

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	~~Phil Caplan and Sean Maloney to the President re: Children's Health Insurance Program Waivers (9 pages)~~	~~02/12/1998~~	~~P5~~ <i>deus 4/6/15</i>

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20463

FOLDER TITLE:

CHIP [Children's Health Insurance Program] Implementation [Folder 1]

2012-0463-S

rc728

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

DEC 12 1996

MEMORANDUM

TO : Darrel Grinstead
Associate General Counsel
Health Care Financing Division

FROM : George Lyon
Associate General Counsel
Civil Rights Division

SUBJECT: Cost-sharing for IHS beneficiaries in expansion
populations

Don Kosi of your staff has asked for our views on whether civil rights issues are raised by a proposal to condition approval of a state's section 1115 demonstration project on its agreement not to impose premiums on IHS beneficiaries who would become eligible for title XIX services under the project.

In particular, we have been asked whether such a distinction would raise an issue under Title VI of the Civil Rights Act of 1964. Title VI prohibits programs receiving Federal financial assistance from discriminating on the basis of race, color or national origin. State Medicaid programs are considered programs receiving Federal financial assistance. Title VI is enforced by the Office for Civil Rights for programs receiving assistance from HHS. Individuals who believe they have suffered discrimination by programs receiving Federal assistance may also bring private Title VI actions against those programs. As a result, states implementing the proposed requirement could be charged with a Title VI violation. Although Title VI does not directly apply to Federal activities, those activities could be subject to review under the Constitution.

HCFA has questioned whether the proposal raises a Title VI issue because it may involve race or national origin-based distinctions. Relying on a line of constitutional cases, IHS has questioned whether the distinction at issue is based on political status (i.e., on the basis of membership in a Federally-recognized tribe) and not race or national origin. We believe that civil rights issues are raised by the proposal, although as discussed below, that does not mean that the proposal necessarily violates Title VI. The Office for Civil Rights has consistently viewed state program distinctions based on Native American status as race or national origin distinctions subject to Title VI review. Even where state program distinctions have been based on

if you are able
to show that you are
acting under your
authority w/ relationship
w/ Indian tribes

States in order
to come under reasonable
test, need to

Page 2 - Darrel Grinstead

IHS eligibility (such as where states have asserted that their assistance programs are "payers of last resort"), the Office for Civil Rights has viewed them as subject to Title VI review because, at a minimum, they may have a discriminatory effect on the basis of Native American status.

The regulation implementing Title VI includes a provision (45 CFR § 80.3(d)) excluding programs limited to individuals of a particular race, color, or national origin:

(d) Indian Health and Cuban Refugee Services. An individual shall not be deemed subjected to discrimination by reason of his exclusion from the benefits of a program limited by Federal law to individuals of a particular race, color, or national origin different from his.

This provision would not appear to apply to the situation at issue. First, the proposed waiver of cost-sharing is not taking place in the context of a program limited to Indians. Second, as we understand it, the proposed exclusion is not required by Federal law. As such, it is not a "program limited by Federal law to individuals of a particular race, color, or national origin."

The fact that the proposed exclusion does not appear to be covered by § 80.3(d) does not mean, however, that the exclusion is necessarily prohibited by Title VI. As a general rule, Title VI incorporates constitutional standards for protection from discrimination.¹ To the extent then that the proposed exclusion may survive constitutional scrutiny, it may also survive Title VI review. Under the Constitution, government action, whether state or Federal, that is based on race or national origin is subjected to strict scrutiny. Under strict scrutiny, race-based distinctions are allowed only where narrowly tailored to achieve a compelling government interest. This standard differs from the rational basis standard, which normally applies to government actions. Under that standard, government actions need only be rationally related to a legitimate government objective.

As noted above, there is a line of cases that applies the rational basis standard to Federal Indian preferences. See, e.g., Morton v. Mancari, 417 U.S. 535 (1974). In Morton the Supreme Court upheld against a claim of race discrimination a Federal statutory employment preference for qualified Indians in

¹ In one area, the regulation implementing Title VI prohibits actions that are not prohibited by the Constitution. The regulation prohibits certain actions that have the effect of discriminating on the basis of race, whereas the Constitution prohibits only intentional discrimination.

Page 3 - Darrel Grinstead

the Bureau of Indian Affairs. The Court ruled that strict scrutiny did not apply because the preference was not directed towards a racial group (all Indians) but a political group (only members of Federally recognized tribes). *Id.* at 553 n.24. The Court emphasized that the issue turned on the unique relationship between the Federal government and Indian tribes, as well as the unique status of the Bureau of Indian Affairs. *Id.* at 551, 554. Because the Court saw the preference as reasonable and rationally tied to the furtherance of Congress' unique obligation to Indians, it ruled that the statute did not violate the Constitution.

Although Morton involved a Federal statutory preference, Indian preferences contained in regulation may also be reviewed under the rational basis test when authorized by Federal statutes. See Alaska Chapter, Associated General Contractors of America v. Pierce, 694 F.2d 1162 (9th Cir. 1982). In Pierce the court upheld, under a rational basis standard, a HUD regulation directing Indian housing authorities to give contracting preference to Indian-owned businesses. The preference had as its authority the part of the Indian Self-Determination Act that directed that preferences be given to Indian-owned economic enterprises in the awarding of Federal contracts with or grants to Indian organizations or for the benefit of Indians. 25 U.S.C. § 450e(b). The court rejected arguments that the Self-Determination Act was limited to the Bureau of Indian Affairs, the Indian Health Service, or those programs dealing directly with Indian self-government or education, and ruled that the Act applied to HUD programs. 694 F.2d at 1165. The court next found that the preferences in the HUD regulation did not go beyond those authorized by Congress. *Id.* at 1166. Because the court found that the regulation furthered the Federal government's trust responsibility towards Indians, as authorized by Congress, it held that the regulation did not violate the Constitution.

The proposed exemption from premiums presents a significantly different situation from those described above. Here the Indian preference would not be in a Federally conducted program but in state programs (albeit state programs receiving Federal assistance). In practice states would be adopting these preferences and administering them in their benefit programs. As a result, states could be the subjects of claims that their preferences are unconstitutional or in violation of Title VI.

As a general rule, states do not have the same role or responsibility as does the Federal government in dealing with Indians. The Supreme Court has noted that it is the unique legal status of Indian tribes under Federal law that permits the Federal Government to enact legislation singling out tribal Indians, which might otherwise be constitutionally offensive. Washington v. Confederated Bands and Tribes of Yakima Indian Nation, 440 U.S. 940, 500-01 (1979). States do not enjoy this

Page 4 - Darrel Grinstead

same unique relationship with Indians. Id. In Washington, however, the Court nevertheless upheld a State's assumption of partial civil and criminal jurisdiction in Indian lands using a rational basis standard. The Court applied the rational basis test because it found that the State acted under explicit authority granted to it by Congress, which itself was exercising its plenary power over Indian affairs. Id.

