

Draft 8/14/97
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The State Children's Health Insurance Program Implementation Overview

The State Children's Health Insurance Program was enacted in the Balanced Budget Act of 1997, with funding for the program available as of October 1, 1997 for States with approved plans. A key goal of the Administration is to assist a number of States in submitting acceptable State plans to participate in the program as soon as practicable. To accomplish this goal, we intend to implement the legislation as a 2 phase effort. Phase 1 will encompass the necessary guideline materials (e.g., State letters, fact sheets, Q&As, and manual transmittals) to inform the States of the provisions of the statute and the interim instructions for submitting information to HCFA that will permit states to develop, establish and implement State plans for the State Children's Health Insurance Program (see "Phase 1 Implementation Plan" for tasks). Phase 2 will encompass the longer range goals and objectives for implementing the program via notice and comment rulemaking and other more formal guidance.

The new program will be administered by the Health Care Financing Administration (HCFA) within the Center for Medicaid and State Operations (CMSO), however, implementation of the new program will involve a crosscutting effort across Health and Human Services. To implement Phase 1, we will establish a policy steering committee to direct and lead the implementation effort. The Steering Committee, led by HCFA and the Health Resources and Services Administration (HRSA), will be comprised of HCFA senior representatives (including the Director of the Office of Legislation, the Director and/or the Deputy Director of the CMSO, the Director of the Family and Children's Health Programs Group within CMSO, as well as other volunteers from the Agency, including the Office of the General Counsel, the Regional Consortia, the Office of Clinical Standards and Quality, the Office of Strategic Planning and the Center for Beneficiary Services) and HRSA senior representatives as well as Departmental representatives including ASMB, ASPE, ASL, IGA and other interested Agencies.

Within HCFA, the Steering Committee will be led by Debbie Chang, Director of the Office of Legislation. Her phone number is 202-690-5960. Within HRSA, Ron Carlson is the lead on this effort. His number is (301)443-1902. Rick Fenton, Deputy Director of the Family and Children's Health Programs Group, will be CMSO's coordinator for policy and implementation activities for the effort. His phone number is 410-786-5920. The goals and objectives of the Steering Committee will be to provide an ongoing forum for policy development and direction for the implementation of the program. The Steering Committee will meet on a frequent basis to review and evaluate policy questions and to provide recommendations to Departmental, OMB and White House decision-makers. The Committee will also direct the activities of the implementation workgroups to assure that the implementation products conform with the Administration's goals and objectives for implementation.

The Steering Committee will greatly assist in the approval of the implementation activities by

DRAFT 8/15/97
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STATE CHILDREN'S HEALTH INSURANCE PROGRAM PHASE 1 IMPLEMENTATION PLAN

I. STATE PLAN DEVELOPMENT

Need to assist States in submitting State Plans in order to participate in the program. Plans must address the 7 areas of sec 2102(a), coverage options (sec 2101), cost sharing (sec 2103), strategic goals and objectives (sec 2107) and other pertinent requirements from the statute. To assist States in submitting plans, HCFA should concurrently take the following actions:

Establish a workgroup to develop and distribute an electronic template for State use in addressing the requirements of an approvable State plan under Title XXI. The template should be a user friendly document that would allow the State to check off the various options included under the law for the program and would allow the State to accurately describe its plans and options under the statute. The template should include a complete set of instructions describing the statutory requirements and options available to the State, and should permit the State to easily describe its coverage options (sec 2101), cost sharing, (sec 2103), strategic goals and objectives (sec 2107) and any other pertinent requirements from the statute. The template would assure the State addresses all the requirements of the plan and would assist HCFA in reviewing the plan.

DELIVERABLES	DUE DATE	COMPL. DATE	RESPONSIBLE COMPONENT
1. Establish Subgroup for Template development. <i>model curriculum plan</i>	8/15	9/10	
2. Subgroup meets and begins to prepare template document. Template must describe statutory requirements of the State Child Health Insurance Plan. Template must include, general background and description; general description of eligibility standards and methodology; description of outreach and coordination; description of plan coverage; description of cost sharing requirements; description of strategic objectives and performance goals; description of public involvement in design and implementation of the program; assurance regarding annual reports and evaluations.	8/22		

DELIVERABLES	DUE DATE	COMPL. DATE	RESPONSIBLE COMPONENT
3a. Prepare draft letter to States from Sally Richardson informing them of the law and our plans. Identify States preparing a new program. Establish contacts from each State (desk system).	8/13	9/10	
3b. Work with intergovernmental groups for policy development.			
4. Clear informational letter with steering committee, OS, WH, OMB.	8/15		
5. Release informational letter.	8/18		
6. Prepare transmittal letter for transmission of template and template document.	8/22		
7a. Work with intergovernmental groups for review.	8/27		
7b. Submit template and transmittal letter to steering committee for review and approval.			
8. Submit template and transmittal letter to OS for review and approval.	9/3		
9. Submit template and transmittal letter WH and OMB for review and approval.	9/5		
10. Release document to States.	9/10		

II. ALLOTMENT PROCESS

Need to identify and inform States of the State specific dollar amount available under Title XXI for Fiscal year 98.

DELIVERABLES	DUE DATE	COMPL. DATE	RESPONSIBLE COMPONENT
1. Establish a work group to calculate allotments.	8/15		
2. Submit recommendations to Steering Committee.	8/22		
3. Obtain clearance from OS/WH/OMB.	8/29		
4. Discuss proposed allotments with States (NGA, advocates, providers).	9/5		
5. Publish <i>Federal Register</i> Notice to inform State of FY98 allotments.	9/10	9/10	
6. Develop procedure for redistribution of unused allotments (not a current priority).	6/98		

III. STATE PLAN APPROVAL PROCESS

Need to prepare and disseminate to States instructions regarding submission, approval, and amendment of SPAs. The instructions will specify the approval process, e.g., 90 days for HCFA action or the plan will be approved; procedures for requesting additional information on plans; procedures and criteria for disapproving plans; procedures for receiving and acting on State plan amendments; and other administrative activities associated with the submission and approval of the State.

A. Develop a manual to notify States of submission, approval and other requirements for amendment of State plans.

DELIVERABLES	DUE DATE	COMPL. DATE	RESPONSIBLE COMPONENT
1. Establish a workgroup.	8/15		
2a. Complete draft guidelines addressing State plan process (e.g., submission rules, HCFA's obligations, approval process).	8/29		
2b. Work with intergovernmental groups in development.			
3. Steering Committee for review and approval.	9/5		
4. OS Approval	9/10		
5. WH/OMB Approval	9/15		
6. Develop guidelines for RO/CO review of plans.	10/1		

B. Assure compliance under title XXI.

DELIVERABLES	DUE DATE	COMPL. DATE	RESPONSIBLE COMPONENT
1. Develop a process to assure compliance (not a current priority).	1/98		

IV. STATE PAYMENT PROCESS

Develop instructions for receiving payments under title XXI, including its enhanced FMAP, claims processing procedures, limitations on payments, data collection requirements, Medicaid coordination and other activities associated with payment of State Children's Health Insurance Program funds.

DELIVERABLES	DUE DATE	COMPL. DATE	RESPONSIBLE COMPONENT
1. Establish a workgroup to develop and design State instructions for submission of claims under title XXI, including collection of information for preventing inappropriate payments and required maintenance of effort issues.	1/98 or 10/97 ¹		
2. Prepare and publish a <i>Federal Register</i> notice specifying State FMAP rates available under title XXI.	1/98 or 10/97		

¹We are exploring options with the Office of General Counsel for States that can begin on 10/1/97. There may be two tracks for States.

V. MEDICAID PROGRAM COORDINATION

Develop instructions and procedures for modifying the Medicaid State plan for expansion populations so States may implement Medicaid expansions under the enhanced payment of the SCHIP program.

