 (about 1.2 million) lack coverage for more than a year. The rest are covered by health insurance most of the time. Data from the National Health Interview Survey conducted by the Department of Health and Human Services show that even among families with incomes of $10,000 a year or less, 97 percent of children get all the care they need. Less than 2 percent cite lack of money or insurance as a reason for not getting care.

To some people, it is incomprehensible that anyone would pass up an entitlement. But parents may be passing up Kidcare because their children are generally healthy and they don't believe government-provided health insurance will make much difference.

What's more, those parents may be right. Strangely enough, there is no evidence that either Medicaid or private insurance makes kids healthier. A recent study by the National Bureau of Economic Research actually found that uninsured kids tended to be healthier than kids covered by Medicaid regardless of income or race. Notably, low-income black and Hispanic children had more illness after they started using Medicaid than before.

This is not a brief for cutting off Medicaid or Kidcare. Rather, it means that most kids are healthy to begin with and that their parents often prefer to obtain what care they need outside entitlement programs—at public-health clinics, for example, or from providers paid for out of pocket. Instead of trying to drag parents into Medicaid and Kidcare, why not simply give them the money to make their own choices? Why not make a credit or voucher available to those who need it to buy insurance, pay bills, or add children to their own coverage? Why not just cut taxes?

The answer has nothing to do with children's health and everything to do with the fact that Al Gore and the Children's Defense Fund need Kidcare more than kids do. There never was a real children's health crisis, just a political benefit from talking about one.

Robert Goldberg is a senior research fellow in the Program on Medical Science and Society at the Ethics and Public Policy Center in Washington, D.C.

BadgerCare Waiver

New Major Issues Raised by HCFA

State foster care kids SPA 9A

Issue #2: Budget Neutrality Test for AFDC-Related Parents Whose Children Have Been Temporarily Removed from Home

Problem Statement: AFDC-related eligible parents (usually mothers) lose their Medicaid eligibility if all of their children are removed from their home and placed into foster care. Most of these parents need mental health and/or substance abuse treatment, and the juvenile court orders placing their children in foster care generally require such treatment as a condition of family reunification. When these AFDC-eligible parents lose their Medicaid eligibility in this situation, it becomes very difficult for them to receive needed and required mental health and/or substance abuse treatment, which in turn delays or prevents family reunification. The BadgerCare waiver requests permission to maintain Medicaid eligibility for these women for no more than 18 months, contingent upon their compliance with a court-ordered mental health and/or substance abuse treatment plan.

Federal Requirement: In seeking approval for this waiver, Wisconsin is required to demonstrate that Medicaid costs with the waiver are no greater than without the waiver. HCFA has a great deal of latitude in defining acceptable parameters for these calculations. All of these "details" can make the difference as to whether a state can show no cost increases (as required by federal law) with the waiver as compared to without the waiver.

HCFA Guidance: In multiple conference calls last fall, we discussed with HCFA the methodology proposed to demonstrate budget neutrality. HCFA did not raise objections to the methodology at that time and encouraged us to continue pursuing this particular approach. Therefore, our budget neutrality calculations were based on that methodology. The methodology used demonstrates that the additional Medicaid costs of covering these mothers when their children are removed from the home will be offset by reduced lengths of stay and case management costs for their children in foster care.

HCFA Objections: HCFA objected to the fact that we used base year case management costs that are currently claimed under Title IV-E although, under our existing state plan, Wisconsin could have claimed these costs as Medicaid case management. HCFA states that the use of actual Medicaid case management costs is the only acceptable method of determining base year costs. However, regardless of whether Title IV-E or Medicaid was actually used for case management, the projected costs for these children are actuarially equivalent. (Actuarially equivalent means that for the purpose of projecting costs, the groups being compared are the same.) In prior Medicaid waivers, HCFA has allowed Wisconsin and other states to project budget neutrality and even set managed care rates based on actuarially equivalent populations.

Methodology and Rationale for Demonstrating Budget Neutrality:

Medicaid Eligibility Supports Family Reunification and Leads to Lower Medicaid Targeted Case Management (TCM) Costs:

- This Medicaid waiver will help parents receive necessary mental health and/or substance abuse services, the receipt of which is usually a juvenile court condition for family reunification.
- Family reunification, in turn, will result in a reduction of the average length of stay in foster care for the affected children.
- The reduction in foster care average length of stay reduces the child foster care caseload and means that less child welfare social worker time will be claimed under the Medicaid TCM benefit.
- The reduction in Medicaid spending on case management for the children in foster care will more than offset new Medicaid costs for covering their parents during the period when the children are removed from the home.

Medicaid Targeted Case Management Has Been a Long-Standing Wisconsin Medicaid Benefit:

- The TCM benefit has been part of the Wisconsin State Medicaid Plan since 1987.
- In 1995, all children placed in foster care were added to the covered target populations eligible for TCM.
- In addition, some children in foster care have been eligible for TCM services since 1987 as part of other allowable target groups.

Foster Care Case Management Activities Previously Claimed Under Title IV-E, But Now to Be Claimed Under TCM:

- In Wisconsin, county social workers perform the case management activities necessary for children placed in foster care (i.e., foster homes, group homes, or residential treatment centers).
- The following foster care case management activities could be claimed under either Title IV-E or Medicaid TCM:
  - placement of children;
  - development of case plans;
  - case reviews;
  - case management and supervision;
  - referral for services;
  - preparation for and participation in judicial determinations.

- Wisconsin has previously billed these case management activities for county foster care workers to Title IV-E, but all the activities listed above could have been billed to Medicaid as TCM activities.

- In fact, counties have billed Medicaid for TCM for certain children in foster care since 1987, when delivered by providers other than county foster care social workers.

- TCM costs for children in foster care have been incurred under an existing Medicaid benefit since 1987 and, as such, meet HCFA's budget neutrality criteria as historical costs for an actuarially equivalent foster care population. A combination of Title IV-E and Medicaid expenditures have been incurred for different types of foster care children since 1987. As a result of this historical claiming, TCM costs for foster care are a legitimate Medicaid expenditure under the State Plan that would have occurred with or without the waiver.

- Also, we will submit expenditure data for the full Wisconsin Medicaid benefits coverage for these children in foster care, following HCFA instructions in our March 4, 1998, conference call on BadgerCare.

Projected costs were based on historical experience for administration of the Wisconsin Medicaid HMO program. Historical administrative costs are shown for calendar years 1993-1997. Projected Administrative costs for calendar years 1998-2003 are projected with the BadgerCare waiver and without the waiver. Historical and projected costs are shown in Exhibit 5-G. Administrative costs will be claimed under Title XIX and Title XXI as allowed by federal regulations.

b) Specific Administrative Cost Assumptions

State Staff -- No increase in state staff was projected. State staff costs were increased by 3% per year to reflect projected salary increases.

Claims Processing -- This is the allocation of fiscal agent contract costs related to capitation claims processing. Costs were projected to increase based on additional capitation claims for new HMO enrollees and an annual inflation increase of 3% allowed in the fiscal agent contract.

HMO enrollment -- These costs are for the HMO enrollment contractor to provide assistance to recipients in choosing an HMO and other enrollment functions.

Quality Assurance reviews -- Projected costs are based on historical costs increased to reflect costs of QA reviews for new recipients.