In this situation, therefore, an important consideration would be the authority by which the Department would be mandating that states exclude IHS beneficiaries from cost-sharing requirements. Consistent with Morton and Pierce, an important consideration is whether the preference is authorized by Federal legislation furthering the Federal government's unique role and responsibility in Indian affairs. Consistent with Washington, it is also important whether that authority can be extended to states. If the Department were acting pursuant to its authority in connection with the Federal government's unique relationship with Indians, and if the Department were authorizing states to further the unique Federal relationship, there could be a legal basis for arguing that the states' exclusion of IHS beneficiaries should be reviewed under a rational basis test. Under that standard the states must demonstrate that their actions are rationally related to the furtherance of their legitimate objectives. A strict scrutiny review would require states to identify their compelling interests and to establish that the preference is narrowly tailored to accomplishing those goals.

The materials provided to us for review primarily summarize the merits of the proposal. They do not address the underlying question of the Department's authority to mandate the preference. From a standpoint of defending Department action from a constitutional legal challenge, a critical question is whether the law authorizes the Department to mandate this as part of its unique relationship with Indians. An explanation of that authority would also be critical in the event that individuals challenge state actions. A state subject to challenge could point to that authority and the Federal mandate in its defense. Aside from the question of legal challenge, it would also be critical in explaining to states the basis for the Department mandate.

cc: Richard Riseberg
Kathleen O'Brien
Donald Kosin
Kitty Marx
Maria Boulmetis

786 8355



DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FAX COVER SHEET

INTERGOVERNMENTAL AND TRIBAL AFFAIRS GROUP
CENTER FOR MEDICAID AND STATE OPERATIONS

DATE:

12/4/98

TO:

Deborah Adler

ORGANIZATION:

TELEPHONE:

456-5707

FAX:

456-5557

PAGES:

4

(Including Cover Page)

FROM:

Mary Vallin

Intergovernmental and Tribal Affairs Group
Center for Medicaid and State Operations
Health Care Financing Administration
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 337-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

(202) 690-5742 or 690-8501 (PHONE)
(202) 205-7906 (FAX)

REMARKS:

Hi, Deborah. As you know, I'm filling in for
Clarke who's mom died. I understand you missed the
clearance panel meeting. See attached. If you need to be
walked through the plans, I can arrange it. Today's
meeting is @ 3:30. Call in # 410-786-3100, code 431683.
~~Please call~~ ~~at~~ ~~if there are any problems with this fax~~
Let me know something.

ALASKA TITLE XXI PROGRAM FACT SHEET

Name of Plan: n/a

Date Plan Submitted: August 28, 1998

Date Plan Approved:

Effective Date: March 1, 1999

Background

- On August 28, 1998 Alaska submitted a Title XXI Plan to expand Medicaid eligibility to children under the State's Medicaid Title XIX plan. The State will use its Title XXI funds to expand Medicaid coverage to children in families with incomes up to 200 percent of the Federal Poverty Level (FPL). Eligible children will receive the full Medicaid benefit package. All Medicaid program policies will apply. Alaska expects to initiate expanded eligibility on March 1, 1999.
- Alaska's current Medicaid program covers children between the ages of 0 and 1 in families with incomes up to 185 percent of the FPL, ages 1 through 6 in families up to 133 percent of the FPL, and children from age 6 through age 19 in families with incomes up to 100 percent of the FPL.

Children Covered Under Program

- The State estimates it's CHIP plan will provide health insurance coverage to an additional 5,050 children by the end of FY 2001.

Administration

- The expanded coverage for children will be administered by the Division of Medical Assistance in the Alaska Department of Health and Social Services.

Health Care Delivery System

- A unique health care delivery system has evolved in Alaska to serve its ethnically-diverse and geographically scattered population. Tertiary services are located only in Anchorage where the majority of residents live. Community hospitals are located in smaller urban communities, and two military hospitals are located in Anchorage and Fairbanks. The

tribal health care delivery system is virtually the only provider of health care services in rural Alaska. Primary care and emergency services are rendered by community health aides who are trained residents of the village with telephone guidance provided by a physician of the health corporation. There are some preferred provider arrangements, however, there are no HMOs in the State.

Benefit Package

- The current Medicaid benefit package will be provided.

Cost Sharing

- There are no cost sharing requirements.

Crowd-Out Strategy

- Insured children with incomes up to 150 percent of the FPL will be eligible for Medicaid under Title XIX if third party coverage is the only eligibility factor preventing them from qualifying for Title XXI coverage. Children with incomes in excess of 150 percent of the FPL whose insurance was voluntarily dropped without good cause will be prohibited from participating in the program for twelve months.

Outreach Activities

- Partnerships with the State and local governments, schools, health care providers, tribal entities, and non-profit corporations serving children are being established to ensure that child health is promoted and that families are aware of the Medicaid expansion.

Financial Information

Total CHIP Allotment -- \$5,664,899
Enhanced Federal Matching Rate -- 71.86%

First Year Costs:

State Share --\$1,838,694
Federal IHS Match Funds --\$247,088
Federal Share --\$4,765,366
Total --- \$6,851,148

Second Year Costs:

State Share --\$3,079,992
Federal IHS Match Funds --\$439,572

Federal Share --\$8,477,612
Total --\$11,997,175

Third Year Costs:

State Share --\$3,181,872
Federal IHS Match Funds --\$465,907
Federal Share --\$8,985,526
Total --\$12,633,305

(Note: IHS expenditures are not charged against the State's Title XXI allotment.)

to Ann Lewis &
Others?

PRESIDENT SCHEDULING REQUEST

November 5, 1998

____ ACCEPT

____ REGRET

____ PENDING

TO: Stephanie Streett, Director of Scheduling

FROM: Bruce Reed and Chris Jennings, Domestic Policy Council
Gene Sperling, National Economic Council
Ron Klain, Office of the Vice President
Melanne Verveer, Office of the First Lady
Ann Lewis, Office of Communications
Minyon Moore, Office of Public Liaison

REQUEST: January event to announce new children's health outreach efforts.

PURPOSE: To launch a nationwide media campaign, including TV and radio spots with the First Lady, a new toll-free number, and other private corporate and volunteer efforts.

BACKGROUND: Reducing the number of uninsured children in America has been a priority for the President, First Lady and Vice President. Last year, we created a \$24 billion Children's Health Insurance Program -- the largest health expansion for children in 30 years. In June, the President announced that 8 Federal agencies would implement over 150 activities to enroll children in CHIP and Medicaid. The proposed event would focus on the private sector actions. The President would: (1) launch a national ad campaign that includes a 1-800 number sponsored by the NGA; (2) announce other private sector activities; and (3) call on volunteer groups to get involved (AmeriCorps is considering launching grassroots outreach effort).