DELIVERABLES		DUE DATE	COMPL. DATE	RESPONSIBLE COMPONENT
1. Develop State Medicaid letter and/or fact sheet. (This may be included in same letter as I-3a.)		9/15	9-10	
	1a. Prepare draft letter and/or fact sheet to States informing them of the law and our plans. Solicit interest from 10 States.	8/13		
	2a. Clear informational letter with steering committee, OS, WH, OMB.	8/15		
	2b. Work with intergovernmental groups in development.			
	3a. Release informational letter.	8/18		
	4a. Prepare transmittal letter for transmission of template and template document.	8/22		
	5a. Submit template and transmittal letter to steering committee for review and approval.	8/27		
	6a. Submit template and transmittal letter to OS for review and approval.	9/3		

VI. MISCELLANEOUS PROVISIONS

DELIVERABLES	DUE DATE	COMPL. DATE	RESPONSIBLE COMPONENT
1. Develop instructions for annual reports and evaluations with appropriate input from internal and external parties.	6/98		
2. Develop instructions for determining relation to other laws (HIPAA, ERISA) with appropriate input from internal and external parties.	6/98		
3. Develop instructions for 12 month option with appropriate input from internal and external parties.	6/98		
4. Develop other definitions with appropriate input from internal and external parties.	6/98		



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the General Counsel
Health Care Financing Division***** DRAFT *****MEMORANDUM

TO : Debbie Chang
Office of Legislation

FROM : Daniel Aibel *Da*
Attorney

SUBJECT: Children's Health Insurance Program

You asked for expedited responses to the following questions concerning the recently enacted Balanced Budget Act of 1997, Pub. L. No. 105-33, which amended the Social Security Act to add a Children's Health Insurance Program as Title XXI. In light of the need for a quick response, we are transmitting this to you in draft form, and we invite your discussion and comment on all issues. We answer each question sequentially:

1. (A) Does the law allow for a process where states that are ready with matching funds October 1st can draw down funds without fully meeting all the requirements under the requirements for child health insurance plans? (Funding appears to be available only when the "child health insurance plan" is approved by Secretary.)

Under section 2101(b) of the law, a State is not eligible for payment unless it has submitted a State plan which "has been approved" The plain meaning of this language is that funding cannot be made available until after the date the State plan is approved. Sections 2101(d) and 2106 indicate, however, that the effective date of a State plan can predate such approval by providing that the plan may be effective "beginning with a calendar quarter that is specified in the plan, but in no case earlier than October 1, 1997." Of course, a State cannot receive retroactive federal funding unless it is actually incurring expenditures during the retroactive period in accordance with the subsequently approved plan.

There is no express provision for conditional approval or provisional funding pending the approval of a State plan. Conditional approval appears to be inconsistent with the statutory provisions indicating that approval is a final decision; under section 2106(e), an approved plan shall continue in effect until the Secretary makes a finding of "substantial noncompliance of the plan with the requirements of this title" (providing the State "a reasonable opportunity before taking financial sanctions). In other words, while the Secretary may review and disapprove plan amendments and the amended plan as a whole at the time an amendment is submitted, there is no easy process for

Page 2 - Debbie Chang

DRAFT

correcting an erroneous approval. Provisional funding prior to approval of a State plan appears to be inconsistent with the statutory requirement at section 2101(b) that "a State is not eligible for payment . . . unless the State has submitted to the Secretary . . . a plan that . . . has been approved under section 2106." Once a State has submitted a State plan which has been approved, however, provisional funding (or "advance payments") may be available under section 2105(e) based on "estimates of expenditures submitted by the State." HCFA could interpret this provision to permit estimates to include expenditures for State plan amendments which are in effect and which the State reasonably anticipates will be approved by the Secretary.

There are some particular rules that apply to the effective date for plan amendments which do not apply to the initial plan. Amendments which restrict eligibility or benefits may not take effect unless the State has provided prior public notice of the change "in a form and manner provided under applicable State law" and cannot be effective for longer than 60 days unless transmitted to the Secretary for approval before the end of that period. Sections 2106(b)(2)(A) and B). Other plan amendments cannot remain in effect after the end of a fiscal year unless previously transmitted to the Secretary for approval.

1. (B) Can states just use the Medicaid route in this case and is a state plan amendment the correct route? Are there other requirements that need to be met if the Medicaid route is used?

A State can use its Title XXI allotment through the Medicaid program even in the absence of a child health assistance plan. However, as we discuss in answer to question 2, a child health assistance plan may be a prerequisite to having any, or a full, Title XXI allotment. The Title XXI allotment will then be reduced by the amount of Medicaid expenditures for any new groups authorized by either sections 1905(u) or 1920A.

Under these provisions, a Medicaid package of benefits to any groups which fall within the following three categories may be offered by a State, and an enhance federal medical assistance percentage (FMAP) rate may be available for expenditures for the first two categories listed below:

- (1) "optional targeted low-income children" as defined in section 2110(b)(1) (who would not qualify for medical assistance under the State plan in effect on April 15, 1997, taking into account statutory expansion of eligibility age) under new section 1905(u)(2);
- (2) children under the age of 19, born on or before October 1, 1983, who are not otherwise Medicaid-eligible under new section 1905(u)(3);
- (3) children during a presumptive eligibility period under new section 1920A.

Page 3 - Debbie Chang

*****DRAFT*****

In order to exercise the option to expand Medicaid coverage to groups included in these new eligibility categories, a Medicaid State plan amendment would be required, since none of these groups would be covered by a State's existing Medicaid State plan. All existing Medicaid requirements would apply to these groups.

A Medicaid State plan amendment providing for eligibility for the first two categories of children (who are specified in new sections 1905(u)(2) and 1905(u)(3)), will establish eligibility for the enhanced FMAP only if the State meets two requirements described in section 1905(u)(1): the State must comply with maintenance of effort requirements contained in section 2105(d) and the State plan must provide for reporting necessary to limit expenditures for the 1905(u)(2) group to the allotment. See 1905(u)(1). Under 1905(u)(2)(B), the amount of expenditures which may be claimed through the Medicaid program at the enhanced FMAP rate for the category of optional targeted low-income children may not exceed the State's allotment under section 2104, decreased by any payments already made for a separate child health assistance plan. Expenditures above the capped allotment would not be eligible for the enhanced FMAP available under 1905(b), but would receive the usual FMAP rate. Since the enhanced rate under 1905(b) is available only if the requirements of 1905(u)(1) are met, arguably, a State could refuse to meet those requirements even for expenditures within the capped allotment, sacrificing the enhanced FMAP for expenditures for 1905(u) groups, in order to extend eligibility to these groups without reducing its Title XXI allotment.

No other title XXI requirements would apply to these groups (and all Medicaid requirements would apply). However, as discussed above, under section 2104(d), Medicaid expenditures for these groups will have the effect of decreasing the Title XXI allotment available for non-Medicaid child health assistance programs.

- 2.) **Is it true that the funding is available October 1st and remains available for 3 years from this date, without the State needing to apply for it? Or does the state need to at least apply for the allotment?**

Funding is available as of October 1, 1997, but payments for each quarter must be based on eligible expenditures (either under a child health assistance plan, or under a Medicaid plan). Payments for Medicaid expenditures are subject to the usual Medicaid funding mechanism. Payments for child health assistance plan expenditures may be made based on advance estimates of expenditures submitted by the State "and such other investigation as the Secretary may find necessary," with retrospective adjustment in later quarters for overpayments or underpayments. Section 2105(e).

While there are some options in how HCFA decides to administer the allotment calculation, it is clear that a State must have an approved plan to maximize its potential allotment. Under section 2104(b)(1), the Secretary "shall allot to each State .

Page 4 - Debbie Chang

*****DRAFT*****

... with a State child health plan approved under this title" This language suggests that, in order to obtain any allotment whatsoever, a State must submit a child health plan. Once a State meets this threshold test, the allotment is calculated pursuant to a complex formula set forth in section 2104(b)(1) based on the number of low income children with no health insurance and a State cost factor. (The territories have fixed allotments under section 2104(c) and are not subject to this calculation.)

Although the language of section 2104(b)(1) can thus be read to require an approved State child health assistance plan before any allotment is made to the State, we believe the better reading is that a State without an approved plan would still receive a minimum allotment. Section 2104(b)(1) is "subject to paragraph (4)," which provides for a minimum allotment of 2,000,000 to each of the 50 States and the District of Columbia.

As a result, HCFA may wish to encourage all States to submit skeletal "no-benefit" child health assistance plans to secure a larger allotment, and to add benefits through plan amendments.

Once an allotment has been made, under section 2104(e), the allotment is available for 3 fiscal years before unused allotments are redistributed to other States.

- 3.) **If Medicaid route is used, does a State need to meet all Medicaid requirements? If a States takes the Medicaid approach, do they need to meet any of the child health requirements? On cost-sharing would the Medicaid rules apply (rules do not allow cost-sharing for kids)?**

If a State uses its child health allotment through a Medicaid expansion, it must meet all Medicaid requirements; there is no exception for the new Medicaid eligibility groups (except to the extent that the presumptive eligibility group is, by its nature, an exception to normal Medicaid eligibility requirements). The only child health requirements are the minimal maintenance of effort requirements (section 2105(d)) and reporting requirements, which apply only to the new Medicaid eligibility groups under 1905(u) (not the presumptive eligibility group). And the State must use the Title XXI definition of an optional targeted low-income child, but that has been incorporated into the Medicaid statute as a Medicaid requirement.

