

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	re: phone number (partial) (1 page)	n.d.	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20146

FOLDER TITLE:

CHIP[Children's Health Insurance Program] Outreach [Folder 11]

2012-0463-S

rc735

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]
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- 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]

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

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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]



William Lasowski <WLasowski@hcfa.gov>

08/27/99 08:01:54 AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: See the distribution list at the bottom of this message

Subject: Updated TANF \$500M Chart--FYI

Since we now have expenditure report submissions for the third quarter (April-June) from all but 8 States (CT, IA, LA, ME, MT, NY, RI, VT) I have updated the attached excel chart to reflect those TANF expenditures reported.

Based upon the submissions to date the current national expenditure total is \$49,701,828, approximately 9.9% of the total allocation.

Please remember that the expenditures here are not all yet final and are subject to change and RO review.



- 500SUM3Q.SUM

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The U.S. Department of Education INSURE KIDS NOW! THROUGH SCHOOLS Campaign



More than 700 Schools and Communities Pledge to Help Enroll Children in Health Insurance

In response to President Clinton and Secretary Riley's call, more than 700 principals and superintendents from school districts in 49 States and the District of Columbia have signed on to the *Insure Kids Now! Through Schools Campaign* since August, committing to take at least one step to help children apply for free and reduced-price health coverage. The U.S. Department of Education is seeking to build a coalition of educational and community leaders committed to using schools to reach out to and help families access these free and reduced-cost health insurance programs for their children. Many have committed to integrate health coverage enrollment into school activities, such as registration, Parents' night, or back-to-school events. Some have volunteered to recruit additional schools and organizations to take part in CHIP/Medicaid awareness and enrollment efforts. Still others have pledged to distribute information to families about children's health insurance options through information packets or district newsletters.

Schools around the nation are employing innovative and far-reaching strategies to reach uninsured children and their families. For example, the "Coaches Campaign" in Massachusetts is made up of high school students and community organizations dedicated to recruiting sports directors and school athletes to spread the word about CHIP/Medicaid. A number of school districts that joined the *Insure Kids Now! Through Schools Coalition* are already training their nurses and paraprofessionals to help enroll children in the programs. Other districts have revised their free and reduced-price lunch forms to ask families if they would like more information on CHIP/Medicaid, and many schools have included CHIP/Medicaid information in their annual letter to remind parents about immunizations.

The *Insure Kids Now! Through Schools Campaign*

Schools are trusted sources of information for families. Educators see the effects of poor health on students' learning and the classroom environment first-hand. As many as 250 million school days are lost each year by children and adolescents 5 to 17 years of age as a result of acute and chronic health conditions. Children without health insurance suffer more from asthma, ear infections, vision problems - treatable conditions that dramatically interfere with classroom participation. And children without health insurance are absent from school more frequently than their peers. CHIP and Medicaid can serve more than 6 million children who are eligible for coverage, but not presently enrolled. To accomplish this goal, the Department of Education:

- Sent a letter to every school Superintendent in the country asking them to pledge their support for this effort.
- Identified health contacts in every state to assist educational leaders with outreach and enrollment.
- Partnered with National Association of Elementary School Principals, National Association of Secondary School Principals, National Parent Teachers Association, Council of Great City Schools, Council of Chief State School Officers, and American Association of School Administrators to further disperse information.
- Is organizing a National Summit on School Based Outreach for Children's Health Insurance, and regional conferences with the Department of Health and Human Services to enable educational, health and community leaders to share what has worked and develop action plans.

How Can Education and Community Leaders Join the *Insure Kids Now! Through Schools Campaign*?

Pledge on-line at the U.S. Department of Education's CHIP web site at <http://www.ed.gov/chip> or call our toll-free number, 1-877-4ED-Pubs, to request a pledge form.

15 *is this selective or su? I recommend that we do all - or if that's impossible, do the entire list.*
CHILDREN'S HEALTH INSURANCE OUTREACH ACTIVITIES CONDUCTED BY PRIVATE SECTOR PARTNERS *don't use this*

October 9, 1999

and the nation's governors
In February of 1999, the President and the First Lady, along with Governors Carper and Leavitt and Secretary Shalala, launched the nationwide "Insure Kids Now" campaign that aims to enroll every eligible but uninsured child in Medicaid and the new Children's Health Insurance Program (CHIP). *a public-private effort*

over About half of the over 10 million uninsured children qualify for these programs but remain unenrolled.

To ensure that families know that their children may be eligible, the President has engaged a broad-based, bipartisan, public-private coalition to use every possible means to educate and assist families in insuring their children.

Downend this #?
The Insure Kids Now campaign has three components: (1) *to publicize the programs and assist in enrollment* a new television, radio, and print media campaign; (2) *to assist families in the process of enrolling* new efforts by private corporations and professional associations; (3) *to simplify the application process +* new outreach strategies designed by grassroots organizations serving millions of people; and (4) *provide other guidance to facilitate enrollment* new proposals and actions from the President, all designed to educate families about the health insurance options available through Medicaid and CHIP. Teachers, volunteers, health care providers, ministers and rabbis will inform parents of the toll free number and the message will be reinforced through PSAs on the radio and television, as well as through the display of the new toll free number on restaurant tray liners, grocery bags, and diaper boxes.

THE PRIVATE SECTOR MAKES AN UNPRECEDENTED COMMITMENT TO CHILDREN'S HEALTH INSURANCE OUTREACH.

At the launch of the Insure Kids Now campaign, private sector corporations nationwide pledged to contribute to this new effort. Accomplishments include:

- Put creating 1-800-first*
- **Educating emergency response workers nationwide.** American Medical Response has conducted community awareness days around the country which included information on Medicaid and CHIP, including the new toll free number for children's health insurance outreach (1-877-KIDS NOW). In the coming months, they will distribute a CHIP logo that includes the toll free number as part of their community outreach materials.
 - **Providing information on Medicaid and CHIP as part of community health fairs across the country.** HOPE for Kids has provided health insurance information to the families of over 100,000 uninsured children and provided application assistance to several thousand children. They are hosting AmeriCorps members in Chicago, Dallas, New York city, Miami, Los Angeles, Philadelphia, Boston, and San Francisco dedicated to identifying and enrolling children in health insurance.
 - **Training college students to provide application assistance.** The Children's Defense Fund launched the SHOUT project last spring, which trains students to provide Medicaid and CHIP application assistance and pairs them with community based organizations that work with eligible families. They plan to expand the project to 10 additional college campuses and medical schools in the Northeast this fall.
 - **Holding health fairs and airing public service announcements in New York, New Jersey, and Connecticut.** In September, the Children's Defense Fund, together with Martha Stewart Living and the K-Mart corporation, launched a three month Child Health Now! Campaign, which features in-store displays and a public service media campaign.

Since those not included w. ll
be offended.