DATE & TIME: January 1999 (possibly on Martin Luther King, Jr. Day if done with AmeriCorps). We are hoping for a scheduling decision as soon as possible since most corporations will commit to help only if we have a date.

DURATION: 1 hour

LOCATION: East Room

PARTICIPANTS: The President, First Lady, Vice President, several Governors, contributing corporations, and children's health advocacy groups.

REMARKS REQUIRED: Yes

MEDIA: Open

CONTACT: Christa Robinson 6-5165

DEC 23 1998 09:15
202 690 6362 P.02/03
The Honorable Joe Lekan
Secretary
Department of Health and Family Services
1 West Wilson Street
P.O. Box 7850
Madison, Wisconsin 53707-7850

Dear Secretary Lekan:

I was very encouraged by our call earlier this month regarding BadgerCare, and I was pleased to have a chance to update you on our discussions regarding the status of our discussions.

We are committed to bringing the remaining BadgerCare issues to resolution as soon as possible. Towards that end, staff from the Health Care Financing Administration (HCFA) and the Department of Health and Human Services (the Department) holding a series of discussions with your staff on the various issues related to BadgerCare. I understand that these discussions have been productive thus far, and I have asked my staff to work aggressively to resolve the outstanding issues.

The progress we have made on several issues causes me to be cautiously optimistic regarding our ability to move forward. We have received your most recent letter, dated November 20, regarding your proposal for modifying the eligibility redetermination process and for establishing enrollment "triggers." We are reviewing this proposal and have asked your staff to provide additional clarification regarding the implementation of enrollment triggers. Based upon your indication in our conversation that enrollment thresholds refer to income eligibility thresholds and not to caps on the number of persons enrolled in the program, I believe that this is a promising approach that will help to protect the State's financial liability.

You have also requested Federal matching funds for adult premiums under Medicaid. By allocating the premiums separately to adults and children, the State can receive Federal matching funds for adult premiums. I am pleased to inform you that the premium allocation methodology you have submitted is acceptable.

I also want to thank you for your flexibility on two significant issues. While we are supportive of your goal to cover absent parents, we remain concerned that the proposal to claim Title IV-E targeted case management costs under Medicaid may not be workable. Your decision to pursue this issue along a separate track will significantly help to move forward toward a final resolution on the BadgerCare package. Also, this approach will allow the Administration for Children and Families and the Department to research

alternative mechanisms in supporting absent parents.

Similarly, your desire to provide coverage for families without the need for a Section 1115 waiver of the Title XXI cost-effectiveness requirement for the purchase of family coverage (Section 2105(c)(3)(A)) is very helpful. The approach we have discussed -- using existing flexibility under Medicaid-- would provide virtually all of the Federal matching funds that the State is seeking, and it would comply with all the Federal statutory requirements.

We have made significant progress. Yet, as I understand it, there are at least three significant issues remaining.

- Employer Buy-in -- We look forward to continuing to work with your staff on the cost-effectiveness of your employer-sponsored insurance buy-in program.
- Budget Neutrality -- As I am sure that you are aware, the budget neutrality issues are very complex. It will be challenging to resolve the issues surrounding the development of an appropriate trend rate and the creation of a budget neutrality methodology that encompasses the enrollment trigger within the short time frame we face.
- Cost Sharing -- We are in the process of devising guidance for states regarding cost-sharing options for tribes under Title XXI.

Finally, we continue to work on a specific time line for moving forward. We recently sent you a draft time line, and I understand that HCFA, the Department and the State have been working from that draft. Before finalizing this document, I think that it would be useful to further assess how our extensive conversations are progressing. However, I will do everything I can to provide you with a final response on your proposal during late January.

We have worked very hard with you and your staff to develop a program that advances our shared goals in a manner that is permissible under both the new Children's Health Insurance Program (CHIP) and Medicaid. I am committed to renewing our efforts and to bringing the remaining issues to closure as soon as possible. I appreciate your commitment to meet the goals of the new CHIP program through an innovative program design. As always, please feel free to contact me with any questions. I hope you have a wonderful holiday season.

Sincerely,

Nancy-Ann Min DeParle
Administrator

DEC 23 1998 14:33
202 690 6362 P.02/03
The Honorable Joe Lekan
Secretary
Department of Health and Family Services
1 West Wilson Street
P.O. Box 7850
Madison, Wisconsin 53707-7850

Dear Secretary Lekan:

I was very encouraged by our call earlier this month regarding BadgerCare, and I wanted to update you on the status of our discussions to date.

We are committed to bringing the remaining BadgerCare issues to resolution as soon as possible. Towards that end, staff from the Health Care Financing Administration (HCFA) and the Department of Health and Human Services (the Department) are holding a series of discussions with your staff on the various issues related to the BadgerCare waiver. I understand that these discussions have been productive thus far, and I have asked my staff to work aggressively to resolve the outstanding issues.

The progress we have made on several issues causes me to be cautiously optimistic *about* ~~regarding~~ our ability to move forward. We have received your most recent letter, dated November 20, regarding your proposal for modifying the eligibility redetermination process and for establishing enrollment "triggers." We are reviewing this proposal and have asked your staff to provide additional clarification regarding implementation. Based upon our conversation that enrollment thresholds refer to income eligibility thresholds and not to caps on the number of persons enrolled in the program, I believe that this is a promising approach that will help to protect the State's financial liability.

You have also requested Federal matching funds for adult premiums under Medicaid. By allocating the premiums separately to adults and children, the State can receive Federal matching funds for adult premiums. I am pleased to inform you that the premium allocation methodology you have submitted is acceptable.

I also want to thank you for your flexibility on two significant issues. While we are supportive of your goal to cover absent parents, we remain concerned that the proposal to claim Title IV-E targeted case management costs under Medicaid may not be workable. Your decision to pursue this issue along a separate track will ~~significantly~~ *help* to move ~~forward~~ toward a final resolution on the BadgerCare package. Also, this approach will allow the Administration for Children and Families and the Department to research alternative mechanisms in supporting absent parents.

DEC 23 1998 14:33
202 690 6362 P.03/03

Similarly, your desire to provide coverage for families without the need for a Section 1115 waiver of the Title XXI cost-effectiveness requirement for the purchase of family coverage under Section 2105(c)(3)(A) is very helpful. The approach we have discussed, ^{which} ~~using~~ existing flexibility under Medicaid-- would provide virtually all of the Federal matching funds that the State is seeking, and it would comply with all the Federal statutory requirements.

We have made significant progress. Yet, as I understand it, there are at least three significant issues remaining. These issues include determining: budget neutrality for the waiver, the cost-sharing levels for members of Tribes, and the cost-effectiveness approach used for the Medicaid employer buy-in program.