Data Processing -- Projected costs are based on historical systems costs and one time costs for CARES and MMIS system changes to implement new eligibility groups with or without the waiver. Costs are expected to increase by 3% per year.

Premium Collection to System -- These are the projected costs to implement and operate a system support wage withholding and other premium collection for the proposed premium cost sharing under BadgerCare.

Eligibility Determination -- These are the projected costs for eligibility support workers at the county and other agencies. Costs are based on projected caseload increases and budgeted costs per case.

5. Eligibility of AFDC/TANF Parents Whose Children Have Been Temporarily Removed From Home

a) New Eligibility - Expansion of Title XIX

Currently Wisconsin does not grant Medicaid eligibility to AFDC/TANF eligible parents (i.e., "AFDC caretaker relatives") who have had all their children removed from their home and placed into foster care (i.e., foster

homes, group homes, or residential treatment centers) by child welfare agencies.

A juvenile court order is always required for a child welfare agency to place a child in foster care, and the juvenile court usually attaches conditions that must be met before the family can be reunified. A large number of the AFDC-eligible parents of children in foster care need mental health and/or substance abuse (MH/SA) treatment, and the juvenile court orders for these families usually require such treatment as a condition of family reunification. Currently in Wisconsin, these parents (primarily mothers) lose their Medicaid eligibility when all of their children are removed from the home, making it very difficult for the parents to receive the needed MH/SA treatment, which in turn delays or prevents family reunification.

Based on suggestions from HCFA representatives, Wisconsin is seeking a "waiver" of Title XIX to cover costs otherwise not reimbursable. Specifically, this Title XIX waiver would allow Wisconsin to provide Medicaid temporary absence eligibility to AFDC-eligible parents if all their children are removed from their home by court order and are placed in foster care, and to cover the foster care costs for the children of those parents during the same period through Title IV.

Wisconsin Medicaid currently enrolls all AFDC-eligible Medicaid recipients in HMOs, wherever possible. By definition, parents who receive Medicaid "temporary absence" eligibility must continue to meet AFDC-related Medicaid eligibility requirements as if their children were still at home, and these parents will continue to be enrolled in MA-HMOs just like regular AFDC-eligible parents.

Wisconsin is not proposing to change Medicaid eligibility for the children in foster care. Children placed out-of-home through child welfare action are automatically Medicaid eligible in Wisconsin. If the child's foster care placement is in a foster home, then the foster parents caring for the child can also receive medical assistance, if they are financially eligible. The state is only seeking to extend temporary absence Medicaid coverage to AFDC-eligible parents after their children are placed. This temporary absence Medicaid coverage will only be provided to those parents whose children are removed through Wisconsin's county-based child welfare system. This Medicaid HMO coverage for the parents would continue for a maximum of 18 months. Medicaid coverage would be contingent upon the parents compliance with a court-ordered treatment plan.

As illustrated in Exhibit 5-H, this Title XIX "waiver" will cost less to the federal government than the non-waiver status quo. A Title XIX waiver is not required for the state to claim FFP for Medicaid Targeted Case Management (MA-TCM) instead of claiming administrative costs under Title IV-E. Consequently, MA-TCM expenditures will show up on both

sides of the waiver budget neutrality equation, but the MA-TCM expenditures will be lower in the "with waiver" scenario. The Title XIX temporary absence waiver will help parents receive necessary MH/SA services, which are necessary for family reunification. Family reunification, in turn, will result in a reduction of the average length of stay in foster care for the affected children. The reduction in foster care average length of stay means that less child welfare social worker time will be billed under Medicaid targeted case management, thus reducing Medicaid expenditures on case management for these families. The reduction in Medicaid spending on case management for the children will more than offset increases in Medicaid coverage for the parents.

b) Caseload assumptions without and with the Waiver

- General Assumptions

  Caseload assumptions are attached in Exhibit 5-E, and include the estimated number of "temporarily absent" children placed into foster care with and without the waiver. The caseload estimates also include the number of parents who would receive temporary absence Medicaid coverage under the waiver. The estimates for children and parents are separated into Milwaukee County only and the remaining counties in Wisconsin, because of the size and impact of Milwaukee County on the statewide child welfare caseload. As described above, the caseload of children in foster care is lower under the waiver, because extending their parents' Medicaid coverage enables more of those parents to meet the MH/SA treatment requirements for family reunification (and to meet them sooner). This improved rate of family reunification results in shorter lengths of stay in foster care for the children, which reduces the child foster care caseload, reduces payments for Medicaid targeted case management for foster children, and also reduces the caseload of parents needing temporary absence Medicaid eligibility.

- Historical Data

  Historical caseload figures shown in this waiver application represent actual child welfare (excluding juvenile justice) out-of-home placements from October 1994 through July 1997. Caseload projections for August 1997 through June 2003 are based on the historical data trends, with modifications made for the "with waiver" scenario as described below. The historical foster care data used for this waiver application, some of which go back to 1988, come from various sources within the Wisconsin Department of Health and Family Services (DHFS). Those sources include: Title IV-E claims data; county child welfare agencies' utilization data; a study for DHFS on out-of-home care by Professor Mark Courtney of the University of Wisconsin- Madison; and other DHFS sources.

c) The main overall caseload assumptions are as follows:

- Among all families where the children are removed from the home through child welfare action, it is assumed that 77% are Medicaid eligible in Milwaukee County and that 45% are Medicaid eligible in all other counties.

- Among the Medicaid eligible families with children removed to foster care, it is assumed in Milwaukee County that 35% of the children are court ordered into kinship care so the parents retain their Medicaid eligibility without need of the waiver; and that 6% of children are court-ordered into kinship care in the remainder of the state with the same effect on their parents' Medicaid eligibility.

- Among the Medicaid-eligible families with children removed to foster care, it is assumed there are an average of 1.5 children per case and one AFDC-related, Medicaid-eligible parent per case.

- In 95% of the cases, if the child welfare agency removes any children from the home, then all the children are removed, and consequently, the parent loses Medicaid coverage through AFDC-related eligibility.

d) Caseload Assumptions Without Waiver

Caseload projections for Milwaukee County children placed out-of-home assume a continuation of the historical 25-month average length of stay in foster care. Similarly, in other counties without the waiver, the historical 10-month average length of stay for children in foster care is projected to continue. The estimated parents caseload is zero in the without waiver scenario, because none of the AFDC-eligible parents would retain their Medicaid coverage when their children are placed out-of-home. However, these parents would still need MH/SA treatment in order to meet the juvenile court-ordered requirements for family reunification, but without Medicaid coverage, they would have a harder time getting it. A small number might be able to afford to pay for a portion of the needed treatment out of pocket. Some of the parents might be able to find some or all of their needed treatment through the county human services system, but subject to waiting lists. A significant number would probably not receive any MH/SA treatment. In all these without waiver alternatives, the lack of Medicaid eligibility delays, interferes with, and/or prevents the parents receiving the MH/SA services necessary for family reunification.

e) Caseload Assumptions With Waiver

With the waiver, children are projected to remain in foster care for an average of only 17 months in Milwaukee County and an average of only 8 months in other counties. As described previously, this shortened the average length of stay for children in foster care is a result of their parents

receiving court-ordered MH/SA services through their extended Medicaid coverage under the waiver, resulting in more and faster family reunification. The shortened average length of stay reduces the child foster care caseload, which simultaneously reduces the caseload of parents needing temporary absence Medicaid eligibility.