- 4.) **Is the 2 phase process outlined in the implementation plan (attachment) permissible under law? Under welfare reform, we used the fact sheet, letter, q and a, manual process, with only 2 formal regs needed.**

While we agree generally with the concept of the 2 phase process described in the implementation plan, we strongly recommend issuing going through a rulemaking process as soon as possible to set forth the principles of the allotment calculation

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process. There are many policy determinations which will have to be made related to the timing of the calculation, and the exact figures to be used. We note that the legislative history is more precise on some issues than the statute, but the legislative history does not have the force of law which the statute or final regulations would have. Moreover, the timing of the calculation and the finality of the allotment calculation may be subject to challenge in the absence of either clear notice of HCFA's interpretation or final regulations. Since there are large sums of money in controversy, we believe that the regulatory process is advisable to help to protect the allocation process from a likely challenge.

Moreover, while it is a statutory requirement, the necessity to submit a child health assistance plan in order to qualify for an allotment (or one larger than the minimum allotment, depending on HCFA's reading of the statute as discussed above) is another source of potential conflict. We would strongly advise giving States formal notice of this requirement, and the timing of the allotment calculation process which indicates by what date an approved plan would be required to ensure an allotment. Such a notice could possibly outline the requirements for a no-benefit State plan amendment which would preserve the right to an allotment.

- 5) **If a State decides to do a combination Medicaid and Child health insurance, what process does the state need to go through? If States initially chooses one option, can they change to the other option? For example, can a State elect to expand Medicaid for the first year and then switch to the child health insurance option the next year?**

As discussed above, a State that wishes to receive more than the minimum allotment must submit a child health assistance plan even if that plan does not provide for any specific benefits (because the State intends to use the Medicaid option).

A Medicaid option can be exercised by the submission of a Medicaid State plan amendment (which can be effective as early as the first day of the quarter submitted) and can be withdrawn by amending the Medicaid State plan to delete this amendment. Under section 1903(a)(1), Medicaid federal financial participation is available only for expenditures under a Medicaid State plan.

The child health assistance option can be exercised by submission of a child health assistance plan, or plan amendment, although federal payments may not be made until the submission is approved by the Secretary. Under sections 2106(a)(2) and (b)(3)(C), a plan or plan amendment which expands benefits or eligibility may be effective retroactively (presumably to the beginning of the fiscal year except no earlier than October 1, 1997) except that a plan amendment may not remain in effect after the end of the fiscal year unless transmitted to the Secretary and within the 90-day approval timeframe. Under section 2106(b)(3)(B), the child health assistance option cannot be

Page 6 - Debbie Chang

DRAFT

restricted or eliminated, in whole or in part, until the State provides prior public notice of the change (in a form and manner provided under applicable State law) and such restriction or elimination cannot be effective for more than 60 days prior to the submission of the plan amendment to the Secretary.

It is important to note that, unless a State amends its child health assistance plan, or Medicaid State plan, the State will be obliged to continue providing benefits described in those plans even after the allotment is exhausted. To our knowledge, HCFA has never approved a Medicaid State plan amendment which was subject to an explicit dollar cap; it is our view that such a cap would violate Medicaid comparability requirements since it would mean that similarly situated individuals in the same eligibility group would receive a differing amount, duration and scope of benefits. See section 1902(a)(10)(B); 42 C.F.R. § 440.240(b). Medicaid funding will be available at the regular FMAP rate under section 1905(b) for the presumptive eligible (for whom the enhanced rate is never available) and optional targeted low-income children described in section 1905(u)(2) (since the enhanced rate is available for that group only up to the capped allotment). The enhanced rate may continue to be available for individuals described in 1905(u)(3) (children born after October 1, 1983 but under age 19), since those expenditures are not subject to the capped allotment. With respect to the Children's Health Assistance Program, States are required to conduct their programs in accordance with their approved State plan (and any amendments). Section 2106(d). The requirements for a Children's Health Assistance Program at section 2103 do not provide for termination of eligibility or benefits in the absence of federal matching funds.

Please let us know if we can be of further assistance.

TO: Ed Grossman

FROM: Jeanne Lambrew

RE: QUESTIONS ABOUT KIDS' LANGUAGE

DATE: August 26, 1997

for all Principals

Sorry I missed your call. HHS is in the throes of determining some of the basics of the program to get it up and running, and some questions have arisen. I figured it might be easier to write them up for your consideration.

First, HHS is having a problem with the state carryover. They argue that without the language that the total funding is "available until expended" there can be no state 3-year carryover. It has something to do with the obligation of the funds. I don't quite understand it all but thought that you might have some insight.

Second, the language suggests that an allotment is only available to a state with an approved plan. For example, if only 25 states have approved plans in 1998, the full appropriation will only be divided by the formula for those 25 states. I don't think that this is the intent -- what do you think?

Third, another question about the carry-over. Is it retrospective as well as prospective? Specifically, if a state does not get an approved state plan until 2000, does it have access to its 1998 and 1999 allotments?

as of the

Any thoughts? We would greatly appreciate your opinion.

Thanks in advance.

last day

*IF NO PLAN -
NO Allotment
for that fiscal
year.*

STATE MOE:

*Does allotment = "obligation"
unused = "unobligated"
by allotment*

unlikely No Participants

Paper Plan

*50 Allotments:
No States can get
More than*

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Current as of 8/20

State Children's Health Insurance Program

QUESTION	ASSIGNMENT	PRIORITY
<i>II. ALLOTMENT PROCESS WORKGROUP</i>		
1. How must States treat funds received from cost-sharing?	Allotment Process Workgroup	High
91. Under section 2401(e) it mentions a 3 year availability of amounts allotted; can a state continue to carry over unspent funds from the first year and use them in the next year as in Title V of the Social Security Act, the Maternal and Child Health Services Block Grant, where in some states they spend the previous years carry over first then used that years money and carry some of it over, or will they have to spend money from all previous years by the end of the third year, and spend each years money with no carry over after that?		
<i>III. STATE PLAN APPROVAL PROCESS WORKGROUP</i>		
2. Which rules would apply if the cost-sharing in a benchmark plan in a State is different from the cost-sharing in Section 2103? Is cost sharing included in actuarial computing? Or is cost-sharing separate?	State Plan Approval Process Group	High
6. Does the Secretary have the right to choose/deny what coverage a State may use as its benchmark benefit package? (§2103(a)(1) and (b))	State Plan Approval Process Workgroup	High
9. What if someone is covered through private insurance but has extremely poor benefits and has high premiums; are they eligible?	State Plan Approval Process Workgroup	High
84. Group coverage can be purchased for children--does it have to be actuarial equivalent?	ASPE	High
93. Will the Administration have specific directions for the ways in which the States are expected to carry out the required coordination of their plans with the others in the public and private sector as discussed in Section 2108(b)(1)(D)?	State Plan Approval Process Group	High
<i>IV. STATE PAYMENT PROCESS WORKGROUP</i>		
13. Who determines the amount of the enhanced Medicaid FMAP and how is it determined? (§2104(d)(2))	State Payment Process Workgroup	High
14. Is cost sharing by beneficiaries considered part of the match? (§2107(d))	State Payment Process Group	High