Finally, we continue to develop on a specific time line for moving forward. We recently sent you a draft time line, and I understand that HCFA, the Department and the State have been working from that draft. Before finalizing this document, I think that it would be useful to further assess how our extensive conversations are progressing. However, I will do everything I can to provide you with a final response on your proposal in late January.

We have worked very hard with you and your staff to develop a program that advances our shared goals in a manner that is permissible under both the new Children's Health Insurance Program (CHIP) and Medicaid. I am committed to renewing our efforts and to bringing the remaining issues to closure as soon as possible. I appreciate your commitment to meet the goals of the new CHIP program through an innovative program design. As always, please feel free to contact me with any questions. Best wishes for the New Year.

Sincerely,

Nancy-Ann Min DeParle
Administrator

Good -

Redraft of
HHS Letter.

Dear State Health Official:

The Balanced Budget Act of 1997 established the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act (the Act). This new Title enables States to expand health insurance coverage for uninsured children through separate State health insurance program (S-CHIP), through Medicaid, or a combination of the two. Title XXI requires States to submit plans for approval by the Secretary of the Department of Health and Human Services in order to receive funds for providing health care coverage. The Department of Health and Human Services has issued several letters to provide policy and State plan guidance on the implementation of Title XXI.

several options for providing coverage w/o cost sharing.
In our consultations with Tribes, a concern has been raised that eligible Indian children may not be enrolling in S-CHIP because of cost-sharing requirements. *describes a* This letter is intended to inform you that States providing health benefits coverage through a separate State (S-CHIP) Title XXI program have the option to exempt American Indians/Alaskan Natives enrolled in State Child Health Insurance Programs from any cost sharing requirements. *as a reminder it* In CHIP Medicaid expansion programs, the Medicaid statute does not permit cost sharing (including premiums, deductibles, copayments and similar charges) for any children ~~under most circumstances~~.

Currently, Title VI of the Civil Rights Act of 1964 prohibits programs receiving Federal financial assistance from discriminating on the basis of race, color, or national origin. However, legal precedent indicates that the Federal government's unique fiduciary relationship with Indian tribes overrides Title VI in this instance and *suggests that* provides both the Federal government and the States ~~with the flexibility to exempt~~ Indians from cost sharing requirements in CHIP. *can provide* *provide*

It is important to note that this legal precedent does not override any aspect of Title XXI. This means that section 2103(e)(1)(B), which prohibits the variation of cost sharing requirements within a State plan in a manner that favors higher income children over lower income children, still applies to States who wish to exempt Indian children from cost sharing requirements.

In order to exempt Indian children from cost sharing requirements that are imposed on most other program enrollees without violating this provision of the statute, States can use the authority provided them by section 2102(b)(1)(A), which gives States the flexibility to determine eligibility based on beneficiary characteristics other than income, such as residency or geographic area. States could use this authority to establish a separate plan specifically for these children. This plan could offer the same benefits, use the same delivery system, and have the same eligibility determination process, but would not include cost sharing provisions. Because the State would be enrolling Indian children in a separate State plan than the rest of the low income children in the State, the differential cost sharing requirements for Indian children would not be subject to the prohibition against cost sharing requirements that favor higher income children over lower income children.

We cannot anticipate at this time exactly how many Tribes may approach States with proposals to discontinue cost sharing, or the conditions upon which they will request such treatment. States should address tribal concerns on these issues in a manner that is consistent with their responsibility to engage in meaningful consultation with Indian tribes, as discussed in the February 24, 1998 letter to State Health Officials on consultation requirements. In addition, HCFA's regional offices are prepared to facilitate negotiations as they arise between Tribes and States on the matter of cost sharing in S-CHIP. Please contact your HCFA regional office with questions about your options regarding cost sharing for AI/AN's.

Sincerely,

Sally K. Richardson, Director
Center for Medicaid and State Operations
Health Care Financing Administration

cc: Michael Trujillo, IHS
Earl Fox, M.D., M.P.H., PHS
Tribal Nations
Yvette Joseph Fox, NIHB

END
① We are concerned
about cost sharing
for all kids,
but recog.

Date: _____

FAX



Health Division



Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

To:

Devorah

Fax:

Phone:

From:

Cindy

Number of Pages (not including cover):

Subject:

Please call if there are any problems with this transmission:

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

Copied
Jennings
COS

THE PRESIDENT AS AGENT

2-23-98

THE WHITE HOUSE
WASHINGTON

February 12, 1998

MEMORANDUM FOR THE PRESIDENT

FROM: PHIL CAPLAN *TCW*
SEAN MALONEY *SM*

SUBJECT: Children's Health Insurance Program Waivers

The attached memo from Chris Jennings seeks your guidance on whether to grant waivers under the two prongs of the new Children's Health Initiative Program (CHIP), and sets out possible options for doing so. As you know, CHIP allows states to expand coverage either through new non-Medicaid block grants, or by expanding their Medicaid programs. The non-Medicaid block grant option has fewer benefit requirements than does the Medicaid option. Even so, certain states that choose the non-Medicaid option are expected to request waivers of CHIP's requirements. Other states that choose the Medicaid option, will likely seek Medicaid/CHIP waivers. Still others will want to expand their existing Medicaid waivers, previously granted by the Administration, to encompass CHIP.

Two issues are presented. First, what sort of waivers, if any, should be granted to states under CHIP's new non-Medicaid block grant option. Second, what sort of waivers, if any, should be granted to states under CHIP's Medicaid option.

I. Non-Medicaid block grant waivers. *All of your advisers agree* that for non-Medicaid block grant programs, waiver decisions should be deferred for one year. The consensus among your advisers is that, because CHIP is a new program, states should have at least a year's worth of experience, followed by an evaluation, before waivers are granted.

Approve (recommended option) ☒ Disapprove ☐ Discuss ☐

II. Medicaid/CHIP Waivers. With respect to Medicaid/CHIP waiver requests, your advisers present three options:

Option 1 — **Defer new Medicaid/CHIP waivers until after one year's program evaluation; allow expansions of existing Medicaid waivers but require that they adhere to CHIP's non-Medicaid block grant requirements.** *HHS favors this option; it believes CHIP sets a benefits floor that we should not fall below and waiver negotiations could delay program implementation/coverage for 5 million uninsured kids. Democrats and children's health advocates would prefer this option; Governors would react strongly and negatively to it.*

*CON med: care of kids
+ B C
orig: me
CS/meg → see
me.*

Option 2 -- Permit Medicaid/CHIP waivers (either existing or new) if states' programs are generally consistent with CHIP's non-Medicaid block grant requirements. *NEC and DPC* support this option. They believe it's a good balance, preserves CHIP's standards, and removes an important disincentive for states to use the Medicaid option. *NEC/DPC* would further allow states to drop modestly below certain CHIP requirements (e.g., permitting cost sharing for those at 133% versus 150% of the poverty level). Base Democrats and advocates, who feel their support for CHIP's less-than-Medicaid requirements was conditioned on no new flexibility in Medicaid, will oppose this option. Governors would prefer it to Option 1, but will still seek greater flexibility.