3. Cost Assumptions Without and With the Waiver

a) General

The cost comparisons in Exhibit 5-E demonstrate Wisconsin's assurance of budget neutrality under the waiver for temporary absence eligibility. In short, under the waiver, the reduction of Medicaid spending on child welfare case management for the children will more than offset the increase in Medicaid spending on general Medicaid coverage for these parents. In addition to the Title XIX budget neutrality, this temporary absence eligibility "waiver" will also result in reduced federal spending under Title IV-E, because the average length of stay in foster care is reduced for the affected children, and in Medicaid because the cost of foster care is greater than for AFDC-only cases.

The cost estimate for this waiver includes three categories of cost. As described earlier, these are: 1) Medicaid fee-for-service (FFS) payments for child welfare case management when the children are removed from the home (FFS because the Medicaid Targeted Case Management [MA-TCM] benefit is outside of the Medicaid-HMO benefit package in Wisconsin); 2) Medicaid-HMO capitation payments for the parents during their children's temporary absence in foster care; and 3) supplemental Medicaid-HMO capitation payments for Milwaukee County parents beyond the regular Medicaid-HMO capitation rate to pay for the necessary extra MH/SA services beyond what the average Milwaukee Medicaid-HMO enrollee receives.

b) Cost Assumptions Without Waiver

The without waiver costs for the children are a product of projected foster care caseloads (shown as member months in Exhibit 5-E) and projected Medicaid-FFS costs for MA-TCM (shown as average paid per child per month in Exhibit 5-H). As described in the caseload section above, the historical caseload figures used in this waiver application represent actual child welfare (excluding juvenile justice) out-of-home placements from October 1994 through July 1997. Without waiver caseload projections for August 1997 through June 2003 are based on the historical data trends. The historical MA-TCM average paid amounts are derived from actual average paid amounts for the MA-TCM base year CY 1996. MA-TCM average paid amount projections for August 1997 through June 2003 are based on actual and projected Medicaid-FFS reimbursement trending for the MA-TCM benefit. Children's costs are greater in the without waiver

scenario due to the longer average length of stay in foster care estimated for this population.

The without waiver costs for the parents are zero, because without the waiver the parents lose their Medicaid eligibility during the time period when their children are removed from the home by child welfare action.

c) Cost Assumptions With Waiver

The with waiver costs for the children are developed the same way as the without waiver costs described above, except that the average length of stay of children in foster care is shorter with the waiver. This decreased average time in foster care produces a lower child caseload, resulting in smaller MA-TCM costs for the children.

The with waiver costs for the parents are a product of projected caseloads for parents (shown as member months in Exhibit 5-E) and projected Medicaid-HMO costs for the full Medicaid-HMO benefit package (shown as per member per month [pmpm] capitation payments in Exhibit 5-E). Because the parents only gain Medicaid eligibility with the waiver during their children's foster care placement, no parental caseloads or costs are shown in Exhibit 5-E before the waiver start date. With waiver parents caseload projections for July 1998 through June 2003 are based on trending forward the actual children's foster care caseload data (covering October 1994 through July 1997), because the number of effected parents is directly proportional to the number of children placed in foster care. The projected Medicaid-HMO capitation rates for July 1998 through June 2003 are based on actual and projected trending from the Medicaid-HMO capitation rate base year CY 1997. Parents' costs are greater in the with waiver scenario because they are Medicaid eligible only with the waiver.

With the waiver there will also be a supplemental Medicaid-HMO capitation payment for Milwaukee County parents beyond the regular Medicaid-HMO capitation rate. According to a DHFS needs assessment for the Milwaukee County child welfare system, Milwaukee parents covered under this waiver will likely need more MH/SA services than the average Milwaukee Medicaid-HMO enrollee receives, and the MH/SA capitation rate supplement will pay for those extra services. (There does not appear to be a similar MH/SA utilization discrepancy in Wisconsin's other counties.) The projections for July 1998 through June 2003 for the MH/SA capitation rate supplement are based on estimated Medicaid-FFS equivalent costs for the additional MH/SA services to be provided, within the constraints of waiver budget neutrality.

Exhibit 5-E

Temporary Absence Eligibility for AFDC/TANF Parents whose Children are Placed Out-of-Home into Foster Care by Child Welfare
(i.e., Children are Temporarily Absent)

Exhibit 5-E: Temporary Absence MA-Eligibility Waiver Cost Neutrality - Comparing Parents and Children on Population and MA Spending

	PARENTS: Population and Expenditures							5-Year Demonstration Waiver Time Period					
	Only During Time When Affected Children Are Placed Out-of-Home Into Foster Care by Child Welfare		**10/01/94 thru 12/31/94 (3 mos)**	**CY 1995 (12 mos)**	**CY 1996 (12 mos)**	**CY 1997 (12 mos)**	**01/01/98 Thru 6/30/98 (6 mos)**	**07/01/98 thru 12/31/98 (6 mos)**	**CY 1999 (12 mos)**	**CY 2000 (12 mos)**	**CY 2001 (12 mos)**	**CY 2002 (12 mos)**	**01/01/03 thru 06/30/03 (6 mos)**	**Grand Total 5-Year Waiver**
Parents WithOUT Waiver	**PARENTS: (Milwaukee Co):**													
	Trending: % Change from previous year		N/A	N/A	N/A	**Base Year**	0.00%	(same= CY 98)	2.25%	2.25%	2.25%	2.25%	2.25%	(N/A)
	MA-FFP % for each CY		60.2163%	59.8400%	59.4363%	59.0238%	58.7513%	(same= CY 98)	58.6225%	58.6225%	58.6225%	58.6225%	58.6225%	(N/A)
	Formerly MA-Elig. AFDC/TANF Parents Who Have Had All their Children Placed Out-of-Home into Foster Care by Child Welfare	*Avg $/mo (AF)=	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	(N/A)
		*Avg $/mo (FFP)=	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	(N/A)
		**Extra avg $/mo (FFP)=	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	(N/A)
		Member months=	0	0	0	0	0	0	0	0	0	0	0	0
		Total spending (FFP)=	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
			not MA eligible	not MA eligible	not MA eligible	not MA eligible	Not MA eligible	not MA eligible	not MA eligible	not MA eligible	not MA eligible	not MA eligible	not MA eligible	
	PARENTS: (Out-State Co's):													
	Trending: % Change from previous year		N/A	N/A	N/A	**Base Year**	0.00%	(same= CY 98)	2.25%	2.25%	2.25%	2.25%	2.25%	(N/A)
	MA-FFP % for each CY		60.2163%	59.8400%	59.4363%	59.0238%	58.7513%	(same= CY 98)	58.6225%	58.6225%	58.6225%	58.6225%	58.6225%	(N/A)
	Formerly MA-Elig. AFDC/TANF Parents Who Have Had All their Children Placed Out-of-Home Into Foster Care by Child Welfare	*Avg $/mo (AF)=	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	(N/A)
		*Avg $/mo (FFP)=	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	(N/A)
		Member months=	0	0	0	0	0	0	0	0	0	0	0	0
		Total spending (FFP)=	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
			not MA eligible	not MA eligible	not MA eligible	not MA eligible	Not MA eligible	Not MA eligible	not MA eligible	not MA eligible	not MA eligible	not MA eligible	not MA eligible	
	WithOUT Waiver Grand Totals=		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Exhibit 5-E: Temporary Absence MA-Eligibility Waiver Cost Neutrality - Comparing Parents and Children on Population and MA Spending