DRAFT

15. If you have a private program on top of Medicaid, can you expand Medicaid eligibility beyond where eligibility in the private program ends? (The State of Pennsylvania, by example) (§2110(b)(1)(B)(ii))	State Payment Process Group	High
19. If a state wanted to pursue a limited Medicaid expansion now and do something more comprehensive in the future, can they get money long after October 1?	State Payment Process Group	High
21. What can and can't be used for state match?	State Payment Process Group	High
86. What counts towards the State's Title XXI match? Do in kind services provided by the public or private sector (e.g., Hospital personnel developing a data collection system for the State's program)? When do states have to have their matching funds (e.g., at the time they apply, at the time they draw down the dollars, by the end of the year)?	State Payment Process Group	High
<i>V. MEDICAID PROGRAM COORDINATION WORKGROUP</i>		
24. Is coverage mandatory/automatic for children on SSI? For that quarter, who pays match for SSI children? How would SSI children be reported? Would they be separately identified?	Medicaid Program Coordination Workgroup	High
25. Can States use any State-only spending, not just child-health related spending, to draw down the match? The provision just says that only non-federal funds can be used to State matching requirements. (See also Question #86)	OGC/Medicaid Program Coordination Workgroup	High
28. If a state wants to expand its 1115 waiver, does that qualify under Medicaid expansion, particularly if benefits are different than Medicaid?	Medicaid Program Coordination Workgroup	High
<i>VI. MISCELLANEOUS PROVISIONS WORKGROUP</i>		
35. Which agency runs the program? (See also Questions #71 and #72)	Miscellaneous Provisions Workgroup	High
<i>OGC</i>		
53. If a state has just expanded Medicaid under a waiver, would that recent expansion qualify under and enhanced matching rate?	OGC	High
54. Does a Existing Comprehensive State-Based Coverage as provided under the law applies only to those already existing programs in NY, Florida and Pennsylvania? (§2103(a)(3) and (d)(1))	OGC	High
56. Is the funding is available October 1st and remains available for 3 years from this date -- without the state needing to apply for it? Or does the state need to at least apply for the allotment?	OGC	High

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57. If Medicaid route is used, does a State need to meet all Medicaid requirements? If a States takes the Medicaid approach, do they need to meet any of the child health requirements? On cost-sharing would the Medicaid rules apply (rules do not allow cost-sharing for kids)?	OGC	High
59. If a State decides to do a combination Medicaid and Child health insurance, what process does the state need to go through? If a States initially chooses one option, can they change to the other option? For example, can a State elect to expand Medicaid for the first year and then switch to the child health insurance option the next year?	OGC	High
60. With respect to the maintenance of effort for 'state-only' programs, does this only apply to FL, NY and PA? In these 3 states, does this mean that the funding must be maintained? Can the funding then be used to draw down to get enhanced match? If so, can the new funding be used only for getting "new children" covered? (ie, not to fund children previously covered)	OGC	High
61. What are the limitations on the 10% set aside. Can the money be used for administration of plans, not just state administration?	OGC	High
62. Does the requirements for basic and additional services apply only when a state decides to provide abenchmark-equivalent coverage? Or does this requirement apply to the other three options (benchmark package, existing state program and secretary-approved coverage) as well? (§2103(a)(2), (c)(1) and (c)(2))	OGC	High
64. If a State's Medicaid eligibility varies depending on the age of the child (for example, Medicaid eligibility under age 6 is at 185% and eligibility for over age 6 is 100%), can a State choose to go up to 235% for one category (under 6 in this example) and up to 200 percent another category (over 6)? (See also Question #15)	OGC	High
65. In determining the HMO with the largest enrollment in the State, can you include subsidiaries of an HMO/	OGC	Medium
66. How many state plans can a state submit under title XXI?	OGC	High
67. Are NY, PA and FL good examples for states to look at, or are they deemed as exceptions?	OGC	High
68. Do states have to get in plan prior to plan being operational to get allotments?	OGC	High
69. Can SCHIP funds (including the 10 percent for non-insurance related items) be used to pay for undocumented children?	OGC	High
71. Does HCFA anticipate that governors will be required to designate a single agency like in Title 19? (See also Question #35)	OGC	Medium
72. If there's no single state agency, what do you do if plans are submitted from legislative and executive branch, or from other state agencies? (See also Question #35)	OGC	Medium

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73. What about a wrap around service package? Can states enrich a less than benchmark program with funds from the state children's health insurance program?	OGC	High
99. What part of DHHS will administer this program? Will there be a designated part of an agency or a specific person in charge? Who should states call with questions?		
100. What will be the role of Governors, providers and children's advocacy groups in implementing the program? What will be the role of the President and the First Lady?		
107. With respect to the maintenance of effort for Medicaid, do the June 1, 1997 & April 1, 1997 dates refer to what State Plans were "in effect", meaning in operation? Would plans submitted or approved but not "in effect" qualify?		
108. Is the Child Health program a "means tested benefit", meaning that legal immigrant children cannot be covered? What about emergency services for undocumented children?		
109. How are we going to define employment with a "public agency" in the State for purposes of insurance coverage under 2110(b)(2)(B)?		

Medicare

.7 - limiting
- 0.2 / - 1.1 = Incentive Payments:

Agenda for Kids' Meeting: September 30

1. Update on document release schedule

- Q.s. and as
- Schedule for next releases

① Tomorrow start MCD Div
- 12 month
- PE
- STATE Plan Amendment
Q+AS on MCD
② Monday
Thursday 20
Govs Next Week?

2. Technical corrections: What (if anything) must be corrected this fall?

Possibilities:

- Annual appropriation
- 10% Federal direct services / Admin
- + 50% for states that have already expanded Medicaid

More controversial issues:

- 3 state spending MOE
- ✓ Exemption of OBRA kids from allotment
- * Tennessee / RI DC A, pro ps.
- Reallocation of allotments for states using Medicaid

3. 1115 issues

For new title: are we clarifying / changing position? NGA letter response

For Medicaid: The following states have indicated that they want to expand 1115s

- Tennessee (premiums may be too high) ~~DE~~ A
- Arkansas (cost sharing is too high; state employee issue)
- Florida (cost sharing is too high)
- Wisconsin (subsidies for adults)
- Massachusetts (buys into group coverage)
- Vermont
- Possibly: Hawaii, New York, Washington, Utah, Oregon

4. [If time] Group / family coverage without a waiver

Is a waiver required?

Crowd out guidance?

is the accounting
Annually
Harder
than quarterly?

Questions about the Group Coverage Waiver

Major design questions

- **Choice or requirement:** Must a family with access to employer-sponsored insurance (ESI) purchase it, or is there a choice between ESI and the public plan?
- **Which employer plans:** Employer plans would have to meet the minimums in statute for benefits and cost sharing. Would the state assess plans employer-by-employer or would there be some process that would select acceptable employer plans (e.g, a certification process or an arrangement directly with a set of employers).
- **Subsidy amount:** How is the subsidy amount determined? Is it the same amount as for a child in a public plan or is it increased or decreased with respect to the family contribution to the employer plan?

Issues

- **Plan-by-plan benefits and cost sharing determinations:** Since Federal funds may only be used for qualifying plans, each families' employer's plan will have to be reviewed to see if it qualifies.
- **Different benefits for families receiving assistance:** The cost sharing protections and the prohibition on covering abortion make it likely that employers' plans will need to be modified to qualify. This could create problems for the employers' benefits managers as well as equity concerns from other employees not receiving the same benefits.
- **Lower employer contribution:** New employers in a state in which low-wage workers have access to premium assistance may set up plans with contributions that are lower than they would otherwise have been. In a state decides to work with employers to determine eligibility, there is a risk that the employer will only agree to modify its benefits if it can change its contribution (e.g., go from 80% / 20% to 60% / 40% with an understanding that the premium assistance of 30% will allow the employee pay less).
- **Higher costs for family than children-only coverage:** If families with access to ESI were required to accept it to receive assistance, they would have to pay more than a family with the same income but no access to ESI. This is because only the cost of the children's part of the premium is subsidized; the parents would have to pay the rest of the premium which could be substantial.

- **Dropping of coverage by co-workers and new employees:** Most states will probably adopt “fire walls” or requirements that children must be uninsured for a certain time period (e.g., 6 months) in order to be eligible. This means that if there are two families in a firm with the same income, one of which purchases ESI and the other doesn’t, the family that purchased ESI cannot be eligible for assistance unless they drop that coverage and their children remain uninsured for the required period of time. Will families who currently pay their full share think it worth it to expose their children to being uninsured for the time period so that they can get the exact same coverage at a lower price? What happens if a family changes jobs?
- **If the families has a choice between the public plan and ESI, the state would have same administrative work.** The state will have to make the determination for employers even if the family chooses the public plan.

There are several types of "crowd out".

Crowding out dollars. A major concern is that the public funding will replace private funding that would have been offered regardless. Examples include:

- Families who would have paid their employee share anyway take the subsidy and reduce their payment. These subsidies help the families but do not buy any additional coverage.
- Employers who would have paid a certain percentage reduce their contribution

Crowding out coverage. A related type of crowd out refers to the source of coverage: the same number of people have insurance, only the number of publicly insured increases and privately insured decreases. Examples include:

- Families who would have purchased coverage through their employers instead buy into the public program.
- Employers who would have offered health insurance coverage to their employees choose not to offer it since employees have access to a public program.