- **Conducting research to improve current outreach efforts.** Wyeth-Lyderle Vaccines conducted a study that indicated that only 17 percent of parents are aware of the new health insurance options available for children. [JML – don't know if these are only uninsured parents or all parents – does not say.] The company also created a CHIP communications handbook for distribution to local advocates and outreach workers that includes information on best practices and a resource directory for children's health insurance outreach.
- **Distribution of 11,000 toothbrushes imprinted with 1877 KIDS NOW.** The American Dental Hygienists Association has distributed 11,000 toothbrushes imprinted with 1877 KIDS NOW to school children in targeted areas throughout the country. In addition, information on the Insure Kids Now campaign was provided on a tear-out flyer in the March 1999 edition of *Access* magazine, which reaches 400,000 dental hygienists nationwide.
- **Hosting an "Insure Kids Now" sign-up day at McDonalds' restaurants in Washington D.C.** The American Hospital Association, together with WJLA-TV, the March of Dimes, and McDonalds', hosted Medicaid and CHIP outreach activities at 330 restaurants on September 25, 1999. In one day, they reached over 2,000 families.
- **Sending "Insure Kids Now" posters to every American Hospital Association member.** The American Hospital Association is sending Insure Kids Now posters featuring the 1877 KIDS NOW toll free number to over 5,000 hospitals to celebrate national Child Health month.
- **Distribution of Insure Kids Now posters to over 35,000 pharmacies nationwide.** The National Association of Chain Drug Stores, together with Johnson&Johnson, have distributed over 35,000 Insure Kids Now posters to pharmacies nationwide. Pharmacists were also given background information to help them answer questions from the public.
- **Including the 1877 KIDS NOW toll free number on reference materials for pediatricians.** Pfizer Pediatric Health included the 1877 KIDS NOW toll free number on the back cover of the 1999 edition of the Pediatric Resource Guide, which is distributed to 25,000 pediatricians and every Kmart pharmacy nationwide.
- **Promoting the Insure Kids Now campaign at the March of Dimes annual fundraiser.** The March of Dimes promoted the Insure Kids Now Campaign during their annual Walk America fundraiser, which placed banners advertising the 1877 KIDS NOW number in over 1000 cities, reaching 1 million volunteers, 20,000 corporate donors, and radio and television audiences in every major media market. In addition, the toll free number was featured in a letter sent to over 2 million donors, volunteers, and corporate supporters.
- **New efforts by religious organizations to promote Insure Kids Now.** Catholic Charities USA, the Evangelical Lutheran Church in America, the National Council of Catholic Women, the National Council of Churches of Christ, the United Methodist Church, the Union of American Hebrew Congregations, the United Synagogue of Conservative Judaism, and the United Jewish Communities sent information on children's health insurance outreach to their hundreds of thousands of members nationwide.
- **Promoting Insure Kids Now in grocery stores nationwide.** In 1999 and 2000, Safeway will include information on Insure Kids Now on over 9.1 million grocery bags in 13 states.

add

DRAFT

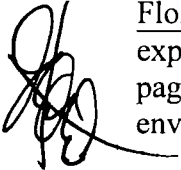
EXAMPLES OF BEST PRACTICES IN SCHOOL BASED CHILDREN'S HEALTH INSURANCE OUTREACH

Alabama ALLKids. The state distributes applications through the public school systems and launching a new Teenage Initiative in Birmingham County to conduct school based outreach activities such as informing student athletes about ALLKids at sports physicals. (Democrat)

Georgia PeachCare. Georgia has undertaken several creative outreach efforts, including implementing a comprehensive back to school outreach campaign for the 1999-2000 school year. Activities include: distributing 1.4 million flyers to students in Georgia's public schools and placing outstationed eligibility workers in K-Marts across the state the weekend before school begins. (Democrat)

Indiana Hoosier Healthwise. Indiana implemented the Hoosier Healthwise Program in July of 1998 and estimated that they would enroll 40,000 children in 6 months. The state not only met that goal, but exceeded it, enrolling 42,400 children by December of 1998. The state has created over 450 enrollment sites – several of them in schools – that provide application and enrollment assistance. (Democrat)

X South Carolina CHIP. The state contacts principals directly to encourage them to get involved in Medicaid and CHIP outreach. Applications are also given to the athletic directors, guidance counselors and school nurses. (Democrat)

 Florida's Healthy Kids. The Healthy Kids program in Florida credits its ability to design and expand its outreach program to accessing TANF outreach dollars. The state distributed it's one page mail-in application form for both CHIP and Medicaid (which included a return addressed envelope) to over 600,000 school children and enrolls children on-site. (Republican)

Illinois' CHIP. The state worked with the Chicago Public Schools to launch an aggressive, school-based outreach campaign where enrollment assistance was provided to eligible families at over 600 public schools as part of their Report Card Pick-up Days in November 1998 and April 1999. Plans are underway to conduct similar efforts with other Illinois public schools as well as parochial/private schools. (Republican)

New Jersey KidCare. The state – which is the first state to use AmeriCorps*VISTA volunteers to identify and enroll eligible children – provides information to interested parents whose children qualify for free and reduced price lunch. School districts across the state provide NJ KidCare materials for distribution to parents through their children, hold enrollment events at schools during registration for Kindergarten and Pre-K and at other times, and trained school nurses and child study team members about eligibility criteria and application completion. (Republican)

X Ohio Healthy Start. The state distributed information and materials on Medicaid and CHIP to schools through the School Nurse Association and will be mailing information to all home and center based child care centers. (Republican)

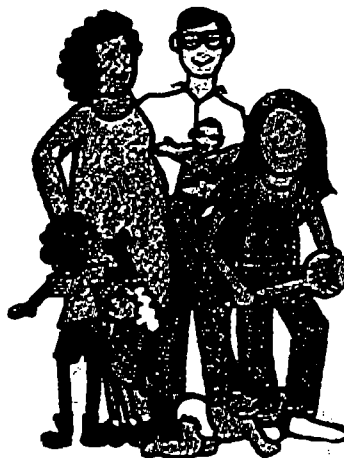


HOLIDAY
Seasonal
Home



Safeway
Savings
Guide
Ad

Working Families:
Does Your Child Need Health Insurance?



Find Out About New Free or Low Cost
Health Insurance For Kids of All Ages!

1-800-777-WJLA



March
of Dimes
Saving babies, together

46, ALL LIMITS ARE PER HOUSEHOLD, PER VISIT.

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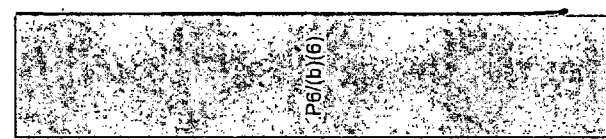
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over 930

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Marjorie
Jackie Noyes
Graham Newson
Joel Alpert

1007 MARJORIE THORPE



Graham Newson
Joel Alpert ↑

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DR ALPERT
Marjorie
Thorpe
Jackie Noyes
Graham
Newson

I think these are okay —
Tuesday's remarks.

Draft #1

President Clinton Introduction

By Joel Alpert, M.D., president, American Academy of Pediatrics

Good morning. I am Joel Alpert, president of the American Academy of Pediatrics. I have the distinct honor of introducing a very special guest this morning. Our guest and I do have some things in common. We admire Franklin Delano Roosevelt, Harry Truman and John F. Kennedy. We both are Yalies, although I was an undergraduate. He went to the law school. We both were elected "president." We both have a passion for our nation's most vulnerable citizens, including those 11 million children without health insurance. And I am humbled by his achievements. His leadership has made a profound difference in the health and well being of the nation's children and adolescents. Just days after becoming president, he signed into law the Family and Medical Leave Act, giving parents a chance to take unpaid leave to care for their children. His accomplishments over these seven years accumulated from there, with the Clinton administration tackling many of the same issues that pediatricians work so diligently to solve. Children's rights in managed care, immunization rates, teenage smoking, gun and media violence, environmental hazards, appropriate child care, Medicaid enrollment, the lack of pediatric drug labeling and adequate federal funding for children's programs

We
usually
say
over
10.

something Along those lines into the
speech?

to name but a few. He also secured the single largest investment in health care for children since 1965—the State Children's Health Insurance Program. President Clinton, you still have more than a year to help us achieve our mutual goal of health insurance coverage for all children and adolescents.