	PARENTS: Population and Expenditures							5-Year Demonstration Waiver Time Period					
	Only During Time When Affected Children Are Placed Out-of-Home Into Foster Care by Child Welfare	**10/01/94 thru 12/31/94 (3 mos)**	**CY 1995 (12 mos)**	**CY 1996 (12 mos)**	**CY 1997 (12 mos)**	**01/01/98 thru 6/30/98 (6 mos)**	**07/01/98 thru 12/31/98 (6 mos)**	**CY 1999 (12 mos)**	**CY 2000 (12 mos)**	**CY 2001 (12 mos)**	**CY 2002 (12 mos)**	**01/01/03 thru 06/30/03 (6 mos)**	**Grand Total 5-Year Waiver**
Parents With Waiver	**PARENTS: (Milwaukee Co):**												
	Trending: % Change from previous year	N/A	N/A	N/A	**Base Year**	0.00%	(same= CY 98)	2.25%	2.25%	2.25%	2.25%	2.25%	(N/A)
	MA-FFP % for each CY	60.2163%	59.8400%	59.4363%	59.0238%	58.7513%	(same= CY 98)	58.6225%	58.6225%	58.6225%	58.6225%	58.6225%	(N/A)
	Formerly MA-Elig. AFDC/TANF Parents Who Have Had All their Children Placed Out-of-Home into Foster Care by Child Welfare — *Avg $/mo (AF)=	$0.00	$0.00	$0.00	$0.00	$0.00	$117.70	$120.35	$123.06	$125.82	$128.66	$131.55	(N/A)
	*Avg $/mo (FFP)=	$0.00	$0.00	$0.00	$0.00	$0.00	$69.15	$70.55	$72.14	$73.76	$75.42	$77.12	(N/A)
	**Extra: avg $/mo (FFP)=	$0.00	$0.00	$0.00	$0.00	$0.00	$17.24	$17.63	$18.03	$18.43	$18.85	$19.27	(N/A)
	Member months=	0	0	0	0	0	11,716	25,055	24,733	21,819	20,527	10,263	114,112
	Total spending (FFP)=	$0	$0	$0	$0	$0	$1,012,143	$2,209,383	$2,230,043	$2,011,542	$1,934,986	$989,199	**$10,387,296**
		not MA eligible	not MA eligible	not MA eligible	not MA eligible	Not MA eligible							
	PARENTS: (Out-State Co's):												
	Trending: % Change from previous year	N/A	N/A	N/A	**Base Year**	0.00%	(same= CY 98)	2.25%	2.25%	2.25%	2.25%	2.25%	(N/A)
	MA-FFP % for each CY	60.2163%	59.8400%	59.4363%	59.0238%	58.7513%	(same= CY 98)	58.6225%	58.6225%	58.6225%	58.6225%	58.6225%	(N/A)
	Formerly MA-Elig. AFDC/TANF Parents Who Have Had All their Children Placed Out-of-Home into Foster Care by Child Welfare — *Avg $/mo (AF)=	$0.00	$0.00	$0.00	$0.00	$0.00	$117.70	$120.35	$123.06	$125.82	$128.66	$131.55	(N/A)
	*Avg $/mo (FFP)=	$0.00	$0.00	$0.00	$0.00	$0.00	$69.15	$70.55	$72.14	$73.76	$75.42	$77.12	(N/A)
	Member months=	0	0	0	0	0	6,467	11,369	9,693	9,674	9,674	4,837	51,714
	Total spending (FFP)=	$0	$0	$0	$0	$0	$447,197	$802,113	$699,261	$713,564	$729,619	$373,018	**$3,764,773**
		not MA eligible	not MA eligible	not MA eligible	not MA eligible	Not MA eligible							
	With-Waiver Grand Totals=	**$0**	**$0**	**$0**	**$0**	**$0**	**$1,459,340**	**$3,011,497**	**$2,929,304**	**$2,725,106**	**$2,664,605**	**$1,362,217**	**$14,152,068**

* = These average monthly $ amounts for Parents are pmpm capitation payments for the entire MA benefit package in the AFDC/HS MA-HMO program.

** = These average monthly $ amounts for Parents in Milwaukee Co. only are supplemental pmpm payments beyond the regular MA-HMO cap. rate for extra mental health and substance abuse services.

	TOTAL CHANGE IN EXPENDITURES FOR PARENTS							5-Year Demonstration Waiver Time Period					
	Only During Time When Affected Children Are Placed Out-of-Home Into Foster Care by Child Welfare	**10/01/94 thru 12/31/94 (3 mos)**	**CY 1995 (12 mos)**	**CY 1996 (12 mos)**	**CY 1997 (12 mos)**	**01/01/98 thru 6/30/98 (6 mos)**	**07/01/98 thru 12/31/98 (6 mos)**	**CY 1999 (12 mos)**	**CY 2000 (12 mos)**	**CY 2001 (12 mos)**	**CY 2002 (12 mos)**	**01/01/03 thru 06/30/03 (6 mos)**	**Grand Total 5-Year Waiver**
Parents With-Waiver Minus Parents WithOUT Waiver	**Total Change in Spending for PARENTS because of Waiver: (with-waiver spending minus without-waiver spending)**	**$0**	**$0**	**$0**	**$0**	**$0**	**$1,459,340**	**$3,011,497**	**$2,929,304**	**$2,725,106**	**$2,664,605**	**$1,362,217**	**$14,152,068**

Exhibit 5-E: Temporary Absence MA-Eligibility Waiver Cost Neutrality - Comparing Parents and Children on Population and MA Spending