Agenda Kids' Meeting, October 14

1. Update on papers / releases

- State Medicaid Directors' letter about approval process

Chen 0017 10/31

- State Medicaid Directors' letter about financial forms

Dec 1, 15th

3 WEEKS

- HHS 1115 paper (also ask about WI, FL, MO, AR; Frist letter)

Dear Gov's Letter - Secretary Broader

2. Technical Corrections

- 50% above Medicaid
- Annual appropriation
- ? 3 state spending MOE
- 10% Federal direct services, admin, outreach

3. Child Care Conference Ideas

Child Care Conference



- Meeting on Thursday to finalize ideas

PETER HARBAGE
HOFF Purn Office 2010



John Rother

HCEA - Implementation
Meeting - Rescheduled //

July Fole

5650

6-2802

OPTIONS

MCD

TITLE XXI

ISSUES

Benefits
Cost Sharing

PUBLIC EMPLOYEES

TECHNICAL CORRECTIONS NEEDED FOR STATE CHILDREN'S HEALTH INSURANCE PROGRAM

I. "Pure" Technicals:

- ◆ **"Waxman kids" reference.** Section 4911(a)(2): section 1902(l)(2)(D) should be changed to section 1902(l)(1)(D).

Explanation: In the new section (u)(2)(C), a reference is made to section 1902(l)(2)(D). There is no such section. It should be changed to section 1902(l)(1)(D).

- ◆ **HIPAA reference.** Section 2110(c)(3): There is a reference to section 2191 of the Public Health Service Act. It should be section 2791.

Explanation: Section 2791 defines group health plan and health insurance coverage.

- ◆ **Allotment floor for States.** Section 2104(b)(4) starts off "subject to paragraph (5)," This reference to paragraph (5) needs to be removed.

Explanation: There is no paragraph 5.

II. Clarifications and Minor Policy Issues -- Consensus Only

- ◆ **Calculation of the 10 percent limit on a fiscal year v. quarterly basis.** A technical correction is needed to permit the application of the 10 percent limit on a fiscal year basis. (Legislative change needs to be developed.)

Explanation: A direct reading of the law is that the 10 percent limit would be calculated on a quarterly basis. This could cause problems for some States who in a particular quarter were above the limit, but are still the limit in a fiscal year.

- ◆ **Calculation of the 10 percent limit on total computable v. Federal share of expenditures.** Amend Section 2105(c) so that the 10 percent limit is based on total computable expenditures.

Explanation: We believe that the 10 percent limit should be calculated on the basis of total computable expenditures and the expenditures applied against the calculated limit should be in total computable expenditures. This provides a consistent treatment of expenditures and provides a higher limit for States.

- ◆ **Tennessee technical correction.** Change the Medicaid MOE to March 31, 1997 rather than April 1, 1997. (Legislative language needs to be developed).

Explanation: A drafting error was made in the date for the MOE for States that choose to expand Medicaid under Title XXI. It should have been March 31, 1997 rather than April 15, 1997.

- ◆ **Rhode Island technical correction.** Change the definition of "Medicaid applicable income level" to allow Rhode Island to get enhanced match for their recent Medicaid expansion (i.e., from 100 to 250 percent for children 8 and above). (Legislative language needs to be developed).

Explanation: We understand the Congressional intent was for Rhode Island to get enhanced match for their recent Medicaid expansion on May 1, 1997. As currently drafted, they only would get enhanced match for children between 250 and 300 percent of poverty because the language of the "Medicaid applicable income level" has a floor and a ceiling. This change would eliminate the floor.

III. Clarifications and Minor Policy Issues -- No Consensus/Consensus Not Known

CONSENSUS

- ◆ **Medicaid eligibility limit for "qualified" children v. poverty-level children (50% issue).** The language of section 2110(b)(4) on income levels should be revised to read as follows: "under the higher income levels under section 1902(l)(2) or section 1905(n) for the age of such child."

Explanation: For States that already have expanded Medicaid to levels near 200 percent of poverty, the apparent goal of section 2110(b)(4) was to permit eligibility expansions by as much as 50 percentage points above the existing Medicaid limits in the new child health programs. Under Section 1902(r)(2), generous income disregards can be used to increase Federal income limits on Medicaid eligibility that are specified in sections 1902(l)(2) and 1905(n). Title XXI, however, only allows for the 50 percentage points to be added to Medicaid expansions of 1902(l)(2). There is no reference to 1905(n) in Title XXI. The language of Section 2110(b)(4) on income levels should be revised to refer to the higher of income levels under section 1902(l)(2) and Section 1905(n). This technical change is needed for States to be able to avail themselves fully of the eligibility expansions intended by the new child health program.

2752

- ◆ **Add "optional targeted low-income child" to exceptions for limits on FFP.** Add the new optional Medicaid eligibility group under Section 1902(a)(10)(A)(ii)(XIV) to the list of exceptions to the limits on Federal matching in Section 1903(f)(4).

Section 1903(f)(4) limits Federal matching to individuals whose family income does not exceed 133 1/3 percent of the AFDC level for the same size family. Congress exempted certain eligibility groups from these limits, most notably the poverty-related groups. To ensure availability of Federal match for this new children's eligibility group, it should be added to the list of exceptions.

- ◆ **Spending MOE on All States.** Apply spending maintenance of effort to all States rather than only New York, Florida and Pennsylvania. (Legislative language needs to be developed.)

Explanation: Currently, the MOE on spending only applies to New York, Pennsylvania, and Florida.

- ◆ **Diabetes and IHS Funding Source** Change the funding of the diabetes grant programs so it does not come out of Title XXI.

Explanation: A substantial portion of funds (\$30 million for diabetes and \$30 million for IHS) has been set aside from the child health program. Over five years, these set asides reduce funding for child health by \$300 million dollars. This set aside may have been a drafting error, and there may be some interest in having the \$300 million put back into

CHIP. The funding for Diabetes and IHS would continue as a mandatory program, but the funding would not come from Title XXI.

- ◆ **Enhanced Match for Waxman Kids** Modify Section 1903(u)(3) so that these children are not eligible for enhanced match.

Explanation: 1903(u)(3) allows Waxman kids to receive an enhanced match that is not counted against the allotment. *Bridget H*

- ◆ **Expenditures must be applied on a quarterly basis and in the order in which they are reported.** This change would allow States to track expenditures on a fiscal year basis. This would help ensure that Title XIX expenditures are applied against the allotment first.

Explanation: Title XIX and Title XXI expenditures must be applied against the applicable fiscal year allotment in the order they are reported on a quarterly basis. This would apply with respect to expenditures reported within the same quarter, but not across different quarters. It would significantly ease the burden on States if a technical amendment were enacted so that this applied on a fiscal year basis, not quarterly.

- ◆ **Period for Which FY Appropriations are Available--Annual vs. No Year.** Add the phrase, "These funds shall remain available until expended or until the period of availability for the funds has expired for that fiscal year." to Section 2104(a). (Legislative language needs to be developed.)

Explanation: States would have more flexibility in terms of when money could be collected. Some believe that the allotment should remain available for a State for up to three years as long as the State submits and receives approval of its State plan at any time within the three year period. Currently, Section 2104(b) of the Act requires a State to submit and have a State plan approved in the first fiscal year of the 3-year period of availability in order to preserve its allotment for that fiscal year; otherwise it loses its allotment for that fiscal year.

HHS would have much more flexibility in terms of when the money had to be given out to States. If this was no-year money, HHS could probably wait 6 to 8 weeks after the close of the fiscal year to approve plans. Currently, this must be done by the end of the fiscal year.

- ◆ **Applicability of Expenditures to Allotments.** Change formula so a current year's expenditures can be applied against a succeeding year's allotment.

Explanation: A current year's expenditures can not be carried forward and applied against a succeeding year's allotment. We believe that for ease of administration and tracking that expenditures from a previous FY should be able to be counted against a current year's

allotment.

- ◆ **Counting of Children with IHS coverage.** In 2104(b)(2)(B), insert at the end "The numbers in such supplements of low-income children who have no health insurance shall be adjusted to add the number of such children who are covered only by a program operated or financed by the Indian Health Service."

Explanation: Representatives from South Dakota have raised concerns that States such as theirs with significant numbers of Indian children, some of whom may have access only to IHS-funded care, may not have received the full SCHIP allotment to which they are entitled because other provisions in the BBA make clear that IHS-only coverage should not be considered "insurance" for these purposes.