Option 3 -- Permit new Medicaid/CHIP waivers if states' programs are generally consistent with CHIP's non-Medicaid block grant requirements (like Option 2 above); but permit states' existing Medicaid waivers to expand but without adhering to CHIP non-Medicaid block grant requirements. *OMB and Treasury* support this option. They think allowing approved waivers to encompass CHIP would help waiver-holding states avoid significant coordination problems. Such states may feel the Administration "reneged" if we don't permit them to extend approved waivers to CHIP. Base Democrats and children's advocates would strongly oppose this option; so too some Republicans, who would see it as an attempt to steer states into Medicaid. Governors would support it.

Option 1 (HHS) ☐ (defer new waivers; allow existing if CHIP-consistent)

Option 2 (DPC/NEC) ☒ (allow new & existing if generally CHIP-consistent)

Option 3 (OMB/Treasury) ☐ (allow new if CHIP-consistent; permit existing without changes)

Discuss ☐

- Under Options 2&3, permit modest cost sharing flexibility

Approve ☒ Disapprove ☐ Discuss ☐

THE WHITE HOUSE
WASHINGTON

January 21, 1998

MEMORANDUM FOR THE PRESIDENT

FROM: Chris Jennings

SUBJECT: Waivers and the Children's Health Insurance Program

cc: Bruce Reed, Gene Sperling, Jack Lew, Josh Gotbaum, Elena Kagan

This memo seeks your guidance on how much, if any, additional flexibility should be given to states in the Children's Health Insurance Program (CHIP) through the use of §1115 waivers. Although waivers have been instrumental in modernizing and reforming welfare and Medicaid, questions have been raised about the feasibility and advisability of granting waivers for the new children's health care program so soon after its enactment.

Despite acknowledging the great amount of flexibility given to the states in the new CHIP grant program, the Governors asked — soon after the law's enactment — if additional flexibility would be given through waivers. HHS's interim response was that it would be difficult to review and evaluate the merits of waiver proposals until we had some experience with the implementation of the new law. Your advisors agreed that this was the appropriate, initial response, but we also underscored that this was not necessarily our final position.

The National Governors Association (NGA) immediately responded by formally requesting that we affirm states' ability to seek new CHIP grant program §1115 waivers. Since then, two other issues have been raised: (1) Will we approve new Medicaid §1115 waivers in the Medicaid option within CHIP, and (2) Will we allow states with current Medicaid §1115 waivers to expand those programs through CHIP (even though some have provisions below the CHIP minimums).

All of your advisors agree that the HHS Secretary does have the authority to grant waivers for CHIP, whether administered through a new non-Medicaid grant program or through Medicaid. They also generally agree that the CHIP waiver policy need not conform to existing waiver policy. However, they (HHS, OMB, Treasury, NEC/DPC) disagree on whether and under what circumstances HHS should approve waivers in CHIP.

Because HHS is holding state conferences this month on CHIP and the annual NGA conference is in February, it is important that we receive direction from you in short order on this issue. This memo, developed in collaboration with HHS and OMB, outlines these issues, provides policy options for your consideration, and summarizes where your advisors stand on these options.

BACKGROUND

Your Administration has given states unprecedented flexibility for their health care programs. Since 1993, we have granted 15 comprehensive Medicaid waivers that test approaches not allowed in Medicaid like experimenting with premiums and cost sharing for low-income populations, waiving benefits, and accelerating enrollment in managed care. States have also used waivers to expand coverage to millions of Americans. In addition, with the Administration's strong support, the Balanced Budget Act secured much greater administrative flexibility for the Medicaid program (e.g., eliminated the need for a waiver for a managed care program, repealed the Boren amendment, and reduced cost-based reimbursement requirements for community health centers). In so doing, we eliminated the need for many time-consuming waivers that we heretofore required from states.

The BBA also created CHIP, which has fewer Federal guidelines than any other health insurance program that the Government oversees. Unlike Medicaid, CHIP allows states that opt to expand through a new, non-Medicaid grant program to cap the number of children covered (i.e., no entitlement requirement); to limit programs to parts of the state; to not cover Medicaid's EPSDT (Early, Periodic, Screening, Detection and Treatment) benefit; and to charge beneficiaries long-sought-after (although limited) cost-sharing. Alternatively, states may expand using the enhanced Federal match through the now more flexible Medicaid program. However, states choosing this option must follow Medicaid rules (e.g., no benefits changes or cost sharing).

Although extremely flexible, CHIP includes standards for accountability, benefits, and cost sharing limits; these were secured by you and Congressional Democrats. Accountability provisions include limits on the type of state contribution (e.g., no provider taxes and donations) and provisions to prevent "crowd out" (substitution of the new coverage for existing coverage). For the new non-Medicaid grant program, we developed a benefit standard that simultaneously ensures that it is valuable but provides great flexibility to states in benefits design. Cost-sharing is allowed in the grant program but limited to moderate premium and copayment schedules for those below 150 percent of poverty and to 5 percent of family income for those above 150 percent. As under current law, states electing the Medicaid option must follow Medicaid rules for benefits (including EPSDT) and cost sharing (for children, none is allowed).

Despite the flexibility in CHIP, some states have indicated that they want §1115 waivers. There are three types of waivers that states are seeking. First, several states want to waive provisions for non-Medicaid, CHIP grant programs (e.g., California wants to impose greater cost sharing above the CHIP limits). Second, others want to waive Medicaid provisions within CHIP's Medicaid option since states choosing the Medicaid option must use all Medicaid rules (e.g., Missouri wants to waive the Medicaid requirement to cover non-emergency transportation). Third, most states that already have Medicaid §1115 waivers want to expand those programs to more children to receive CHIP's higher matching rate — even though some include provisions that are significantly below the new CHIP minimums (e.g., Arkansas has higher cost sharing requirements than allowed in CHIP). It is important to note that the provisions that states want most to waive are the benefits and cost sharing minimums we worked to secure before signing off on the budget agreement.

CONSENSUS RECOMMENDATION: DEFERRING NON-MEDICAID CHIP WAIVERS

Your advisors have achieved consensus on one of the major issues. For CHIP non-Medicaid grant programs, we believe the Administration should consider waiver applications only after a state has had at least a year's worth of experience, followed by an evaluation of its children's health insurance program. As we gain experience with the new CHIP grant program, we will have a better understanding of what types of CHIP demonstrations are appropriate and will develop guidelines at that point.