	CHILDREN: Population and Expenditures							5-Year Demonstration Waiver Time Period					
	Only During Time When Affected Children Are Placed Out-of-Home Into Foster Care by Child Welfare	**10/01/94 thru 12/31/94 (3 mos)**	**CY 1995 (12 mos)**	**CY 1996 (12 mos)**	**CY 1997 (12 mos)**	**01/01/98 thru 6/30/98 (6 mos)**	**07/01/98 thru 12/31/98 (6 mos)**	**CY 1999 (12 mos)**	**CY 2000 (12 mos)**	**CY 2001 (12 mos)**	**CY 2002 (12 mos)**	**01/01/03 thru 06/30/03 (6 mos)**	**Grand Total 5-Year Waiver**
Children WithOUT Waiver	**CHILDREN (Milwaukee Co):**												
	Trending: % Change from previous year	(N/A)	3.3%	1.8% (base yr)	1.4%	2.8%	(same= CY 98)	2.8%	2.8%	2.8%	2.8%	2.8%	(N/A)
	MA-FFP % for each CY	60.2163%	59.8400%	59.4363%	59.0238%	58.7513%	(same= CY 98)	58.6225%	58.6225%	58.6225%	58.6225%	58.6225%	(N/A)
	Children Placed Out-of-Home Into Foster Care by Child Welfare. ***avg $/mo (AF)=	$433.63	$447.94	$456.00	$462.38	$475.33	$475.33	$488.64	$502.32	$516.39	$530.85	$545.71	(N/A)
	***avg $/mo (FFP)=	$261.11	$268.05	$271.03	$272.92	$279.26	$279.26	$286.45	$294.47	$302.72	$311.20	$319.91	(N/A)
	These are the Children Who Were Removed From the Homes of the Parents Described Above. member months=	7,350	29,858	30,968	30,697	16,132	17,631	38,697	41,024	40,697	40,012	20,005	198,066
	^total spending (FFP)=	$1,919,159	$8,003,435	$8,393,296	$8,377,753	$4,505,077	$4,923,747	$11,084,788	$12,080,610	$12,319,721	$12,451,532	$6,399,777	**$59,260,175**
	CHILDREN (Out-State Co's):												
	Trending: % Change from previous year	(N/A)	3.3%	1.8% (base yr)	1.4%	2.8%	(same= CY 98)	2.8%	2.8%	2.8%	2.8%	2.8%	(N/A)
	MA-FFP % for each CY	60.2163%	59.8400%	59.4363%	59.0238%	58.7513%	(same= CY 98)	58.6225%	58.6225%	58.6225%	58.6225%	58.6225%	(N/A)
	Children Placed Out-of-Home Into Foster Care by Child Welfare. ***avg $/mo (AF)=	$433.63	$447.94	$456.00	$462.38	$475.33	$475.33	$488.64	$502.32	$516.39	$530.85	$545.71	(N/A)
	***avg $/mo (FFP)=	$261.11	$268.05	$271.03	$272.92	$279.26	$279.26	$286.45	$294.47	$302.72	$311.20	$319.91	(N/A)
	These are the Children Who Were Removed From the Homes of the Parents Described Above. member months=	4,675	19,061	19,338	19,889	9,895	9,873	19,746	19,746	19,746	19,746	9,873	98,730
	^total spending (FFP)=	$1,220,816	$5,109,178	$5,241,276	$5,428,013	$2,763,249	$2,757,226	$5,656,277	$5,814,653	$5,977,463	$6,144,832	$3,158,444	**$29,508,896**
	WithOUT Waiver Grand Totals=	**$3,139,975**	**$13,112,613**	**$13,634,572**	**$13,805,766**	**$7,268,326**	**$7,680,973**	**$16,741,065**	**$17,895,263**	**$18,297,185**	**$18,596,365**	**$9,558,221**	**$88,769,071**

Exhibit 5-E: Temporary Absence MA-Eligibility Waiver Cost Neutrality – Comparing Parents and Children on Population and MA Spending

	CHILDREN: Population and Expenditures							5-Year Demonstration Waiver Time Period					
	Only During Time When Affected Children Are Placed Out-of-Home Into Foster Care by Child Welfare	10/01/94 Thru 12/31/94 (3 mos)	CY 1995 (12 mos)	CY 1996 (12 mos)	CY 1997 (12 mos)	01/01/98 thru 6/30/98 (6 mos)	07/01/98 thru 12/31/98 (6 mos)	CY 1999 (12 mos)	CY 2000 (12 mos)	CY 2001 (12 mos)	CY 2002 (12 mos)	01/01/03 thru 06/30/03 (6 mos)	Grand Total 5-Year Waiver
Children With Waiver	**CHILDREN (Milwaukee Co):**												
	Trending: % Change from previous year	(N/A)	3.3%	1.8% (base yr)	1.4%	2.8%	(same = CY 98)	2.8%	2.8%	2.8%	2.8%	2.8%	(N/A)
	MA-FFP % for each CY	60.2163%	59.8400%	59.4363%	59.0238%	58.7513%	(same = CY 98)	58.6225%	58.6225%	58.6225%	58.6225%	58.6225%	(N/A)
	Children Placed Out-of-Home Into Foster Care by Child Welfare. ***avg $/mo (AF) =	$433.63	$447.94	$456.00	$462.38	$475.33	$475.33	$488.64	$502.32	$516.39	$530.85	$545.71	(N/A)
	***avg $/mo (FFP) =	$261.11	$268.05	$271.03	$272.92	$279.26	$279.26	$286.45	$294.47	$302.72	$311.20	$319.91	(N/A)
	These are the Children Who Were Removed From the Homes of the Parents Described Above. member months =	7,350	29,858	30,968	30,697	16,132	17,574	37,583	37,100	32,728	30,790	15,394	171,168
	^total spending (FFP) =	$1,919,159	$8,003,435	$8,393,296	$8,377,753	$4,505,077	$4,907,679	$10,765,759	$10,924,878	$9,907,459	$9,581,660	$4,924,662	**$51,012,098**
	CHILDREN (Out-State Co's):												
	Trending: % Change from previous year	(N/A)	3.3%	1.8% (base yr)	1.4%	2.8%	(same = CY 98)	2.8%	2.8%	2.8%	2.8%	2.8%	(N/A)
	MA-FFP % for each CY	60.2163%	59.8400%	59.4363%	59.0238%	58.7513%	(same = CY 98)	58.6225%	58.6225%	58.6225%	58.6225%	58.6225%	(N/A)
	Children Placed Out-of-Home Into Foster Care by Child Welfare. ***avg $/mo (AF) =	$433.63	$447.94	$456.00	$462.38	$475.33	$475.33	$488.64	$502.32	$516.39	$530.85	$545.71	(N/A)
	***avg $/mo (FFP) =	$261.11	$268.05	$271.03	$272.92	$279.26	$279.26	$286.45	$294.47	$302.72	$311.20	$319.91	(N/A)
	These are the Children Who Were Removed From the Homes of the Parents Described Above. member months =	4,675	19,061	19,338	19,889	9,895	9,701	17,054	14,540	14,511	14,511	7,255	77,572
	^total spending (FFP) =	$1,220,816	$5,109,178	$5,241,276	$5,428,013	$2,763,249	$2,709,001	$4,885,132	$4,281,635	$4,392,716	$4,515,712	$2,321,076	**$23,105,273**
	With-Waiver Grand Totals =	$3,139,975	$13,112,613	$13,634,572	$13,805,766	$7,268,326	$7,616,681	$15,650,891	$15,206,513	$14,300,175	$14,097,372	$7,245,738	$74,117,571

*** = These average monthly $ amounts for Children are the average paid per child per month (MA Fee-for-Svc), exclusively for MA Targeted Case Management (MA-TCM) reimbursement for Child Welfare foster care case management activities. These average monthly MA-FFS payments do not factor in length of episode of care

^ = For consistency, all foster care case management expenditures are shown as reimbursed under the MA-TCM benefit, but prior to waiver implementation, Title IV-E is actual revenue source for foster care case management. However, Title 19 will become actual revenue source for this foster care case management, and because no waiver is required to do so, these MA-TCM expenditures are shown in both with-waiver and without-waiver scenarios

Children With-Waiver Minus Children WithOUT Waiver	TOTAL CHANGE IN EXPENDITURES FOR CHILDREN:							5-Year Demonstration Waiver Time Period					
	Only During Time When Affected Children Are Placed Out-of-Home Into Foster Care by Child Welfare	10/01/94 thru 12/31/94 (3 mos)	CY 1995 (12 mos)	CY 1996 (12 mos)	CY 1997 (12 mos)	01/01/98 thru 6/30/98 (6 mos)	07/01/98 thru 12/31/98 (6 mos)	CY 1999 (12 mos)	CY 2000 (12 mos)	CY 2001 (12 mos)	CY 2002 (12 mos)	01/01/03 thru 06/30/03 (6 mos)	Grand Total 5-Year Waiver
	Total Change in Spending for CHILDREN because of Waiver (With-Waiver Spending minus Without-Waiver Spending)	**$0**	**$0**	**$0**	**$0**	**$0**	**($64,292)**	**($1,090,174)**	**($2,688,750)**	**($3,997,009)**	**($4,498,993)**	**($2,312,482)**	**($14,651,700)**