Your actions have certainly qualified you for the title of "the children's president." It is with great pride that I stand here before you to introduce the president of the United States, William Jefferson Clinton.

spoke to Earl? losing me

I believe you will
help us use your final
↓

Dr. Joel Alpert's Presidential Address to
The 1999 AAP Annual Meeting
Washington D.C.
October 11, 1999
8:00 - 8:25 a.m.
Draft 9

← This is the
speech AAP is scheduled
to give tomorrow for
unwinding their new proposal
problems are

Standing on this podium and looking out at this large audience filled with pediatricians, our families, friends and guests, I am truly grateful for the honor you bestowed upon me as Academy president. I want to thank everyone... my colleagues... Academy staff... my family... especially Barbara, my wife... and all of you who have helped to make this an outstanding and fulfilling year.

starred.

For the past year I have been your spokesperson and ambassador accumulating 500-thousand frequent miles and two-hundred-plus nights in hotels. Leading the American Academy of Pediatrics has been an extraordinary experience. After all we are the most prestigious of medical organizations... because our mission from the day we were founded has been the health of children. Our mission is to address what for children has been previously unachievable... and make it achievable.

Today, I will report on the results of our collective efforts this past year. I'll begin with some of our recent Academy success stories.

We now number 55-thousand members... about one quarter of us are in training as residents or candidate fellows. This year we created a new medical student and pediatric career support program. Our medical students can now be affiliate members of our resident section.

Our alternate district chairmen have accepted the challenge of helping chapters develop pediatric clubs. And incidentally, every pediatric department chairman now belongs to the AAP. Your national leaders are now regular speakers at the resident section meetings. We must continue to reach out to... all of our young members, because they are the future of our profession and our Academy.

And all of our members benefit from the Academy's activities this past year... which took place under the leadership of our executive director, Joe Sanders. By reorganizing the national office ... and by adding cutting edge computer technology... your Academy is taking a giant leap into the next century.

The Future of Pediatric Education II Project has been completed. The Academy is already implementing one main FOPE II recommendation... we are building our Medical Education Home. The AAP has always provided access to learning. The medical education home soon will serve as a central and secure location for all of our credentials and CME records.

The Center for Child Health Research is up and running. It's new executive director has been appointed... he is Michael Weitzman, a former chair of the Academy's Committee on Community Health Services. Building on PROS and the Functional Outcomes studies... I believe the Center will successfully address many of today's challenging and unanswered research questions facing pediatricians.

Just this past week we saw major progress in Congress... when the Patient Care Bill of Rights... which the AAP supports... passed in the House. We will continue to advocate for this bill until it is law.

Immunization is not only one of the greatest medical success stories of this year... but of this century. Immunization risks are miniscule compared with the risk of diseases such as polio, measles and Haemophilus influenzae. Don Cook, our next president, will speak about Academy efforts to counter vaccine misinformation in his remarks to the Business Luncheon on Tuesday.

Along with our successes... we have also had our share of disappointments.

①

Today, you see me wearing the colors of Columbine High School on my lapel. I do so as a reminder that to date, despite our efforts, the epidemic of school and community shootings continues. Our Academy position to ban handguns and assault weapons is the right position. Other countries have media violence but they do not have guns. Other countries have mental illness but they do not have guns. I know some view gun control an attack on the constitution. You can tell me about "rights" but the right I care about is a child's right to grow up... with out being gunned down! We cannot rest until we guarantee our nation's children that simple right... by successfully banning handguns and assault weapons everywhere in this country.

We have been in the forefront of the tobacco debate... which of course has recently re-ignited with the filing of a federal civil lawsuit against tobacco companies. More young people... 3-thousand a day... continue to take up smoking. We must encourage the states to make proper use of tobacco settlement funds they have received. These funds should go to prevent smoking... and not to build highways. The battle against big tobacco will not be over until we have won it! The tobacco industry continues to profit at the expense of children. We will achieve the previously unachievable. We will hold the tobacco industry accountable... and put an end to youth smoking!

And the biggest and most challenging goal we must achieve is that of universal health coverage for children.

That was my message to you when you nominated me for the office of AAP President. I also said we must achieve universal access to pediatricians, and pediatric medical and surgical subspecialists. I have been true to my word, and universal coverage and access have remained my focus throughout my terms as vice president and president.

I could have softened my message... but I had confidence... and I will always have confidence that our members support what is best for children.

I used both the spoken and the written word to get my message out at every opportunity. I believe that with my passion and your passion we can achieve universal coverage for children. We can make the previously unachievable achievable.

It is simply unconscionable that the United States remains the only industrialized nation that does not insure all of its people. "Unconscionable" is a word I have used frequently this year, because our country - the world's most powerful democracy, in the midst of the longest, most sustained economic expansion in modern history - has largely ignored the plight of the nearly 45 million uninsured Americans, over 11 million of whom are children.

How can I say that America's children are ignored? After all, the Balanced Budget Act of 1997 established the States Children's Health Insurance Program... S-CHIP... and provided 48-billion dollars for ten years to insure children. S-CHIP represents the largest infusion of dollars into child health since Medicaid began... and the Academy has devoted our resources, both human and financial, to make S-CHIP work.

And Medicaid insures children. Medicaid has existed for almost forty years and today provides health insurance for almost one in four children.

Although Medicaid and S-CHIP are important steps in the right direction, in my opinion, they are seriously flawed. They currently do not promote the best interests of children or their pediatricians. As we learned only last week, the numbers of the uninsured are continuing to increase: one million more than last year, one-third of whom are children.

ultimately doomed to fail?

To benefit from Medicaid and S-CHIP, families face substantial enrollment barriers. Race, language, culture, and geography -hamper those who are eligible. Recipients must overcome bureaucratic hurdles and cumbersome enrollment procedures. Even when these barriers are overcome, eligibility must be reestablished, because enrollment is time limited. Medicaid and S-CHIP require ongoing means testing,

which varies by location and income. This is why we find millions of uninsured children who are unenrolled, despite being eligible.

Our country has more than fifty Medicaid and S-CHIP programs with different eligibility standards and enrollment procedures. Nearly forty years after Medicaid began, we continue to have not only more uninsured children, but also more children growing up in poverty. Child poverty in the U.S. has nearly doubled since the 1960s... and is the highest in the industrialized world.

Now contrast the state of children with the state of the elderly. In the three plus decades that Medicare has provided elderly Americans with universal coverage, poverty among the elderly has decreased by two-thirds... from 32 percent to eleven percent.

Medicare has, in large part, eliminated the disparities in access to medical care historically associated with socioeconomic status. Of course Medicare has problems, and must be made solvent and provide seniors with adequate prescription drug benefits. But I am confident that those issues will be addressed, since seniors vote. Medicare will remain solvent and universal, and will serve all of the elderly.

I know there is controversy surrounding the role the government plays in a program such as Medicare. But I've never heard of a person over 65 who objected so strongly to government involvement that he or she refused to use Medicare. Why? Because this program is needed and in the end, Medicare works for the elderly.

Incidentally... now that I have Medicare there are only two ways I can lose it. The first I am in no hurry to do... and the second is to somehow get younger and turn 64 again... a highly unlikely event.

And imagine, for the moment, that it was the elderly instead of children who were subjected to Medicaid and S-CHIP restrictions. If we were politicians, would we be talking today about programs that would insure, at best, two-thirds of the uninsured elderly? If so, we wouldn't need term limits. We would quickly be voted out of office.