Sec. 2110(b) defines "targeted low-income child" as one not covered under a group health plan or under health insurance coverage, as those terms are defined in sec. 2791 of the PHS Act. Neither definition includes IHS coverage for these purposes. Additionally, sec. 2105(c)(6)(B) specifically excludes programs operated or financed by IHS from the non-duplication requirements. However, we have learned that the CPS data apparently does count children with IHS-only coverage as insured. This is inconsistent with other provisions of the BBA. The adjustment provided in this amendment would make the CPS data used for SCHIP allotment purposes, consistent with the intent expressed of these other provisions. (Note: this amendment is limited to children with IHS-only coverage. Those with additional coverage, such as from Medicaid, would still be considered "insured. Representatives from South Dakota have raised concerns that States such as theirs with significant numbers of Indian children, some of whom may have access only to IHS-funded care, may not have received the full SCHIP allotment to which they are entitled because other provisions in the BBA make clear that IHS-only coverage should not be considered "insurance" for these purposes.

Agenda for the Children's Health Implementation Meeting, November 4

1. Discussion of the family group coverage waiver issues /1115 Process

2. Update on schedule for releases, guidance, etc

3. Discussion on technical corrections / modification to old qs and as
Do we send Paper to Hill at this point

- [If the right staff are there, the IMD issue should be raised]

Congress has indicated many things may be changed.

4. Miscellaneous

- Well child care definition Work group

- Privatization and children's eligibilitiy

- Public access to state plans

Letter Fin.
Form -

How to Say
Technical

- Delete Admin.

AZ letter
Cover Memo
Gen meeting
WA Business Group

MO

90 Day Clock:

NGA WANTS 90 Calendar

Q+As - ROUND ONE

PA
AL

CHILDREN'S HEALTH INSURANCE PROGRAM
STATUS REPORT - NOVEMBER 3, 1997

Attached please find a listing of materials in development by the Children's Health Insurance Program (CHIP) steering committee and the status of these products in terms of projected completion dates.

<u>PRODUCT</u>	<u>STATUS</u>
1. The fourth set in an on-going series of Frequently Asked Questions and Answers, focusing on several major issues raised by NGA, is being finalized.	To be released within 1-2 weeks and posted on the HCFA CHIP website.
2. A draft State letter on financial issues is being reviewed.	To be released within 2 weeks and posted on the HCFA CHIP website.
3. A draft State letter on State plan issues is being reviewed.	To be released within 2 weeks and posted on the HCFA CHIP website.
4. One or two more sets of Frequently Asked Questions and Answers are being researched.	To be released within 3-5 weeks and posted on the HCFA CHIP website.
5. Two sets of regulations are in development, addressing:	
(A) Payment Process and Allotments incorporating the information in the released Q&As and the State payment letters.	NPRM 1/98 incorporating related Q&As and the Dear State letter on financial issues; to be posted on HCFA CHIP website. Final Regulation - 6/98
(A) State Plan Issues incorporating the information in the Q&As, and the State letters on the template, the approval process, and the Medicaid coordination letter.	Interim final regulation with opportunity for comment for publication 2/98; to be posted on HCFA CHIP website. Final regulation - 10/98
6. Training sessions for regional offices and departmental staff on State plan submission, approval and implementation processes are being planned.	To be held December 1997.

Thurs.
Frid.

① Payment
+ Allotment
② State
Plan

Agenda for Kids' Health Meeting: December 2, 1997

1. Releases: what's gone out; what is still in clearance
2. State plans: what has been received; any major issues
3. Regional conferences: are we still doing these? If so, when
4. Outreach: Budget ideas as well as non-budget
5. 1115 memo process (OMB thinks that they are writing it)
6. Response to the Bliley/ Commerce Committee document

① Today: St. Plan

② STATE Financial Foundr Wed. Thursday

③ Child health Initiative
Quality of Care
Outreach

End of February:

High Income Brain

DO ANYTHING

1115 Waivers

Sumon Variance.
Guidance.

AL

CA

6 Plans.

Dear Colorado - Stopped Clock

① Enhanced

② Admin

③ Prumptive
Eligibility

MA
CT

WV: kids OK

Michigan

ID.
WY

OUTREACH

1- Single Appl.
Screen + Enroll
Outreach Examples.

Kids' Agenda: March 10, 1998

1. Process

Decisions from Tuesday's meeting - *Learn with said around minutes*

State plan approvals - *Final review panel; early notification of ST Debbie will come back w/options on final.*

2. Public employee issue letter

Just Better to 2 states:

3. California

4. Washington State issue / options

R. Legist. goes out this week

Supp. House - Amendment year Oct 1998

5. Options for 10 percent limit fix

Next WEEK OPTIONS

WA, others don't St. Legislature Sessions

6. *1115 Rollout

Does increase spending Do Not oppose

- Are we approving waivers as part of the CHIP plan approval process
- Timing and method for the rollout

7. *Plan for Provider Tax Issue Resolution

Legislation?

A couple issues in Secretary's authority

Weekly Update:

CHIP - Opt.

Opt 2 - Not approved too we believe is impractical.

- W7: Go to state, ask to change some of law

- OAC: Line item veto if BBA in effect against plan w/ taxes

Lost Clearance Panel

1. Summary of Plan Documents

1. Plan

2. Key Request

3. Provider Tax

10 days left.

Carl.

1. outside 10% Cost: say don't health
25%

2. Family Value - Risk Selection:

3- Cost Sharing: \$5 flat fee

4

Drafting Tomorrow:

✓

Agenda: Kids' Health Implementation, March 19

1

Update

- What is happening with extension of deadline for application to 10/1/99?
- Qs and As
Letter earlier
- When is the draft reg expected to come through?
- Oversight request and NGA letter
Roll out

2

1115 roll out strategy

Dear State mca letter
Normal 1115
90 - Day Issue
MONTH



Ask: *Rob Weiner*
- NY Provider Tax

3

NY / crowd out

4

10 percent limit options : *Sympathetic % services*
2-years overtime

22 Plans:

5

Outreach policies and Minnesota and Washington

Add: Protocol - WH INVOLVED
Final DOCUMENT -

Appeals:

S-

6755

3974

Refund to people

~~Shall or Man~~

In General, Comm. encouraged
go through Chair

↓
Pick

↓
Respond

Our people can

FACA

APRIL 29

SUNDAY AFTERNOON
CONCERTUAL
Question

Tonight - Plan
Comm.

Kids Meeting: April 21, 1998

1. **States updates:** MO, NJ, CT, RI and ID [HHS]
[Also, ask for a count of the total states with submitted and approved plans]
2. **Update on releases:**
 - **VFC:** Not gone out yet; legal opinion needed on whether vaccines are considered a benefit, even when directly purchased, so that their expenditures are not subject to the 10 percent cap. HHS should have an opinion.
 - **10 percent limit:** HHS will give an opinion on possible flexibility (I think only legislative solution is an option)
 - **State employees:** Apparently, there are some additional states that do not pay the dependent share so that the exception may be larger than we thought.
 - **Crowd out discussions:** HHS has planned meetings with NGA and Hill [check to see that OMB and Treasury are invited]
3. **1115 Policy:** HHS's recommendation is:
 - Only comprehensive (meaning expanding to adults?) that are budget neutral and are demonstrations should be approved
 - 90 day clock should apply only if most of the Medicaid 1115 pertains to the state's Title XXI proposal.
 - Roll out: No letter but briefings to NGA and Hill
4. **Outreach:** [You might summarize private side, ask how report is coming]

SECTION 1115 WAIVERS OF TITLE XXI-MEDICAID EXPANSIONS UNDER CHIP

ISSUE

A decision is needed on what type of application process states will be required to follow in seeking Medicaid section 1115 waivers for CHIP expansions funded under Title XXI. Additionally, a decision is needed on whether the Title XXI 90-day review clock should be imposed on such waivers.

BACKGROUND

The Administration has decided to allow states to seek Medicaid section 1115 waivers under very specific conditions. Waiver applications would only be considered in limited cases where the state elects the Medicaid expansion option, and only when the State's proposal is consistent with what would otherwise be allowable in a separate state child health insurance program (S-CHIP).

The Department has received one State application that will be affected by this policy regarding waivers. The State of Missouri has submitted a Medicaid expansion Title XXI plan, and has requested a section 1115 waiver to implement a small reduction to the benefit package.