Exhibit 5-E: Temporary Absence MA-Eligibility Waiver Cost Neutrality - Comparing Parents and Children on Population and MA Spending

	TOTAL MA-FFP EXPENDITURES						5-Year Demonstration Waiver Time Period						
Total Waiver Cost-Neutrality	Only During Time When Affected Children Are Placed Out-of-Home Into Foster Care by Child Welfare	10/01/94 thru 12/31/94 (3 mos)	CY 1995 (12 mos)	CY 1996 (12 mos)	CY 1997 (12 mos)	01/01/98 thru 6/30/98 (6 mos)	07/01/98 thru 12/31/98 (6 mos)	CY 1999 (12 mos)	CY 2000 (12 mos)	CY 2001 (12 mos)	CY 2002 (12 mos)	01/01/03 thru 06/30/03 (6 mos)	5-Year Demonstration Waiver Total
	Total Change in Spending for PARENTS because of Waiver (With-Waiver minus Without-Waiver Spending)	$0	$0	$0	$0	$0	$1,459,340	$3,011,497	$2,929,304	$2,725,106	$2,664,605	$1,362,217	$14,152,068
	Total Change in Spending for CHILDREN because of Waiver (With-Waiver minus Without-Waiver Spending)	$0	$0	$0	$0	$0	($64,292)	($1,090,174)	($2,688,750)	($3,997,009)	($4,498,993)	($2,312,482)	($14,651,700)
	COST-NEUTRALITY (break-even or savings with Waiver) (Cost-Neutral if sum is $0 or a negative $ amount)	$0	$0	$0	$0	$0	$1,395,048	$1,921,322	$240,554	($1,271,903)	($1,834,388)	($950,266)	($499,633)

Exhibit 5-F

SUMMARY COMPARISON OF COSTS - WITH AND WITHOUT WAIVER

AFDC/HEALTHY START MEDICAID COSTS WITHOUT WAIVER

	5-Year Historical Data						Waiver Years					
					Base Year	Based on Actual Jan-Oct Mbr Mos	2.05% Rate Incr	2.25% Annual Rate Increase Assumed				
Fee-for-Service	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
AFDC < Age 19	$94,022,218	$90,842,474	$81,883,217	$71,620,966	$55,933,329	$25,809,106	$16,281,822	$16,361,180	$16,729,306	$17,105,715	$17,490,594	$17,884,132
AFDC > = Age 19	$109,345,299	$107,660,050	$101,740,728	$86,153,576	$69,986,763	$32,293,729	$20,372,684	$20,471,980	$20,932,600	$21,403,583	$21,885,164	$22,377,580
Healthy Start Children < Age 19	$17,250,982	$24,965,478	$28,392,182	$29,711,307	$32,114,541	$14,818,492	$9,508,652	$9,393,894	$9,605,256	$9,821,374	$10,042,355	$10,268,308
Healthy Start PW All Ages	$24,417,513	$31,931,319	$29,359,887	$27,257,815	$28,316,170	$13,065,824	$8,327,796	$8,282,825	$8,469,188	$8,659,745	$8,854,589	$9,053,817
FFS Total: All Elig Categories	**$245,036,012**	**$255,399,321**	**$241,376,014**	**$214,743,665**	**$186,350,803**	**$85,987,151**	**$54,490,955**	**$54,509,878**	**$55,736,350**	**$56,990,418**	**$58,272,702**	**$59,583,838**
	5-Year Historical Data					Based on Actual	Waiver Years					
					Base Year	Jan-Oct '97 Enrlmt	*No Rate Incr*	2.25% Annual Rate Increase Assumed				
In HMO	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
AFDC < Age 19	$103,001,513	$107,729,116	$116,518,922	$129,116,337	$130,906,045	$135,173,367	$116,972,144	$113,238,223	$115,786,083	$118,391,270	$121,055,074	$123,778,813
AFDC > = Age 19	$44,081,176	$45,727,807	$48,481,762	$53,540,683	$52,841,118	$54,563,652	$47,216,604	$45,709,381	$46,737,842	$47,789,444	$48,864,706	$49,964,162
Healthy Start Children < Age 19	$1,159,781	$5,197,886	$9,398,821	$10,237,565	$14,541,269	$57,880,196	$96,040,151	$106,547,558	$108,944,878	$111,396,138	$113,902,551	$116,465,359
Healthy Start PW All Ages	$818,156	$2,946,343	$4,465,768	$4,812,659	$6,827,264	$22,970,922	$45,625,348	$48,092,222	$49,174,297	$50,280,719	$51,412,035	$52,568,806
FFS Total: All Elig Categories	**$149,060,626**	**$161,601,152**	**$178,865,272**	**$197,707,244**	**$205,115,696**	**$270,588,137**	**$305,854,247**	**$313,587,385**	**$320,643,101**	**$327,857,571**	**$335,234,367**	**$342,777,140**
Grand Total Paid FFS & HMO	$394,096,639	$417,000,473	$420,241,286	$412,450,908	$391,466,499	$356,575,288	$360,345,202	$368,097,263	$376,379,451	$384,847,989	$393,507,069	$402,360,978
Expansion Groups -without Waiver							1998	1999	2000	2001	2002	2003
BadgerCare												
Annual Cost - Services for children							$3,517,167	$31,340,129	$35,864,815	$35,807,371	$33,544,777	$15,319,971
Annual Cost - Services for adults							$3,760,859	$35,901,717	$40,459,381	$39,835,083	$36,803,943	$16,604,785
Total Costs - BadgerCare							$7,278,027	$67,241,846	$76,324,196	$75,642,454	$70,348,720	$31,924,756
Temporary Absence Foster Children												
Annual Cost for Children**				$21,912,789	$22,939,825	$23,390,188	$25,445,074	$28,557,405	$30,526,271	$31,211,881	$31,722,231	$16,304,697
Annual Cost for Parents				$0	$0	$0	$0	$0	$0	$0	$0	$0
Total for Temporarily Absence Foster Children				$21,912,789	$22,939,825	$23,390,188	$25,445,074	$28,557,405	$30,526,271	$31,211,881	$31,722,231	$16,304,697
Grand Total Expansion Groups - without waiver				$21,912,789	$22,939,825	$23,390,188	$32,723,101	$95,799,251	$106,850,467	$106,854,335	$102,070,951	$48,229,453

MEMO

TO: Gary Claxton, Cheryl Austein, Debbie Chang, Dan Able
FR: Cindy Mann, Vicky Pulos and Joan Alker
RE: Medicaid crowd out policies for CHIP expansion groups
DATE: January 11, 1999

As per our previous discussions, attached is a memo explaining our concern with the legal interpretation that underlies the decision to allow waiting periods in Medicaid for CHIP expansions and our suggestions for alternate ways to allow such policies. We believe this interpretation is not necessary in order to approve crowd out policies in Medicaid expansions and that it sets a damaging precedent that could undermine essential features of the Medicaid program.