In June, the AAP and six other medical organizations issued a joint statement entitled, "All Americans Must Have Health Insurance." Note the language: not should, but must! The other six organizations who signed the statement besides the AAP were the AMA, Family Physicians, the Internists, the Surgeons, Emergency Medicine, and the O-B-G-Y-Ns... and we have since been joined by many others, including the American Medical Women's Association. The statement went on to say that Americans must have insurance with a benefit package that provides quality care, as our keynote speaker, Don Berwick, will discuss. And these same organizations are providing the strongest possible support for a meaningful patient care bill of rights.

In the statement we included as a core value that the interests and well being of our patients is paramount. This is what matters. Our patients, their families will know that it is their interests, not ours, that come first!

Organized medicine, if it stays the course, is will enter the new millennium as the advocate for solving the problems of the insured, the uninsured, and of course... the underinsured.

Patients coming first as a core value was in the AAP Children First Plan, developed in 1988, during Don Schiff's presidency. In 1992, the AAP, believing that health care reform was likely, signed on to major health care reform. But public support for health care reform waned as a result of a secretive process and... in the end... a complicated, poorly understood plan. In addition, small businesses joined with the insurance industry to conduct a brilliant advertising campaign against reform. The campaign featured a warning that we would lose control and choice, and that did happen. But it happened because of managed care, and not because of government intervention.

In March of this year, a New York Times article stated that children are the ones in this country who need health insurance least. The article reported that children are generally healthier than adults; when children get sick, they are cheaper to treat; and children have already been singled out by S-CHIP.

The article's facts are correct. Children are generally healthier. Children are less expensive to treat. But the article's conclusion is wrong when it says that S-CHIP will do the job. Our conclusion is: Children should receive health insurance not least, not last, but next. *

We know that children with health insurance receive more medical care, are healthier during childhood, and become healthier adults. The issue is not dollars. We have the money. Our country spends one-hundred percent more on health care than any other industrialized nation - more than two-billion dollars a day, more than one-trillion dollars a year, and we are heading for four-billion dollars a day and two-trillion a year within a decade. And we know that children are the least expensive age group to insure. So how can we provide universal coverage for children? The Academy needed a dual strategy. While we are trying our best to make S-CHIP work, we needed to develop an approach that would insure all children.

The charge to develop our strategy was given to the Task Force on Health Insurance Coverage and Access to Care.

The Task Force has surveyed approximately 15-hundred members... one-thousand randomly... and learned that all pediatricians surveyed believe in universal coverage for children. We learned, using additional Academy data, how badly the current systems are failing. We learned that increasing numbers of pediatricians who had always participated in Medicaid and then SCHIP are being forced... through inadequate reimbursements... to limit their participation. We learned that as fast as children were enrolled in SCHIP, others were losing Medicaid. We learned that although committed to universal coverage for children... our members remain cautious when it came to a complete government program. And we learned we have no love affair with the private sector... as managed care organizations and insurance companies aggressively pursue the bottom line... and all too often quality of care becomes secondary. We know that there are millions of children who are badly underinsured by private policies that do not even cover basic preventive services.

The Task Force proposal, which the Board has just approved, is a bold step. And I believe it is also a crucial step beyond rhetoric and into action... that will make universal coverage a reality... and make the previously unachievable, achievable.

Our proposal has four key elements:

One:

Eligibility will be automatic, which means children will either have public or private insurance, but they will have insurance.. We will preserve the best, but only the best of the private system.

Two:

All children will be enrolled without means testing. Medicaid and S-CHIP will be replaced. Family contribution could vary according to family income. Every attempt would be made to safeguard the existing contribution to child health insurance from federal, state, and private sources.

Three:

All programs, public and private, would meet Academy benefit standards with access to pediatricians and pediatric medical and surgical subspecialists. Every plan must provide appropriate reimbursements using RBRVS with a conversion unit with a fair value.

And Four:

We must ensure the quality of all programs... again, we will hear more about quality from Don Berwick. And there is a role for the states... which could be responsible for program oversight, accountability and quality monitoring, but not determining standards or reimbursements.

Our proposal includes pregnant women, choice of clinician, guaranteed continuous coverage, and access to pediatric medical and surgical subspecialists. It includes cost sharing... and can be financed through a

number of mechanisms... including a broad based federal tax. Incidentally, such a tax would provide benefits to younger families, to families with children. Those are families who presently pay a Medicare tax with almost no likelihood of short term benefits.

Under our strategy crowd out, which happens when employer-based systems drop coverage for children and let a public plan pick up the slack, is a possibility. But crowd out is not necessarily a bad thing. Frankly, unless the private plans meet our criteria, they should be dropped.

The Task Force is chaired by Rick Buccarelli of Florida. I want to personally thank all of the members of the Task Force... who are sitting here in the front row. Thank each of you for your hard work, which, of course, has only begun!

We presented our proposal to the Chapter Forum... and since then we have received excellent and useful questions and comments... almost all of them constructive and supportive.

I encourage you all to visit the Members Only Channel of the AAP web site and learn more about the proposal... and e-mail the Task Force your comments and questions. This blueprint for action is still taking shape, and your input counts.

After we have fully educated ourselves, we will embark on a major campaign to educate our patients, our communities, Wall Street, and legislators.

Our proposal is politically viable because it serves many constituencies. It serves children, most importantly, by providing them with quality universal coverage. It serves parents because they will be able to enroll their children... and to maintain their enrollment... with ease. It serves legislators, because it eliminates the embarrassment of having uninsured children. It serves tax payers, because it uses tax dollars wisely, preventively and efficiently. And our proposal serves pediatricians... by including not only Academy quality benefits... but also appropriate reimbursement.

We estimate the additional cost of our proposal is 45 billion dollars annually... most of which is due to improving benefits, especially in the private sector.

Reimbursement is critical. If we keep on providing our services at unacceptably low rates, our services will be perceived as less and less valuable. What we provide has value! The time when pediatricians are undervalued, underpriced, and underpaid has got to come to an end... now!

Don Cook has established a Task Force on Reimbursement. The Task force will link its work with the ongoing work of the Task Force on Universal Coverage.

I want to come back to how important it is to abolish means testing. By making enrollment automatic we have set the bar high... and that is where the bar should be. To those who believe the bar is set too high, setting it lower has not worked. I don't know of a single pediatrician who believes that today's bar is what anyone wants. In fact, the bar is so low that almost all of us... children and pediatricians... are tripping over it.

For those who believe the bar is not high enough... we can raise it once we've cleared it at its new height. Because ultimately... the job will not be done until every American has health insurance... and faces no financial barrier to needed medical care.

When I began my term as your president, I said I wanted universal coverage to be on our nation's radar screen and part of the year 2000 election debate. We have succeeded. In recent weeks, presidential candidates, including Vice President Gore and Senator Bradley... have spoken out. And we will take our proposal to them. But this is not an issue just for Democrats. It is a bipartisan issue and we will take our proposal to the Republican candidates... Governor Bush, Senator McCain, Elizabeth Dole, Senator Hatch... and if necessary... to Pat Buchanan... Donald Trump and Warren Beatty! We expect that each will listen - then we will listen to them... and we compare their proposals with our proposal.

And why do I expect them to listen? Because they know that we have political clout. The Wall Street Journal just two weeks ago commented that physicians could affect the races that decide who ends up controlling the House. I'm quoting from the Journal now: "The biggest influence of physicians isn't their votes, but their influence on patients and others in the community." End quote. And pediatricians have influence because we have a track record of serving children!

The candidates know we have that influence, and we must be prepared to use it. Today I am calling on all of our friends, elected officials, especially governors and congressmen, religious and business leaders, advocacy groups from the AARP to the Children's Defense Fund, to join with us in achieving health insurance for all children.