The vehicle for granting waivers would be the existing section 1115 authority. Section 1115 allows states to seek waivers of Medicaid provisions in order to test innovative approaches to health care delivery. As part of the demonstrations, States have chosen to expand eligibility in 10 of the 16 approved and implemented section 1115 demonstrations. It is important to note, and it will be crucial to emphasize to states, that section 1115 waivers are time-limited (five years in duration) and thus will not remain in effect for the duration of State Title XXI programs.

The review process for section 1115 waiver applications is both comprehensive and complex, and calls for heavy involvement by Departmental reviewers and the Office of Management and Budget. States have historically been required to submit detailed information on their proposed program, their proposed budget neutrality methodology, and information about how the section 1115 demonstration authority will be utilized to test innovative approaches to the delivery of health care. Section 1115 is a demonstration authority, and was not designed to simply allow states to have flexibility in reducing benefit packages and imposing cost sharing. If a state proposes a section 1115 waiver under CHIP, but the proposal is not embedded in a larger demonstration with a rigorous research design, it will be very difficult to continue to make it appear that the Department is using its demonstration authority to test innovative approaches.

Another key characteristic of approved section 1115 demonstrations is budget neutrality. In order for a section 1115 proposal to be approved, a state must demonstrate that the cost with the waiver will be no higher than the expected cost without the waiver. Budget neutrality often represents the most difficult part of the section 1115 waiver review process.

It is important to note that there is no review clock for section 1115 waivers. This is in contrast to the Title XXI review process, which is subject to a statutory 90-day review period. If HCFA

NEW-
Does this
mean only
Approved
if expanding
to
Adults?
IF A
STATE IS
ONLY expanding
for kids,
WHAT
does
this
mean?

does not approve a state's plan or stop the clock with a formal request for additional information, the Title XXI application is deemed approved. The Office of General Counsel (OGC) has issued an opinion regarding the 90-day clock and section 1115 waivers connected with CHIP applications. OGC concluded that a Title XXI application containing a request for a Section 1115 waiver would still be subject to the 90-day clock, although the Section 1115 waiver request is not required to be subject to any clock. This could result in Title XXI applications being denied because the Department has not had sufficient time to act on the Section 1115 request.

ISSUE A

The issue is whether to require states seeking section 1115 waivers which are connected to CHIP applications to submit full section 1115 applications, including a rigorous research design, and, where applicable, budget neutrality, or to implement a new, streamlined process in keeping with the Title XXI application process.

Option 1

Require states to follow the existing section 1115 process, including a research design and, where appropriate, budget neutrality. Under this option, states would be required to submit a full section 1115 application separately from the Title XXI application.

Pros

- ▶ Will discourage states from indiscriminately seeking section 1115 waivers under CHIP when they could simply submit an application to implement an S-CHIP program instead.
- ▶ Will preserve the integrity of the section 1115 process.
- ▶ Does not tinker with the current section 1115 review process, which was the result of comprehensive negotiations with the National Governors' Association (NGA).

Cons

- ▶ May not be supported by NGA and the states.
- ▶ May not be supported by Congress.

Option 2

Create, for the purpose of Title XXI only, a super-streamlined section 1115 application process. Under this option, the section 1115 waiver request could be separate from a Title XXI application or contained within it.

Pros

- States will likely appreciate the simplicity.

Cons

- May encourage states to apply for waivers for reduced benefit packages and higher cost sharing.
- Fails to preserve the integrity of the section 1115 waiver process. In the future, it may be difficult to resist pressure to further simplify the 1115 process for issues other than Title XXI.

Recommendation

The Steering Committee recommends that States should be required to follow the existing Section 1115 waiver process.

ISSUE B

The issue is whether the 90-day review clock will apply to state requests for section 1115 waivers under CHIP, or whether these waiver requests will be considered on a separate time line.

According to OGC, the 90-day clock applies to Title XXI plans regardless of whether a State has requested a section 1115 waiver. Once a State submits a Title XXI plan or plan amendment, the 90-day clock governs. If the Secretary does not disapprove or does not seek additional information, the plan or plan amendment would be deemed approved. The Title XXI deemed approval would not give the State any waivers it sought under section 1115, since they are not governed by the 90-day clock. Given a deemed approval, a State might operate the plan despite its failure to comply with those provisions of Title XIX or XXI for which it was seeking a waiver. This could lead HCFA to take compliance actions under Title XIX or XXI.

Option 1

Make section 1115 waivers of Title XXI provisions subject to the same 90-day review clock as the overall Title XXI application. (The 1115 waivers are not subject to the 90-day clock by law, but DHHS could have a policy to this effect.)

Pros

- ▶ Will be supported by NGA and the states.
- ▶ Is likely to be supported by Congress.

Cons

- ▶ Has the potential to create very difficult review situations. This would be especially true in cases where a state submits a section 1115 waiver under CHIP that is part of a larger, more complex demonstration, as is the case with the Missouri proposal.
- ▶ Does not preserve the integrity of the section 1115 process.

Option 2

Maintain a separate review period, with no clock, for Section 1115 waivers under CHIP.

HCFA could address the problem of differing clocks by asking the State if the 1115 waiver is "inextricably linked" to its Title XXI plan submittal. If the State does not want HCFA to proceed with final action on the Title XXI plan without first granting its 1115 waiver, it can respond to our request that it cannot supply the needed information to HCFA until it receives final approval of its 1115 request. This would stop the 90-day clock.

If the State does want HCFA to proceed with final action on the Title XXI plan even if HHS has not made a decision on the Section 1115 waiver request, it can respond that it wishes HCFA to proceed with approval of XXI regardless of the status of the waiver request. HCFA should advise States that to the extent that their XXI plans depend upon waivers, it may not be possible to act within 90 days. This could result in HCFA disapproving XXI plans if they are linked to waiver requests and the State is unwilling to sever them.

Pros

- ▶ Allows for thorough review of applications for section 1115 waivers under CHIP.

- ▶ May encourage states to seek section 1115 waivers under CHIP only when absolutely necessary, because they will understand that the section 1115 request may slow the Title XXI review process.

Cons

- ▶ Will not be supported by NGA and the states.
- ▶ May not be supported by Congress.

Option 3

Section 1115 waivers of Title XXI Medicaid expansions would not be subject to the 90-day clock except in cases where the State proposes to expand coverage for children only, and make changes consistent with Title XXI. For example, if a State proposed to modify cost-sharing so that it is consistent with the Title XXI limits, the waiver would be subject to the 90-day clock. In cases where more complex issues are involved (i.e., budget neutrality for non-children), we would not want to commit to completing review of the State's application in 90 days. In these more complex cases, the waiver would be subject to the principles on Section 1115 waivers agreed to with the National Governors' Association in 1994.

In this case where the 90-day clock did not apply, we would ask very early in the process whether the waiver request was "inextricably linked" to the Title XXI plan as described in option 2. Ideally, the State would agree to not formally answer the CHIP questions until the Section 1115 waiver issues were resolved.

If this did not happen, we would ask the State questions related to the Section 1115 waiver as a means of stopping the clock.

Pros

- ▶ Gives HHS time for thorough review -- including constructing a baseline -- of the difficult and time-consuming 1115 waiver requests.
- ▶ Shows willingness to address NGA and States' concern about timely consideration of 1115 waiver requests.

Cons

- ▶ May not be the preferred option of NGA and States.

Recommendation

The Steering Committee recommends requiring States to follow the existing Section 1115 process (Issue A, Option 1). Additionally, the Steering Committee recommends (Issue B, Option 3) that the Section 1115 waivers be considered within the 90 day clock only if there are no budget neutrality issues. If budget neutrality were an issue, then the State would not be subject to a 90-day clock.

Roll Out of Policy --

The recommendation is to present these recommendations as our policy *internally* and that we do not issue a State Officials letter outlining our policy and process decisions. We would, however, tell both the Hill and States about our policy, but in a low profile manner. Although there are three States with pending plans (VT, WI and MO) that have requested Medicaid waivers of section 1115, all three involve broader populations than children or have budget neutrality issues. None of these States has proposed waivers of significant Medicaid rules for children and we are working successfully with them on using a separate review period for the portion requesting a waiver. For example, Missouri has agreed not to respond to our CHIP questions until the State's 1115 waiver issues have been resolved.

The concern has been raised that if we issue a letter to the States, we will be raising a controversial issue that may make States unhappy, either with the policy itself, or for those States that have already been approved, that we are now giving States additional flexibility under Medicaid that they were not aware of. Advocates and democrats on the Hill would be concerned that we are allowing 1115 waivers for Medicaid under Title XXI and therefore, "eroding the Medicaid program" which they fought hard to protect. In addition, making the policy public might encourage more States to apply for 1115 waivers under Medicaid for children. Finally, of late, the controversy over the issue has quieted somewhat in the outside world, and we would rather not raise this controversial issue externally if it can be avoided.