We believe that deferring approvals for waivers of the already extremely flexible CHIP is advisable because this enables us to see how the program you signed into law last summer will work. Granting waivers now would place great pressure on us to weaken the accountability and benefits standards that we secured in the Balanced Budget negotiations that base Democrats and advocates think are too modest anyway. Having said this, waiver policy for CHIP may well be advisable after we have had time to learn about the program's strengths and weaknesses.

If you agree, we will inform Governors of this policy in a response to their letter. While we believe that Governors will be disappointed with this position, they will likely appreciate that our policy is temporary and that we open up the prospect for waivers soon after they implement their children's health programs.

Decision

☒ Agree on deferring non-Medicaid grant program waivers until plans in place for one year

☐ Let's discuss

ISSUE: POLICY FOR MEDICAID WAIVERS

The other types of waivers, about which there is disagreement amongst your advisors, concern the Medicaid option within CHIP. We all agree that our Medicaid waiver policy should be modified to acknowledge the fact that the Congress did pass legislation that explicitly outlines new guidance on balancing the need for greater flexibility with the need for accountability. However, we differ on how our policy should be modified to reflect this policy change and, more specifically, the extent to which we would hold Medicaid waivers to the CHIP standard.

There are two questions. The first is whether we grant new waivers to states that expand CHIP coverage through Medicaid. States have indicated that they are interested in expanding coverage through the Medicaid option, but since the law allows no flexibility from Medicaid rules, they want waivers, particularly in the area of cost sharing. The second question is whether we allow states that already have Medicaid §1115 waivers to expand those programs, without change, to get the CHIP allotment and higher match. The following are the options proposed by your advisors.

OPTION 1 (HHS): Defer new Medicaid CHIP waivers (with minor exceptions) and allow expansions of existing Medicaid waivers if consistent with CHIP standards for non-Medicaid grant programs. HHS recommends that we apply the same policy for new Medicaid and non-Medicaid, grant program waivers. It would hold off on approving any new Medicaid waiver under CHIP until we have at least a year's experience plus an evaluation. (The only exception would be for waivers for small, incidental provisions that have little or no effect on most children — like Missouri's desire to waive the Medicaid requirement for non-emergency transportation.) For states that have waivers already, HHS would allow them access to the new enhanced matching dollars only if they met CHIP's non-Medicaid grant program standards.

Although HHS/OMB have, in years past, approved a number of Medicaid waivers that have less generous benefits than even the new CHIP grant program, HHS believes the new law set a floor that we should not fall below. They fear that once we open the door to waivers, we will have a difficult time maintaining these standards. In addition, they are concerned that waiver negotiations will delay implementation of new programs in a number of states. Rapid implementation is one critical component to covering our target 5 million uninsured children.

If you choose this option, the Democrats and children's health advocates will applaud our decision to respect the rules enacted in the widely praised new health insurance program for children. However, Governors — who are hoping that we will allow some type of Medicaid waivers — will surely react strongly and negatively to this policy.

OPTION 2 (NEC/DPC): Allow Medicaid CHIP waivers (new or old) if generally consistent with CHIP standards for non-Medicaid grant programs. This option would allow new waivers through the Medicaid option of CHIP if those waivers were consistent with the standards provided under the new CHIP grant model. In other words, states choosing the Medicaid CHIP option could waive Medicaid rules as long as the benefits, cost-sharing and other accountability provisions are in line with the CHIP grant program standards. Existing (old) Medicaid §1115 waiver programs could also receive the higher matching rate, but they too would have to meet CHIP standards; in a number of cases, this would mean they would have to strengthen some of their benefits/cost-sharing protections to access these additional dollars. Although a few states would have to reduce cost sharing requirements to comply with CHIP, we believe that the higher matching rate available under CHIP would be sufficient to offset these costs.

DPC/NEC believes that this option strikes an appropriate balance by maintaining the integrity of the CHIP program and the Balanced Budget Act and giving the new standards time to be tested. It also removes an important disincentive for states to use the Medicaid option in CHIP. Many states would prefer to use their already-in-place Medicaid programs because it is administratively simple. Moreover, having a seamless Medicaid program serving both poor and children of working parents has obvious advantages. However, allowing any new Medicaid waivers through CHIP will be criticized by our base Congressional Democrats, some Republicans, and advocates. They believe that their support for the flexibility in the non-Medicaid CHIP program was conditional on no new flexibility in Medicaid. The Governors would like this approach better than the HHS option, but they could be counted on to say that it is still not flexible enough.

Within this option, NEC/DPC also recommends that the Secretary have the authority to approve Medicaid CHIP waivers that may be modestly below those standards provided for in the new CHIP grant program. While we strongly believe that the CHIP standards should be the guiding principle for Medicaid waivers, we also recognize that it is unwise and unrealistic to treat the new law's standards as "lines in the sand" that can never be crossed regardless of a waiver's merits. One good example is in the area of cost sharing.

In both previous Medicaid waivers and our internal policy positions, we have allowed limited cost sharing that exceeds the CHIP grant program standards. Such cost sharing can appropriately increase beneficiaries' cost sensitivity in using health services and decrease possible employer insurance dropping problems, since such a policy would more accurately mirror marketplace coverage. While we recommend providing this additional flexibility authority, we also believe that waivers of the CHIP grant standards for children not be granted below 133 percent of poverty -- the level your Administration advisors had previously concluded (during the balanced budget discussions) achieved the balance between appropriate and excessive cost-sharing.

While some might point out that it is inconsistent to allow flexibility below CHIP standards for Medicaid and not the grant option, we believe that the advantages of this approach far outweigh this criticism. First, the CHIP standards were designed for the grant program -- not Medicaid. Second, Medicaid waivers are quite variable and have never been publicly held by Democrats and advocates to the same standards as legislated changes to public programs. And thirdly, as described above, having an additional incentive to administer the children's health program through Medicaid is desirable.

Giving HHS the authority to allow any cost sharing flexibility in Medicaid will likely anger base Congressional Democrats and some moderate Republicans. They will argue (as does HHS) that once we sanction higher cost sharing below 150 percent of poverty, decisions will be perceived as arbitrary, making it difficult to say no to states that demand even greater flexibility. We believe these are valid concerns and should be seriously considered. However, we are also well aware of states (such as Wisconsin) who will be requesting cost-sharing levels just under 150 percent (i.e., 143 percent of poverty) that we would find difficult to oppose on purely policy grounds.

OPTION 3 (OMB & TREASURY): Allow new CHIP Medicaid waivers if consistent with CHIP standards for non-Medicaid, grant programs, but allow existing Medicaid waivers to expand with no change. For states requesting new Medicaid waivers, OMB/Treasury agree with DPC/NEC option that the CHIP standards should guide approval of such waivers (also allowing for greater cost sharing for families no less than approximately 133 percent of poverty). This policy should be re-evaluated after states gain experience with their programs, at the same time the Administration is re-considering non-Medicaid, grant program waivers.