Over the past year, I have traveled a great deal as your president. And sometimes I found inspiration in unlikely places. In the baggage claim at Dulles Airport, I saw a billboard with a quote from Alexis de Tocqueville. It was 100 years ago that he said, "America is great because America is good. When American is no longer good, it will no longer be great." We should heed his words. It is time now for us to be good to children. Then our nation will ensure its greatness.

As the century is about to turn, perhaps the tide can turn in favor of children once again. 100 years ago... this nation passed landmark legislation on child labor. 100 years later as we enter a new century... it is time for us to pass landmark health legislation on behalf of children.

If we have the will, we can solve the challenge of financial barriers to health care for America's children. We have a choice. We can be remembered as the nation, the generation, the society, and yes, the profession that sat idly by while children went uninsured... when mothers tried to get their children care but were turned away by bureaucracy or lack of money. Or we can be known as the generation and profession that finally eliminated the problem of the uninsured.

Yes... we will face strong opposition and uncertainty, but we must stay the course... until we reach the goal of universal health coverage for America's children.

And so as I leave the office of Academy president, I leave you my passion... and I ask that you make it your passion. Our collective challenge is to turn words into accomplishments. We must make the previously unachievable, achievable... and children, and then ultimately all Americans, must receive quality health care as a basic human right.

Thank you very much.

(6)

as of 10/8/99
New proposal
AAP unveiling Monday.

The American Academy of Pediatrics' Proposal to Insure American's Children

The American Academy of Pediatrics reaffirms its commitment that all of America's children (through age 21) must have health insurance. The implementation of Title XXI (SCHIP) has been an important step toward reaching this goal. However, the Academy believes that now is the time to take an even bolder step forward to extend coverage to all children. The Academy recommends that while preserving the best of the private sector, we pursue a new national children's program that will replace Medicaid and SCHIP. This proposal would create a health care system with uniform eligibility, benefits and administrative procedures.

The key elements of this proposal would include:

- ◆ All children through age 21 will be automatically eligible without means testing. Family contributions would vary according to family income.
- ◆ Families may choose to enroll their children in a private insurance plan or they will be automatically enrolled in the new national children's program. Incentives will be developed in minimize further erosion of employer - based contributions.
- ◆ All programs, public and private, would meet American Academy of Pediatrics benefit standards.
- ◆ All children will have access to primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists.
- ◆ Assurances would need to be developed to ensure the quality and integrity of all programs. For example, states could be responsible for program oversight, accountability and quality monitoring.
- ◆ Every attempt would be made to capture the existing contributions to child health insurance from federal, state & private sources.

PRINCIPLES:

- ◆ Provide every child with health insurance
- ◆ Right available to ALL children and pregnant women without means testing
- ◆ Administrative simplicity
- ◆ Choice of clinician(s)
- ◆ AAP age-appropriate benefit package
- ◆ Fully portable and continuous coverage
- ◆ Access to pediatric medical subspecialists and pediatric surgical specialists
- ◆ Appropriate levels of reimbursement
- ◆ Coordinate and complement existing maternal and child health programs to help ensure maximum health benefits to families

Enactment of this proposal would increase societal spending on child health by about \$44 billion in the year 2000. The major reason for this increase in spending is the need to have all private plans meet quality standards.



STATE OF TENNESSEE

RON SUNDQUIST
GOVERNOR

THIS GIVE
COPY TO MIKE
OPK fax as FYI to
Deborah 486-5557
Jon Ryan- 410-786-8534
Cheryl Austen

September 15, 1999

Mr. Todd Bledsoe
Deputy Assistant to the President for Intergovernmental Affairs
Old Executive Office Building, Room 106
Washington, D.C. 20502

Dear Mr. Bledsoe:

Thank you for your recent assistance with Tennessee's Medicaid Children's Health Insurance Plan (MCHIP) program approval. While Fred DuVal is the person who was with the president at the National Governors' Association annual meeting when we first discussed the project, it is my understanding that you took his place in serving as a White House reference point on the project.

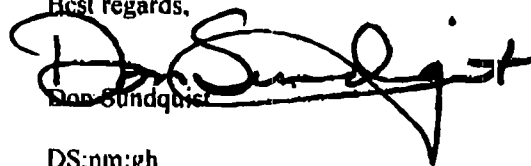
We were notified last week that our small MCHIP program has been approved. This will provide the enhanced CHIP matching rate for approximately 10,000 Tennessee teenagers. My staff has told me that Andy Hyman and Peter Harbage at HCFA have both been very helpful as well, and we are appreciative of their efforts, also.

I realize that states with 1115 Waivers for their Medicaid programs present special challenges to HCFA as they attempt to add or integrate CHIP programs. However, these states, in many cases, are those that are the most successful in serving children who would not otherwise have any insurance available.

While these Tennessee teenagers are now eligible for the enhanced match rate, we still have a proposal pending that would potentially cover approximately 50,000 additional children. We are providing coverage to these youngsters right now through our TennCare for Children program, but we believe we should be able to earn the additional FFP available through the CHIP program. Nancy Menke, on my staff, and Theresa Lindsey, with our Department of Health, will continue to work with you, Mr. Hyman, and Mr. Harbage to try to work through the remaining issues on our full MCHIP proposal that is still pending at HCFA.

I certainly appreciate President Clinton's personal interest in Tennessee's program and in the national potential for the CHIP program. Thank you again for your subsequent interest and assistance.

Best regards,


Ron Sundquist

DS:nm:gh

cc: Andy Hyman
Peter Harbage
Nancy Menke
Theresa Lindsey

State Capitol, Nashville, Tennessee 37243-0001
Telephone No. (615) 741-2001



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

September 22, 1999

Note To: Jeanne Lambrew, Domestic Policy Council
Mark Miller, OMB
John Callaghan, ASMB
Gary Claxton, ASPE
Jane Horvath, ASL

From: Rachel Block
Acting Director, CMSO
HCFA

Subject: CHIP Enrollment Data

Attached please find the CHIP quarterly aggregate enrollment summary for each State that is generated from the Statistical Information Management System (SIMS). In addition, we have included a status report of all States' CHIP and Medicaid quarterly submissions (updated weekly); and a provisional analysis of 3rd quarter FY 1999 enrollment data conducted by the Office of the Actuary.

As of September 20, 1999, of the 47 States that must report statistical data for the third quarter that ended June 30, 1999, 40 States have submitted CHIP data. Also, 32 of these States have submitted their required Medicaid data.

Of the 45 States that must report statistical data for the second quarter that ended March 31, 1999, 38 States have submitted CHIP data. Also, 28 of these States have submitted their required Medicaid data.

Because this data is incomplete, we ask that the raw data and any resulting analysis or enrollment projections not be shared publicly unless the Department and the Administration has agreed to the content and presentation of the information.

Thank you for your consideration.