It is possible for HCFA to approve crowd out policies either through the section 1115 waiver process or possibly through an interpretation of that aspect of the definition of targeted low-income children that requires such children to be "uninsured." For the reasons explained in the attached memo, the waiver process is preferable. Under either alternative, crowd out policies can be permitted for Medicaid CHIP expansions without undermining essential components of the Medicaid statute and the protections that federal law assures to all Medicaid-eligible children, including those covered through Medicaid CHIP expansions. HCFA's current interpretation that relies on the "determined eligible" language in section 2110 stretches the statute beyond its plain meaning, contravenes longstanding Medicaid rules, and opens the door for state-imposed restrictions on eligibility, including enrollment caps. This is clearly not what was intended either by the new law or by the Administration's efforts to protect against crowd out.

Thank you for being attentive to this important issue and open to our suggestions. We look forward to talking to you about this issue once you have had an opportunity to review the memo.

MEMO

TO: Interested Parties
FR: Cindy Mann, CBPP and Vicky Pulos and Joan Alker, Families USA
RE: State authority under Title XIX to create waiting periods before uninsured children can be enrolled in Medicaid
DATE: January 11, 1999

In an effort to allow states to impose anti-crowd out waiting periods in Medicaid CHIP expansions, HCFA has apparently determined that states are permitted to impose conditions of eligibility for the targeted low income child Medicaid coverage group (section 1905(u)(2)) that are not otherwise permissible under Medicaid. Leaving aside any concerns about waiting periods for Medicaid-eligible children, this interpretation of federal law has very troubling implications. It contravenes longstanding Medicaid rules that prohibit states from creating eligibility conditions not specifically authorized by federal law, and it violates the principle that if a state elects the Medicaid option for its CHIP expansion, all of the requirements and protections of the Medicaid program, including the Medicaid entitlement, apply.

Specifically, HCFA has allowed a few states, including Maryland and Missouri, to impose waiting periods without insurance as a condition of eligibility in the Medicaid program for their expansion group. HCFA may also have approved a new Medicaid condition of eligibility for Idaho. As described in the Idaho state plan, the state would be permitted to deny Medicaid coverage to otherwise eligible uninsured children in the expansion group who were not previously insured but who the state determines may have access to employment-based insurance. All of these states used their Title XXI funds to expand their Medicaid programs under section 1905(u)(2).

This memo reviews HCFA's initial interpretation of federal law that allowed these state policies and the implications of this interpretation. It then considers alternative avenues which might allow anti-crowd out waiting periods but that would not give rise to such troubling consequences. This memo takes no position on whether allowing waiting periods in Medicaid is a good idea; it is intended only to explain why it is critical that if HCFA allows states the authority to impose waiting periods in Medicaid for the expansion population that it not rely on an interpretation of federal law that would permit

states to impose other eligibility conditions and limitations that are not otherwise authorized by federal law.

HCFA's Rationale

In an attempt to identify a legal basis for anti-crowd out provisions in states with Medicaid CHIP expansions, our understanding is that HCFA has at least initially determined that the new Medicaid eligibility category created by the child health law (the 1905(u) category) permits states to impose eligibility criteria in addition to those otherwise authorized under federal Medicaid law so long as such criteria are consistent with the purposes of Title XXI. So far, states have only sought to adopt additional eligibility criteria that address the problem of crowd out. However, the rationale that HCFA relies on to support these crowd out provisions clearly opens the door for other eligibility restrictions that states may wish to impose.

The Balanced Budget Act of 1997 created a new Medicaid coverage group at 1905(u)(2) that is subject to enhanced federal match. The Medicaid statute defines the new group as consisting of an optional targeted low-income child as defined in 2110(b)(1).

Section 2110(b) (1) states in pertinent part:

(1) Subject to paragraph (2), the term 'targeted low-income child' means a child –
  (A) who has been determined eligible by the State for child health assistance under the State plan,
  (B) Who is a low-income child, ...and
  (C) Who is not found to be...covered under a group health plan or under health insurance coverage ....

HCFA has at least tentatively concluded that the language in section 2110(b)(1)(A), which describes a targeted low-income child as one *who has been determined eligible by the State* for child health assistance, permits states to impose additional eligibility requirements to the extent that these requirements are consistent with Title XXI. Crowd out eligibility conditions are consistent with Title XXI, according to HCFA's analysis, because they are specifically mentioned in section 2102(b). Section 2102(b)(3)(C) requires the state child health plan to include provisions that assure "that insurance provided under the State child health plan does not substitute for coverage under group health plans."

By interpreting the "determined eligible" language in section 2110 to allow states to impose their own eligibility criteria for Medicaid expansion groups and relying on section 2102 to set the parameters of the additional eligibility criteria that can be applied, HCFA's interpretation of the CHIP statute opens the door for eligibility restrictions that go well beyond crowd out policies. Section 2102(b)(1)(A) permits states broad discretion to

impose eligibility criteria *in their non-Medicaid TITLE XXI programs,* including criteria restricting coverage to certain geographic areas or limiting the duration of eligibility. Once HCFA permits states to adopt additional eligibility criteria in their Medicaid programs under these provisions, there appears to be no statutory basis for HCFA to prevent states from further limiting Medicaid eligibility. HCFA's reading of the statute would seem to permit states to limit Medicaid eligibility to only some regions in the state and to allow states to impose Medicaid time-limits or enrollment caps for the expansion population.

HCFA's Interpretation Is Not Consistent with the Plain Meaning of the Statute or Congressional Intent and Undermines Longstanding Principles of Federal Medicaid Law

It has long been established that federal law sets the parameters of the eligibility rules that can be imposed by states in the Medicaid program. This aspect of the federal-state partnership under Title XIX prevents states from covering populations that are not specifically authorized under Title XIX and it also prevents states from imposing additional eligibility criteria in their Title XIX programs that would keep individuals eligible under federal law from participating in the program. This longstanding principle assures that states cannot narrow the scope of the federal entitlement or eliminate it altogether, for example, by establishing time limits and enrollment caps.

Nothing in the child health law was intended to alter this fundamental aspect of federal Medicaid law. The BBA gave states two options for expanding coverage: creating or expanding a non-Medicaid program that meets the criteria described in Title XXI or expanding the Medicaid program in accordance with criteria allowable under Title XIX. The point of intersection between the two options is the definition of a targeted low income child. That definition does not authorize states to adopt additional eligibility criteria in its Medicaid program that are not otherwise authorized by federal law; it merely acknowledges that children who are eligible as "targeted low-income children" must be found eligible by the state based on all applicable criteria. In the case of a non-Medicaid program, the eligibility criteria otherwise applicable are those allowed under section 2102. In the case of the Medicaid option, the eligibility criteria otherwise applicable are those specified in Title XIX or other statutes explicitly relating to Medicaid.

The eligibility criteria specifically addressed in the definition of targeted low-income child relate to age, income, insurance status, and ineligibility for Medicaid criteria in effect on a specified date. Obviously this was not intended to be an exclusive list of eligibility criteria for a child to qualify for an enhanced matching payments under the Medicaid program. The child must otherwise be "determined eligible" for Medicaid. For example, federal law explicitly applicable to Medicaid imposes eligibility criteria related

to citizenship and immigration status, and the Medicaid statute itself imposes eligibility criteria related to residence within the state and to asset ownership. These are the kinds of eligibility criteria, otherwise applicable to Medicaid coverage, which also apply to the new Medicaid category of targeted low-income children.