For states with waiver programs already approved (since the 1994 NGA waiver agreement), OMB and Treasury recommend that we recognize their history and different situation and not hold them to the CHIP standards. We anticipate that these 11 states will want to expand their current waiver programs under CHIP; OMB and Treasury think they should be permitted to do so with no changes. Although this option provides only a few more states with additional flexibility in cost-

sharing or benefits under CHIP than the DPC/NEC option, it helps these states avoid significant coordination problems by sanctioning CHIP programs consistent with approved waiver programs. In addition, lower income children in these states might pay more in premiums than the higher income children newly eligible under CHIP. Waiver states will consider the Administration to have reneged if we don't permit them to carry their waivers to CHIP. This option excludes pre-NGA agreement waivers (e.g., Tennessee) since states have been held to a higher standard since then.

Allowing existing Medicaid waivers into CHIP unchanged will surely be noticed and strongly opposed by base Democrats and children's advocates. They believe that some of the waivers that we have approved to date, such as Tennessee and Arkansas, have gone too far by allowing states to impose "excessive" cost sharing on low-income beneficiaries and waive EPSDT. Ironically, this policy may also be criticized by some Congressional Republicans, who think that many of our CHIP implementation decisions are steering states toward the Medicaid option. It would, however, be the most acceptable option to the NGA and the relevant (existing waiver) states.

Decisions

Medicaid Waivers

- _____ OPTION 1: Defer new Medicaid waivers in CHIP (with minor exceptions)
Allow existing waivers to expand through CHIP if consistent with CHIP standards for non-Medicaid, grant programs
- _____ OPTION 2: Allow new & existing Medicaid waivers in CHIP if consistent with CHIP standards for non-Medicaid, grant programs
- _____ OPTION 3: Allow new Medicaid waivers in CHIP if consistent with CHIP standards for non-Medicaid, grant programs
Allow existing waivers (post-NGA agreement) to expand through CHIP with no program changes even if they fall significantly below new CHIP grant standards

_____ Let's discuss

Cost Sharing Flexibility

- _____ OPTION 1: Hold all Medicaid waivers to the cost sharing in CHIP for non-Medicaid, grant programs
- _____ OPTION 2: Authorize the Secretary to approve, within limits, Medicaid waivers in CHIP with cost sharing below CHIP standards for non-Medicaid, grant programs

_____ Let's discuss

STATES WITH MEDICAID 1115 WAIVERS (Chronological Order)

STATE	Approved	Eligibility Limit	Benefits for New Eligibles	Cost Sharing: New Eligibles
Arizona	10/82	Existing eligibles	Medicaid benefits	None
Oregon	3/93	People < 100% PL	Prioritized benefits	Premiums: \$6 to 28 No copays or deductibles
Hawaii	7/93	People < 300% PL, plus assets test	No long-term care	Premiums: \$142 - 168 Copays: \$5
Maryland	10/93	Children 133-185% PL	No inpatient, outpatient, emergency room, some EPSDT; no long-term care	Copay: \$5
	10/96	Existing eligibles	Medicaid benefits	None
Rhode Island	11/93	Children < 250% PL	Medicaid benefits	Premiums: From 185-250% PL: \$1.50 - \$10.75 No copays or deductibles
Tennessee	11/93	People up to 400% PL, with enrollment cap	Medicaid benefits	Premiums: \$14.25 to 475 Deductibles: \$250 / \$500 Coinsurance: 2 to 10%
Florida	9/94	People < 250% PL	<i>Excludes some EPSDT, transportation, some long- term care and mental health</i>	<i>Premiums: \$90 - 550 / mo Deductibles: Up to \$500 Copays: \$10-200 or 20%</i>
Ohio	1/95	People < 100% PL	Medicaid benefits	None
Massachusetts	4/95	People < 200% PL	Medicaid benefits	Premiums: Variable Deductibles: \$100 / \$250 Copays: \$5 / 10
Minnesota	4/95	Children < 275% PL	Medicaid benefits	Premiums: \$4 to 104 / mo No copays or deductibles
Delaware	5/95	People < 100% PL	Medicaid w/ small changes	None
Vermont	7/95	People < 150% PL	No transportation, long-term care	Premiums: Above 25% PL: \$5 to \$20 every 6 months Copays: \$3 for dental
Kentucky	10/95	Existing eligibles	Medicaid benefits	None
Oklahoma	10/95	Existing eligibles	Medicaid benefits	None
Illinois	7/96	Existing eligibles	Medicaid benefits	None
Alabama	12/96	Existing eligibles	Medicaid benefits	None
New York	7/97	Home relief pop.	Medicaid benefits	None
Arkansas	8/97	Children < 200% PL	No EPSDT, limited long- term care & mental health	Copays: \$10 outpatient; 20% inpatient ; \$5 for drugs

Italics indicated approved but not implemented. States above the line were approved prior to NGA 1994 agreement.

DATE

FROM Director
Center for Medicaid and State Operations

SUBJECT Recommendation for Approval of a Section 1115 Waiver for a Modification to
the State of Missouri's Title XXI Plan Entitled "Managed Care Plus"--**DECISION**

TO Administrator
THRU: ES _____

ISSUE

The State of Missouri has requested section 1115 demonstration authority to modify the cost sharing provisions under their Title XXI Plan entitled, "Managed Care Plus (MC+)" . Your approval is required to implement the modifications to the demonstration.

BACKGROUND

On September 26, 1997, Missouri submitted a Title XXI State Plan to expand insurance coverage to children within the State's existing Medicaid managed care delivery system, MC+ . The State is using their Title XXI funding to expand Medicaid eligibility to children with incomes up to 300% of the Federal Poverty Level (FPL). The Department granted the State a Section 1115 waiver to allow them to offer a reduced Medicaid benefit package to the children. The State began enrollment and marketing on July 1, 1998 and began providing health care services on September 1, 1998.

On June 26, the State requested modifications to their Title XXI Plan. This request came about as a result of legislation which was passed by the Missouri State Legislature and which was effective August 26, 1998. One of the modifications requested would require a \$5 co-payment at the time of professional service for uninsured children with a family income between 185 percent of the Federal Poverty Level (FPL) and 225 percent of the FPL. The other modification requested would require a \$10 co-payment at the time of the professional service, a \$5 co-payment per prescription, and a monthly premium for those children with a family income from 226 percent of the FPL and 300 percent of the FPL. Providers will be allowed to not provide a service if the payment is not made. Co-payments would not be required for well-baby or well-child visits and immunizations and total payments would be capped at 5 percent of the family's gross income. Non-payment of the premiums within 20 days of the premium due date would result in a six-month disenrollment from the MC+ program. All of these modifications are in accordance with Title XXI provisions; however, since this is a Medicaid expansion, Section 1115 waivers are required for the State to

implement the legislation.