GROSS COUNTS OF CHIP ENROLLMENT DATA
FROM HCFA-21E FORMS SUBMITTED TO DATE

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----- FISCAL YEAR=1998 QUARTER=1 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
MASSACHUSETTS	0	0	0	0	.	0

----- FISCAL YEAR=1998 QUARTER=2 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
MASSACHUSETTS	0	0	0	0	.	0
NEW JERSEY	6	6	0	6	1.0	0

----- FISCAL YEAR=1998 QUARTER=3 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
COLORADO	6,797	1,931	195	17,753	2.6	0
FLORIDA	11,502	11,502	42	14,563	1.3	0
MASSACHUSETTS	0	0	0	0	.	0
MICHIGAN	26	26	1	31	1.2	0
NEW JERSEY	103	95	0	179	1.7	0
NEW YORK	214,977	47,262	9,362	563,771	2.6	0

----- FISCAL YEAR=1998 QUARTER=4 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
ARIZONA	8	8	3	12	1.5	8
CALIFORNIA	15,984	15,984	29	18,018	1.1	15,989
COLORADO	10,377	2,317	720	26,870	2.6	14,847
CONNECTICUT	895	895	17	1,268	1.4	895
FLORIDA	25,446	17,160	191	60,406	2.4	0
MAINE	719	686	4	896	1.2	719
MASSACHUSETTS	8,288	8,288	173	13,349	1.6	8,288
MICHIGAN	181	156	3	276	1.5	182
NEW JERSEY	2,900	2,751	14	4,642	1.6	6,352
NEW YORK	261,766	55,863	10,167	680,854	2.6	282,741
OREGON	6,488	6,488	314	12,876	2.0	0
PENNSYLVANIA	57,481	19,055	7,215	541,356	9.4	0
UTAH	5,236	5,236	63	9,368	1.8	5,335

----- FISCAL YEAR=1999 QUARTER=1 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
ALABAMA	12,988	12,988	0	0	0.0	0
ARIZONA	1,316	1,316	48	2,113	1.6	0
CALIFORNIA	39,672	27,794	231	77,417	2.0	0

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----- FISCAL YEAR=1999 QUARTER=1 -----
(CONTINUED)

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
COLORADO	12,830	2,538	790	33,005	2.6	0
CONNECTICUT	1,889	1,011	74	4,651	2.5	0
FLORIDA	34,627	11,191	1,299	84,448	2.4	0
GEORGIA	213	213	0	340	1.6	0
ILLINOIS	125	113	1	167	1.3	0
MAINE	1,645	728	63	3,599	2.2	0
MASSACHUSETTS	12,672	4,586	1,771	31,655	2.5	0
MICHIGAN	4,656	4,478	24	11,240	2.4	0
NEVADA	2,705	2,703	0	6,848	2.5	0
NEW JERSEY	6,691	3,405	119	15,259	2.3	0
NEW YORK	304,122	65,198	14,349	779,252	2.6	0
NORTH CAROLINA	19,640	20,502	91	30,673	1.6	0
OREGON	11,930	5,755	1,624	31,422	2.6	0
PENNSYLVANIA	58,615	7,320	16,238	511,902	8.7	0
UTAH	5,078	2,495	377	12,750	2.5	0
VIRGINIA	1,148	1,148	104	1,949	1.7	0

----- FISCAL YEAR=1999 QUARTER=2 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
ALABAMA	17,532	4,544	0	0	0.0	0
ARIZONA	11,445	8,066	1,098	23,420	2.0	0
CALIFORNIA	87,587	35,733	1,189	196,364	2.2	0
COLORADO	15,135	2,744	470	40,435	2.7	0
CONNECTICUT	2,860	1,043	275	7,573	2.6	0
DELAWARE	816	816	15	924	1.1	0
FLORIDA	49,857	17,950	1,131	120,942	2.4	0
GEORGIA	8,715	8,513	7	13,430	1.5	0
ILLINOIS	2,120	1,739	19	4,577	2.2	0
IOWA	760	760	53	985	1.3	0
KANSAS	7,955	7,955	447	17,238	2.2	0
MAINE	2,294	595	397	4,936	2.2	0
MASSACHUSETTS	15,278	5,181	2,027	41,493	2.7	0
MICHIGAN	8,251	3,874	57	20,843	2.5	0
MONTANA	948	948	26	2,815	3.0	0
NEVADA	6,164	1,861	241	27,750	4.5	0
NEW HAMPSHIRE	805	805	1	1,618	2.0	0
NEW JERSEY	10,190	3,751	318	26,068	2.6	0
NEW YORK	330,741	75,022	44,514	869,202	2.6	0
NORTH CAROLINA	33,835	14,366	381	98,911	2.9	0
OREGON	15,803	5,353	4,932	36,826	2.3	0
PENNSYLVANIA	69,397	10,741	5,649	194,884	2.8	0
UTAH	7,126	3,872	863	19,007	2.7	0
VIRGINIA	8,145	5,406	283	18,515	2.3	0

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----- FISCAL YEAR=1999 QUARTER=3 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
ALABAMA	21,229	3,697	0	0	0.0	0
ARIZONA	16,068	7,516	1,474	38,501	2.4	0
CALIFORNIA	129,443	43,377	2,580	319,477	2.5	0
COLORADO	19,362	3,935	1,155	51,680	2.7	0
CONNECTICUT	3,524	944	162	9,449	2.7	0
DELAWARE	2,577	1,952	800	5,272	2.0	0
FLORIDA	75,988	30,394	2,617	190,310	2.5	0
GEORGIA	32,203	23,629	81	61,388	1.9	0
ILLINOIS	5,179	2,563	87	12,846	2.5	0
IOWA	1,821	988	102	4,468	2.5	0
KANSAS	11,910	4,579	843	30,707	2.6	0
MAINE	2,464	572	460	5,336	2.2	0
MASSACHUSETTS	17,679	3,129	3,162	44,136	2.5	0
MICHIGAN	11,958	3,831	1,244	29,936	2.5	0
MONTANA	924	37	49	2,669	2.9	0
NEVADA	6,193	1,579	266	34,041	5.5	0
NEW HAMPSHIRE	360	40	8	960	2.7	0
NEW JERSEY	14,282	4,464	262	37,462	2.6	0
NEW YORK	388,038	101,849	51,964	993,753	2.6	0
NORTH CAROLINA	46,269	12,940	736	123,486	2.7	0
OREGON	16,175	4,338	3,591	39,491	2.4	0
PENNSYLVANIA	76,272	12,344	6,490	208,909	2.7	0
UTAH	10,337	2,650	1,337	28,219	2.7	0
VIRGINIA	11,793	3,635	700	31,964	2.7	0
WEST VIRGINIA	2,204	2,204	0	4,021	1.8	0

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----- FISCAL YEAR=1998 QUARTER=1 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
IDAHO	958	958	253	1,309	1.4	0
INDIANA	13,355	4,764	1,080	34,295	2.6	0
MASSACHUSETTS	21	21	4	118	5.6	0
RHODE ISLAND	2,232	540	306	6,346	2.8	0

----- FISCAL YEAR=1998 QUARTER=2 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
IDAHO	2,351	1,646	386	4,710	2.0	0
ILLINOIS	18,193	10,444	599	51,352	2.8	0
INDIANA	14,687	3,075	2,193	38,473	2.6	0
MASSACHUSETTS	1,266	330	300	3,187	2.5	0
NEW JERSEY	5,020	4,347	12	12,482	2.5	0
OHIO	14,710	14,602	2,654	24,421	1.7	0
RHODE ISLAND	2,476	421	322	7,281	2.9	0

----- FISCAL YEAR=1998 QUARTER=3 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
CALIFORNIA	0	0	0	17,339	.	0
FLORIDA	16,405	10,561	607	34,843	2.1	0
IDAHO	1,407	685	347	2,956	2.1	0
ILLINOIS	20,558	2,316	961	57,833	2.8	0
INDIANA	15,653	2,812	2,240	41,476	2.6	0
MASSACHUSETTS	2,309	954	529	5,892	2.6	0
MICHIGAN	4,050	1,322	1,079	6,898	1.7	0
MISSISSIPPI	12,433	1,290	591	35,116	2.8	0
NEBRASKA	17	17	8	46	2.7	0
NEW HAMPSHIRE	3	0	0	0	0.0	0
NEW JERSEY	8,827	4,512	97	21,692	2.5	0
OHIO	32,527	19,787	8,578	71,367	2.2	0
RHODE ISLAND	2,775	471	358	8,157	2.9	0