When Congress wanted to accord states the discretion to adopt their own eligibility criteria for the children it would cover with the new block grant funds, it did so clearly and explicitly, as it did in the context of Title XXI non-Medicaid programs. Section 2102(a)(5) authorizes states seeking payment under 2105 (non-Medicaid) to adopt "eligibility standards consistent with subsection (b)." Section 2102 (b) describes permissible types of eligibility criteria for the new block grant programs, such as standards relating to geographic areas to be served, that are not permissible in Medicaid. It is particularly unlikely that Congress would have intended the "determined eligible" language in section 2110 to be an open-ended invitation for states to impose their own eligibility standards in the Medicaid program.

Under the BBA, Congress intended to give states a choice between the traditional Medicaid entitlement and a block grant approach. Prior to passage of the new legislation, Congress debated the merits of a Medicaid approach versus a block grant approach. The resulting compromise was intended to offer a Medicaid entitlement option at the same time that states were given the choice of a non-entitlement option. Any interpretation of the statute that would open up the Medicaid program to new restrictions not specifically authorized by federal law, including restrictions that could undermine the Medicaid entitlement, is clearly not consistent with the delicate compromise arrived at in the legislation.

Options Under Federal Law That Might Permit States to Impose Crowd Out Rules.

There are three possible interpretations of federal law that might provide an alternate legal basis for state anti-crowd out rules in Medicaid CHIP expansions.

The Waiver Option

The interpretation consistent with our understanding of federal law and Congressional intent is that the statute does not permit states to impose waiting periods for Medicaid expansion groups but that anti-crowd out policies would be permitted through the section 1115 waiver process. This interpretation of federal law is consistent with the legislative history of the new law as described above and does not run the danger of creating new and troubling legal precedents. In addition, the 1115 waiver process gives HCFA a seat at the table when state crowd out policies are designed. By contrast, if the statute is interpreted to allow states to impose anti-crowd out mechanisms, HCFA's authority to approve the parameters of a state's anti-crowd out policy would be circumscribed. For example, if states had the option to impose waiting periods under the

statute, HCFA would have very limited authority to assure that reasonable exemptions to the waiting periods were allowed. Anther advantage to the waiver approach is that waivers are time-limited and, at least theoretically, require an evaluation of the policy which is the subject of the waiver. This is particularly appropriate in the context of crowd out policies where there are important questions about whether and to what extent publicly-financed coverage expansions affect the availability of affordable private coverage for low-income children.

These advantages from the federal perspective would clearly be perceived as disadvantages from the states' perspective, but if HCFA were to make it clear that crowd out waivers for states that had expanded substantially through Medicaid were consistent with Congressional intent and, as such, would be "welcome" and promptly reviewed, state resistence could be minimized. Waivers could be offered to the states which already believe they have approval to impose anti-crowd out waiting periods in Medicaid.

The definition of "uninsured" child may permit states to impose crowd out policies in Medicaid

Alternatively, a more narrow reading of the definition of "targeted low-income child" than the one HCFA has relied on might permit crowd out policies in Medicaid without opening the door to other, unauthorized, eligibility criteria. The overall purpose of the children's health insurance provisions was to reduce the number of uninsured children. For this reason, the definition of targeted low-income child provides at section 2110 (1)(C) that children eligible for the new block grant funding must be uninsured. The language used is in the present tense and therefore may not seem to authorize a period without insurance as a condition of eligibility. However, given Congressional intent to prevent crowd out, it may be reasonable for HCFA to interpret this language as permitting anti-crowd out waiting periods.

Basically, HCFA could rely on this statutory provision to allow states some latitude in defining "uninsured" in light of Congressional concern over crowd out. The Secretary could determine that states have the authority to deny coverage to children who drop private coverage for the purpose of evading the statutory requirement and qualify for coverage as an "uninsured" child. To prevent this kind of evasion, states could be permitted to develop reasonable definitions of "uninsured" to include periods in which a child might have been insured but for the dropping of private coverage that cannot otherwise be explained. In our view, whatever the weaknesses may be in this language in terms of supporting state anti-crowd out provisions, it seems clear that this language provides stronger support for a crowd out waiting period than does the "determined eligible" language in section 2110(1)(A).

The advantage of this interpretation is that it is rooted in statutory language that specifically addresses the problem of crowd out, and thus it does not in any way open the door to additional eligibility criteria inconsistent with the Medicaid entitlement. In contrast to the waiver approach, however, it would allow waiting periods for children who lacked insurance coverage without any of the review or evaluation components that are part of a waiver approach.

Medicaid children uninsured for a specified length of time may constitute a 'reasonable classification' under Title XIX

A much less satisfactory approach would be to interpret another provision in Title XIX that allows states the authority to cover "reasonable categories" of children to permit states to impose a period without insurance as a condition of eligibility in order to discourage crowd out. This approach has been suggested by HCFA as possibly resolving the crowd out issue, but it also would allow other state-imposed restrictions in Medicaid and thus is troubling because it may not solve the key problem associated with the "determined eligible" interpretation.

Section 1902(a)(10)(A)(ii) gives states the option of providing Medicaid as categorically needy to any group or persons described in 1905(a) who are not mandatory eligibles. Among these optional categorically needy groups are children under age 21, commonly known as "Ribicoff children." The implementing regulations provide that states may offer Medicaid to individuals under age 21 or reasonable categories of such individuals who are not receiving cash assistance, but who meet the income and resource requirements of the State's AFDC plan. 42 CFR 435.222. The regulation lists "examples" of reasonable classification, including certain children in foster care, in subsidized adoptions, and in certain institutional settings.

The so-called Ribicoff group of children is not limited to children with incomes or resources below traditional AFDC standards; see preamble to the final rule adopting 42 CFR 435.222, January 19, 1993. A state, therefore, might be able to cover children in its Medicaid CHIP expansion under this category and receive the enhanced CHIP matching rate assuming the children otherwise met the definition of targeted low-income children. By relying on the "reasonable categories" provision applicable to this eligibility group, the Secretary could then approve a state's election to limit coverage to children who would not otherwise be eligible for Medicaid and who have been without insurance for a certain period of time.

Opening the door to the "reasonable classifications" provisions, however, may invite state proposals for creating other categories of children (ie., limitations) that go beyond the issue of crowd out. Unlike the waiver option which can be limited by federal negotiation, or the statutory option based on section 2110(B) which is explicitly limited to eligibility rules relating to insurance status, this option might suggest to states new

opportunities to evade other Medicaid requirements so long as they could justify the limitation as a "reasonable category." For example, a state might argue that a geographic limitation was reasonable because only some counties in the state were prepared to contribute to the cost of expanded Medicaid coverage.

Conclusion

Concern over crowd out should not prompt HCFA to approve policies that deny Medicaid coverage to children who have no access to affordable health care or to interpret federal law in such a way that undermines the federal law guarantees that are a central feature of the Medicaid program. Alternative interpretations of federal law that would permit states to adopt reasonable crowd out policies in the even that they substantially expand coverage through Medicaid can accommodate the concern about crowd out without putting basic Medicaid principles at risk. We believe the waiver route is the better alternative; it is supported by the statutory language and allows HCFA the leeway it seeks to allow reasonable crowd-out policies for Medicaid CHIP expansions.