Because Section 1115 requires that waiver authority can only be used for “experimental, pilot, or demonstration ” projects, we required an evaluation plan describing how the State would evaluate what impact if any, the cost-sharing requirements would have on the children as a condition of approval of Section 1115 waivers. In response, the State has submitted three proposed evaluation plans. In each case, we provided technical assistance and copies of other, approved evaluation designs.

DISCUSSION

Through a September 11 Missouri MEDICAID Bulletin, we discovered that the State had begun to impose the cost-sharing requirements on the children prior to receiving Section 1115 waivers. We also discovered that the State was allowing the providers the discretion to not provide care to those children who could not pay the co-payment of \$5 or \$10 depending upon their income. On October 22, we sent a letter to them reminding them that the Medicaid waivers to allow this had not been approved and to immediately stop imposing cost-sharing on the children.

In a October 29 call with Greg Vadner, Missouri Medicaid Director, he indicated that the State was willing to fund their program with State-only funds until such time as the waivers are approved and would continue to impose the cost-sharing on the children and to allow the providers to not provide services if the co-pay is not paid. They are taking this course of action because of the requirement to comply with the State law which became effective August 28.

Because the State has indicated that they do not have the expertise on staff to develop a detailed evaluation design and that they do intend to contract with an evaluator to design and implement the evaluation we propose that we approve the necessary waivers to allow them to impose cost-sharing on the children provided the following Special Terms and Conditions are agreed to by the State:

1. The State will contract within one year with a contractor to design and implement an evaluation on the effects of not providing non-emergency medical transportation and on the effects of imposing cost-sharing on children.
2. The State will submit its Scope of Work(s) for the evaluations to be used in the request for proposals for review and approval by HCFA.
3. The State will submit the formal evaluation design(s) from the contractor prior to acceptance of the design(s) by the State for review and approval by HCFA.

This will allow the State to begin to move forward with implementing their program in accordance with their State law as well as ensuring for the Department that the cost-sharing

provision and the lack of non-emergency medical transportation will be properly evaluated.

DEMONSTRATION AUTHORITY

Waivers

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this letter, shall apply to the MC+ demonstration program. Subject to the approval of your research plan, the following matching authority and authority to operate without complying with the following requirements, as specified in the State application and subsequent discussion, is approved for a 5-year period beginning the first day of the month effective when capitation payments are made in the MC+ demonstration.

1. Premiums Section 1916(a)(1)

To enable the State to charge premiums up to \$65 for those children below age 19 with family incomes with family incomes between 226 and 300 percent of the FPL.
2. Disenrollment for Non-Payment of Premiums Section 1916(c)(3)

To enable the State to disenroll children within family income between 226 and 300 percent of the FPL within 20 days of non-payment of premiums.
3. Copayments Section 1916(a)(2)(A)
Section 1916(a)(3)

To enable the State to impose copayments that are not nominal on children below age 19 with family incomes with family incomes between 226 and 300 percent of the FPL.
4. Denial of Services for Failure to Pay Co-payments Section 1916(e)

To enable the State to permit providers to deny services when copayments are not made by children within family income between 226 and 300 percent of the FPL within 20 days of non-payment of premiums.

Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the SSA, expenditures made by the State under MC+ for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of this project, be regarded as expenditures under the State's Title XIX plan.

Expenditures to provide Medicaid coverage to children up to age 19 with family

incomes up to 300 percent of the FPL, provided that (1) there has not been a failure to fulfill premium obligations for more than 20 days; and (2) with respect to a particular service, any required copayment has been made for the service.

RECOMMENDATION

We recommend that you approve the Special Terms and Conditions and the Section 1115 waivers for the State of Missouri's Managed Care Plus Program. If you concur, please sign the attached award letter.

Sally K. Richardson

Attachment

DECISION

Concur: _____ Nonconcur: _____ Date: _____

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing

Administration

7500 Security Boulevard
Baltimore, MD 21244-1850

Mr. Greg Vadner
Director
Missouri Department of Social Services
Division of Medical Services
P.O. Box 6500
Jefferson City, Missouri 65102-6500

Dear Mr. Vadner:

We are pleased to inform you that your modification request to impose cost-sharing requirements on children up to age 19 with incomes below 300 percent of the Federal Poverty Level (FPL) in your Section 1115 Medicaid demonstration, entitled "Managed Care Plus (MC+)," has been approved. This approval is under the authority of section 1115 of the Social Security Act (SSA).

Our approval of this modification (and the waivers and the Federal matching provided for thereunder) is conditioned upon compliance with the enclosed special terms and conditions, which set forth in detail the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to our receiving your written acceptance of the award within 30 days of this letter.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this letter, shall apply to the MC+ demonstration program as modified. The following waivers, as specified in the State's modification request and subsequent discussions, are approved for a 5-year period beginning on the date of this letter.:

Waivers

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this letter, shall apply to the MC+ demonstration program. Subject to the approval of your research plan, the following matching authority and authority to operate without complying with the following

requirements, as specified in the State application and subsequent discussion, is approved for a 5-year period beginning the first day of the month effective when capitation payments are made in the MC+ demonstration.

1. Premiums Section 1916(a)(1)

To enable the State to charge premiums up to \$65 for those children below age 19 with family incomes with family incomes between 226 and 300 percent of the FPL.
2. Disenrollment for Non-Payment of Premiums Section 1916(c)(3)

To enable the State to disenroll children within family income between 226 and 300 percent of the FPL within 20 days of non-payment of premiums.
3. Copayments Section 1916(a)(2)(A)
Section 1916(a)(3)

To enable the State to impose copayments that are not nominal on children below age 19 with family incomes with family incomes between 226 and 300 percent of the FPL.
4. Denial of Services for Failure to Pay Co-payments Section 1916(e)

To enable the State to permit providers to deny services when copayments are not made by children within family income between 226 and 300 percent of the FPL within 20 days of non-payment of premiums.

Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the SSA, expenditures made by the State under MC+ for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of this project, be regarded as expenditures under the State's Title XIX plan.

Expenditures to provide Medicaid coverage to children up to age 19 with family incomes up to 300 percent of the FPL, provided that (1) there has not been a failure to fulfill premium obligations for more than 20 days; and (2) with respect to a particular service, any required copayment has been made for the service.

We extend our congratulations on this award and look forward to working with you during the course of the project.

Sincerely,

Nancy-Ann Min DeParle

Enclosure

SPECIAL TERMS & CONDITIONS

II. GENERAL CONDITIONS

G. Special Evaluation Requirements

1. The State will contract within one year with a contractor to design and implement an evaluation on the effects of not providing non-emergency medical transportation and on the effects of imposing cost-sharing on children.
2. The State will submit its Scope of Work(s) for the evaluations to be used in the request for proposals for review and approval by HCFA.
3. The State will submit the formal evaluation design(s) from the contractor prior to acceptance of the design(s) by the State for review and approval by HCFA.