----- FISCAL YEAR=1998 QUARTER=4 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
CALIFORNIA	0	0	0	25,264	.	0
FLORIDA	26,218	8,890	2,796	66,516	2.5	27,435
IDAHO	4,207	1,535	999	9,112	2.2	0
ILLINOIS	22,899	2,644	1,169	64,204	2.8	27,780
INDIANA	20,551	4,818	2,617	56,206	2.7	21,172
IOWA	4,798	2,317	368	12,390	2.6	4,798
KENTUCKY	4,507	4,507	1,168	7,210	1.6	4,507
MAINE	2,485	2,222	59	4,238	1.7	2,485
MARYLAND	6,326	2,501	37	15,007	2.4	6,326

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----- FISCAL YEAR=1998 QUARTER=4 -----
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STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
MASSACHUSETTS	9,160	8,878	136	19,981	2.2	9,242
MICHIGAN	5,043	1,461	1,236	12,701	2.5	6,044
MISSISSIPPI	5,477	742	172	10,351	1.9	5,477
MISSOURI	10,809	10,809	0	10,809	1.0	10,809
NEBRASKA	2,115	1,351	4	2,260	1.1	2,119
NEW HAMPSHIRE	71	0	0	0	0.0	0
NEW JERSEY	13,289	3,903	595	35,229	2.7	16,953
OHIO	40,778	18,104	11,580	93,039	2.3	49,565
RHODE ISLAND	2,790	360	392	8,420	3.0	4,245
SOUTH DAKOTA	376	372	36	793	2.1	376
TEXAS	25,176	23,202	370	54,403	2.2	25,176
WEST VIRGINIA	161	161	29	291	1.8	160

----- FISCAL YEAR=1999 QUARTER=1 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
CALIFORNIA	0	0	0	31,143	.	0
DISTRICT OF COLUMBIA	711	368	147	1,316	1.9	0
FLORIDA	28,674	5,826	3,410	75,920	2.6	0
IDAHO	4,639	1,431	1,548	9,038	1.9	0
ILLINOIS	24,813	2,540	1,069	70,381	2.8	0
INDIANA	24,981	4,260	2,513	69,786	2.8	0
IOWA	6,293	1,258	836	16,569	2.6	0
LOUISIANA	3,509	3,509	49	6,494	1.9	0
MAINE	4,627	1,997	393	10,020	2.2	0
MARYLAND	10,338	2,633	147	27,807	2.7	0
MASSACHUSETTS	18,241	6,214	2,120	49,086	2.7	0
MICHIGAN	5,540	1,103	914	14,828	2.7	0
MISSISSIPPI	8,077	546	109	23,010	2.8	0
MISSOURI	23,950	13,131	261	60,002	2.5	0
NEBRASKA	4,356	3,420	1,156	10,379	2.4	0
NEW HAMPSHIRE	174	0	0	0	0.0	0
NEW JERSEY	15,777	2,916	907	44,228	2.8	0
NORTH DAKOTA	87	87	16	134	1.5	0
OHIO	47,783	18,447	13,615	112,518	2.4	0
RHODE ISLAND	2,855	328	391	8,661	3.0	1,737
SOUTH DAKOTA	1,519	644	165	3,777	2.5	0
TEXAS	37,078	11,093	2,179	98,703	2.7	0
WEST VIRGINIA	321	187	71	710	2.2	0

----- FISCAL YEAR=1999 QUARTER=2 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
ALASKA	2,274	2,274	0	2,274	1.0	0
CALIFORNIA	0	0	0	36,584	.	0
DISTRICT OF COLUMBIA	1,177	431	182	2,546	2.2	0
FLORIDA	28,970	4,386	3,662	76,862	2.7	0
IDAHO	4,537	1,446	1,161	9,971	2.2	0

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----- FISCAL YEAR=1999 QUARTER=2 -----
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STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
ILLINOIS	26,630	2,101	830	76,983	2.9	0
INDIANA	27,063	3,238	2,021	76,209	2.8	0
IOWA	6,052	998	946	16,123	2.7	0
MAINE	5,953	1,747	843	13,186	2.2	0
MARYLAND	12,889	1,170	196	35,798	2.8	0
MASSACHUSETTS	142,606	13,068	2,944	68,972	0.5	0
MICHIGAN	6,233	1,253	723	16,687	2.7	0
MISSISSIPPI	9,719	511	534	28,033	2.9	0
MISSOURI	34,104	13,290	1,029	87,784	2.6	0
NEBRASKA	5,164	2,055	1,302	12,923	2.5	0
NEW HAMPSHIRE	414	397	215	906	2.2	0
NEW JERSEY	11,169	1,848	428	31,074	2.8	0
NORTH DAKOTA	135	74	44	285	2.1	0
OHIO	51,105	16,852	14,261	123,778	2.4	0
SOUTH DAKOTA	1,827	544	219	4,821	2.6	0
TEXAS	40,358	5,733	4,999	108,297	2.7	0
WEST VIRGINIA	438	177	151	989	2.3	0

----- FISCAL YEAR=1999 QUARTER=3 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
ALASKA	4,878	2,652	0	12,834	2.6	0
CALIFORNIA	0	0	0	43,491	.	0
FLORIDA	27,735	3,309	3,574	74,787	2.7	0
IDAHO	4,705	1,329	1,193	10,583	2.2	0
ILLINOIS	28,761	1,803	994	83,810	2.9	0
INDIANA	28,909	3,239	1,585	83,042	2.9	0
IOWA	6,713	876	1,137	18,051	2.7	0
LOUISIANA	17,808	4,621	547	50,988	2.9	0
MAINE	6,674	1,736	1,239	14,661	2.2	0
MARYLAND	15,359	1,273	353	43,563	2.8	0
MASSACHUSETTS	29,188	5,086	3,135	80,979	2.8	0
MICHIGAN	7,610	1,022	1,312	21,176	2.8	0
MISSISSIPPI	20,750	904	1,524	61,020	2.9	0
MISSOURI	42,817	14,572	357	114,135	2.7	0
NEBRASKA	4,717	1,276	735	38,151	8.1	0
NEW HAMPSHIRE	258	56	327	1,062	4.1	0
NEW JERSEY	1	0	0	3	3.0	0
NORTH DAKOTA	145	66	73	304	2.1	0
OHIO	53,357	16,170	14,724	130,624	2.4	0
RHODE ISLAND	4,726	706	238	13,477	2.9	0
SOUTH DAKOTA	2,180	659	306	5,603	2.6	0
TEXAS	37,918	3,942	5,490	102,593	2.7	0
WEST VIRGINIA	590	263	141	1,327	2.2	0
WISCONSIN	3,391	3,379	337	6,123	1.8	0

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----- FISCAL YEAR=1998 QUARTER=1 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
INDIANA	246,014	28,968	32,771	671,433	2.7	0
MASSACHUSETTS	7,010	6,978	287	20,711	3.0	0
MICHIGAN	633,123	86,771	86,058	1,799,830	2.8	0
PENNSYLVANIA	732,790	24,782	47,191	2,108,530	2.9	0
RHODE ISLAND	54,076	6,997	6,532	161,533	3.0	0