Kids' Implementation Agenda, April 29, 1998

1. Follow up on crowd out and data discussions
2. VFC and 10 percent limit policies / letters
3. Massachusetts employer subsidies issues
4. Federal interagency report update
5. State update

[How do you assure
that]

2830

Ask about
crowd out

**PHOTOCOPY
PRESERVATION**

May, Note

Connaught

Kids' Agenda, May 12, 1998

Roll-out of waiver process
NMA OK too.

OK

1. 10 percent limit: See attached paper

→ OK to send. Long conversation. Probably center design a package that is less costly on a per capita basis. → We also want to send up legislation on 10% cap implementation options to provide more state flexibility.

2. Data strategy

- Financial / quarterly
- Crowd out / monitoring
- Evaluation
- Income

3. Revising final state plans

4. Finalizing MA?

- works w/ 5% cap still

5.

Interagency report: Legislative and Statutory Barriers:

EXAMPLES

1- TANF-LINE OPTIMIZED

2- EXTENDING TRANSITIONAL BENEFIT

3- INDIAN TRIBES AS CHIP PLANS

4- RYAN White Providers as PE providers.

6. VFE letter

Out as of 5/11

Family coverage - Dept under review

PR

OK if OMB says so on crowd out. 15% threshold will go out.

Idaho - 150% rise

- Oklahoma

- AZ - MSA option - No good for CHIP

410-781-017

T. Lewis

66

Kids' Agenda, May 19, 1998

For

1. Updates on:

- ✓ ~~PA~~ → crowd out FIT.
- ✓ ~~MA~~ → ~~State~~ - ~~cont. starting~~ dr will I-L I child wr
- ✓ ~~OK~~ → Thursday & Friday

2. Income data follow up - Danny + Gary will gather more info. for Friday discussion; Meet w/ NGA Next Wednesday

3. 10 percent limit

- Letter on variance Comments as soon as possible; to go out this week.
- Legislative options

4. Wisconsin

- Decided that we ~~at~~ don't really like HHS recommendation of 10% of Allotment (v expenditures); started to talk about other options, but Gary, Bonnie, OMB think tobacco \$ should alleviate this problem.
- Family coverage variance versus regular 1115

① "Cost effectiveness"

Their method is highly problematic

We're recommending (?) they look at employer-based coverage

② Budget Neutrality "Pass Through"

1971(b) - Welfare Reform

Pass through - Problem - kids separated out, Not legal

HHS:

RECOMMEND:

Cover adults in employer-based plan
Others go into Medicaid
Want High Cost Sharing + Match for Cost

by June 1

MAY 26, 1998

Kids' Agenda, May 26

1. States update

- Wisconsin:

2-hour staff Conference call. WEDNESDAY

How did the roll-out go?

CJ: Did we promise the ~~Congre~~ssmen to help work on legislation? How does this interact with Obey's legislation? What are the ramifications for tobacco?

- MA, PA, OK to be announced this week
WI: LATE THIS WEEK
TODAY

2. Qs and As:

- We'll send over comments; some policy concerns

3. Interagency outreach report: Discussion of executive order options for release of report [Note: there has been no formal discussion of these ideas with HHS yet; if you want, we can postpone this discussion]

- Direct a standing Federal interagency council to oversee implementation of plans, possibly with HHS in the lead, quarterly meetings
- Create formal group to examine coordination of eligibility systems across Federal programs. Could include NGA, Congressional staff, private sector systems experts, advocates, to develop recommendations and models
- Support administrative and legislative actions to strengthen and expand outstationing. Currently, outstationing is limited to provider sites, and only people at FQHCs and DSH sites can assist in initial processing.
- Direct AmeriCorps to spearhead state and local campaigns ??

IDaho: MEDICAID EXPANSION

Eligibility

1902(a)(17) - Comparability
Benefits, Eligibility
Problem

October

"self-reliance expert" intake
worker. Should have purchased
other insurance; standards
are good enough; "reasonable"
person standard
appeals -

2 weeks ago - only THIS.

Kids' Agenda, June 8, 1998

- **Update on approvals:**

IDAHO - possibly

- 17 approved (Oregon and Texas will make it 19).
- Can we approve 5 more before June 22? NO

- **Nevada: Screen and enroll.** They refuse to make families fill out the Medicaid application if they appear Medicaid-eligible, which may be a violation of "screen and enroll" *2 weeks*

- **New Hampshire: Foundation issue**

4 ISSUES [STATE INVOLVED IN Creation
Foundation CONTINUES to
RECEIVE PROFITS
BOARD
MISSION

- **Wisconsin:** State called; Governor won't do it; HCFA said that they would help with technical assistance on legislation -- what does this mean?

Not Rejecting
Roth Bilirakis Letter

- Mayor's meeting?

Agree to provide
statutory change
on cost effectiveness

- **Federal interagency report**

- Public / private council and executive directive
- Eliminating the statutory and regulatory barriers sections *on*

- **Qs and as:** Major policy issues

Next Week



Letters - IMMIGRANTS

UPDATE, 1999 Deadline

*VERMONT - CHIP - 1115 Tighlerson,
under insured
Adults w/ No Children*

Agenda for Kids' Meeting, June 30, 1998

NH
MD
VT
MN

1. Update on states

- NH: Did the state submit information on options; are we on schedule
- NV: When are they resubmitting? *Fall*
- UT: Are they ok with cost sharing (issue with 5% limit below 150% of poverty)
- TN and Arkansas: Retroactivity; higher cost sharing
- WI: Are we working on legislative fix; what's going on

MN = 1115

2. Schedule for other guidance / regs: are there more letters forthcoming; when does the interim reg come out?

10% limit leg. lang.

3. Data issues

NY - Appealing Retroactivity

- ✓ HHS wants state defined income and family size, only for CHIP kids
- OMB wants Federally defined (Census definition) income and family size for all children (Medicaid and CHIP)
- My opinion: get state defined income and family size for all kids (Medicaid and CHIP); have them submit definitions of income and family size and report by cost sharing category (so we know how many kids are receiving \$5 premium, etc.)

4. Outreach follow-up

- Who is assigned to this; encourage them to convene / contact agencies
- Mention fall event

Kids' Implementation Meeting
July 28, 1998

Ben

450

750

15,000

Mark Miller

1. Update on states

- Arkansas
- Maryland: announced tomorrow

2 WEEKS
options - Next week

2. Cost sharing limit below 5 percent: Should we have one; what percent

- Montana and cost sharing ☒ Montana

DEDUCTIBLE: \$3/mo/child

3. 1115 and New Mexico: They want a Medicaid 1115 for cost sharing

want to go to 185%

5,000
kid

\$15

4. Likely amendments to appropriations bills on kids

- Gorton / Washington state RI:
- Wisconsin
- Vaccines for Children (Feinstein)

MD - MOE

5. Data discussion

10%

- Process on crowd out questions, income breaks, etc

TOBACCO - May Be Som

8/5/9

INDIANS - ALLOTMENTS

Disability

Kw!

4-0767

Kids' Agenda, August 18, 1998

I. Update on where we are with States

- SD *Ready*
- MO and NM Medicaid 1115]
- Wisconsin: how did roll out go

→ 4:30 Today
Tomorrow State

II. Guidance:

- How did last week's roll out of Qs and As go?
- SS # letter (see attached): Should we wait until the public charge issue is resolved? Is OMB ok with this (they previously wanted to add new crowd out questions)
- Flexibility letter (see attached): Should we send?
- What is the timing of the reg?

III. Outreach:

- What's going on with Federal Interagency Group?

Kids' Agenda, September 8, 1998

FL = Today

I. States update

AZ = Done

MT = Almost - Penalty

WV = Format

NH = Letter

VA = Abortion

II. 1115 states :

- Missouri's cost sharing waiver
Phit = CHIP, 1115 still waiting

- New Mexico's new 1115 -
haven't submitted

- Wisconsin: khd briefing last
Friday

Washington - working
Wyoming - Jan.
Hawaii - Next Spring
Vermont - withdraw
Regular FY4

III. Cost sharing below 150 percent of poverty

HHS still working on position

IV. Update on outreach activities

Recission: \$500 million
presumably won't affect
States