----- FISCAL YEAR=1998 QUARTER=2 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
CALIFORNIA	0	0	0	7,893,283	.	0
ILLINOIS	797,130	52,660	35,591	2,296,151	2.9	0
INDIANA	241,909	30,653	29,103	660,258	2.7	0
MASSACHUSETTS	367,888	25,331	7,945	1,069,887	2.9	0
MICHIGAN	632,382	85,590	80,540	1,810,556	2.9	0
NEW JERSEY	364,140	28,090	15,264	1,041,038	2.9	0
OHIO	603,850	63,469	63,620	1,688,932	2.8	0
PENNSYLVANIA	726,414	25,077	47,581	2,094,546	2.9	0
RHODE ISLAND	54,493	6,561	5,556	161,975	3.0	0

----- FISCAL YEAR=1998 QUARTER=3 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
CALIFORNIA	0	0	0	7,897,601	.	0
FLORIDA	830,674	104,328	78,730	2,266,430	2.7	0
ILLINOIS	795,220	49,261	46,145	2,280,663	2.9	0
INDIANA	242,007	29,185	30,066	660,788	2.7	0
MASSACHUSETTS	385,029	25,542	10,509	1,118,771	2.9	0
MICHIGAN	631,799	85,850	119,322	1,795,395	2.8	0
NEBRASKA	98,298	29,545	19,512	271,147	2.8	0
NEW HAMPSHIRE	3	0	0	0	0.0	0
NEW JERSEY	364,797	28,521	15,604	1,041,052	2.9	0
NEW YORK	1,358,414	88,640	104,842	3,880,047	2.9	0
OHIO	600,914	58,007	69,108	1,671,702	2.8	0
PENNSYLVANIA	719,760	24,171	48,955	2,071,609	2.9	0
RHODE ISLAND	54,181	6,545	6,210	153,355	2.8	0

----- FISCAL YEAR=1998 QUARTER=4 -----

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
CALIFORNIA	0	0	0	7,875,981	.	0
FLORIDA	835,877	118,710	72,527	2,277,570	2.7	971,000
ILLINOIS	788,069	56,011	43,753	2,232,769	2.8	1,167,843
INDIANA	249,034	39,240	27,550	669,186	2.7	203,889
IOWA	119,806	19,061	12,739	324,003	2.7	158,387
MAINE	82,454	6,498	7,076	200,510	2.4	82,464

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FISCAL YEAR=1998 QUARTER=4
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STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
MARYLAND	284,314	79,288	17,578	790,540	2.8	311,711
MASSACHUSETTS	400,173	28,860	33,856	1,130,697	2.8	417,606
MICHIGAN	637,827	93,369	128,437	1,800,678	2.8	749,131
MISSISSIPPI	236,361	17,273	17,255	686,089	2.9	236,361
MISSOURI	302,111	55,489	0	846,102	2.8	0
NEBRASKA	99,190	29,545	17,385	276,990	2.8	109,470
NEW HAMPSHIRE	71	0	0	0	0.0	0
NEW JERSEY	367,787	30,463	17,616	1,046,435	2.8	423,051
NEW YORK	1,336,764	86,779	108,490	3,809,416	2.8	1,428,183
OHIO	602,272	67,345	70,265	1,664,917	2.8	697,836
OREGON	185,820	25,360	27,828	502,568	2.7	0
PENNSYLVANIA	716,209	26,004	50,314	2,057,196	2.9	822,107
RHODE ISLAND	54,558	6,985	6,120	162,380	3.0	70,195
SOUTH DAKOTA	18,624	4,072	2,735	49,236	2.6	27,950
TEXAS	1,249,826	177,709	120,107	3,371,684	2.7	1,671,752
UTAH	95,105	15,283	14,855	252,397	2.7	0

FISCAL YEAR=1999 QUARTER=1

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
ARIZONA	285,882	34,645	27,752	786,686	2.8	0
CALIFORNIA	0	0	0	7,871,266	.	0
DISTRICT OF COLUMBIA	66,539	6,497	13,203	166,234	2.5	0
FLORIDA	842,699	111,872	70,997	2,313,034	2.7	0
ILLINOIS	775,727	45,451	44,051	2,230,629	2.9	0
INDIANA	256,780	39,260	19,482	704,774	2.7	0
IOWA	115,674	15,378	12,000	306,910	2.7	0
MAINE	80,530	5,596	5,979	199,705	2.5	0
MARYLAND	264,464	42,572	15,983	740,129	2.8	0
MASSACHUSETTS	388,498	24,691	24,311	1,100,134	2.8	0
MICHIGAN	631,083	86,870	95,476	1,797,665	2.8	0
MISSISSIPPI	234,337	13,509	16,960	670,485	2.9	0
MISSOURI	364,360	62,130	12,493	1,032,239	2.8	0
NEBRASKA	99,055	36,413	13,743	283,353	2.9	0
NEVADA	63,730	9,108	8,797	173,301	2.7	0
NEW HAMPSHIRE	174	0	0	0	0.0	0
NEW JERSEY	359,775	21,737	17,188	1,036,517	2.9	0
NEW YORK	1,265,978	49,022	116,836	3,646,170	2.9	0
NORTH DAKOTA	22,918	3,043	2,461	61,269	2.7	0
OHIO	596,366	61,762	72,199	1,654,784	2.8	0
OREGON	181,953	24,052	24,977	495,791	2.7	0
PENNSYLVANIA	708,620	24,381	44,065	2,041,029	2.9	0
RHODE ISLAND	55,041	6,802	5,713	163,492	3.0	0
SOUTH DAKOTA	19,266	3,185	2,604	52,226	2.7	0
TEXAS	1,238,636	160,497	116,735	3,372,643	2.7	0
UTAH	94,110	13,957	13,134	253,302	2.7	0
VIRGINIA	287,218	55,604	61,550	780,048	2.7	0

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STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
ARIZONA	288,139	34,063	4,414	883,497	3.1	0
CALIFORNIA	0	0	0	7,864,552	.	0
DISTRICT OF COLUMBIA	61,801	4,168	9,409	162,864	2.6	0
FLORIDA	848,794	105,174	66,730	2,337,005	2.8	0
GEORGIA	715,027	38,268	113,503	1,753,839	2.5	0
ILLINOIS	763,715	36,595	35,622	2,216,108	2.9	0
INDIANA	275,201	35,607	15,585	763,539	2.8	0
IOWA	111,007	11,929	11,492	309,066	2.8	0
KANSAS	98,411	12,112	7,281	274,376	2.8	0
MAINE	79,701	5,999	5,380	199,110	2.5	0
MARYLAND	266,851	22,260	15,380	749,828	2.8	0
MASSACHUSETTS	388,161	23,494	28,087	1,093,890	2.8	0
MICHIGAN	618,269	73,704	74,519	1,774,901	2.9	0
MISSISSIPPI	232,575	11,597	17,407	644,237	2.8	0
MISSOURI	360,739	54,515	12,061	1,032,853	2.9	0
NEBRASKA	101,641	17,485	13,316	291,922	2.9	0
NEVADA	64,507	9,464	8,963	174,699	2.7	0
NEW JERSEY	352,557	26,445	14,345	1,010,860	2.9	0
NEW YORK	1,248,990	50,022	104,241	3,609,568	2.9	0
NORTH DAKOTA	22,628	2,561	2,872	62,034	2.7	0
OHIO	589,581	61,807	65,686	1,645,034	2.8	0
OREGON	185,942	27,617	22,826	508,543	2.7	0
PENNSYLVANIA	705,925	24,409	43,319	2,034,510	2.9	0
SOUTH DAKOTA	19,688	3,228	2,616	53,338	2.7	0
TEXAS	1,223,260	140,622	128,037	3,339,842	2.7	0
UTAH	94,821	14,372	13,763	257,591	2.7	0
VIRGINIA	344,713	41,340	59,271	937,892	2.7	0

FISCAL YEAR=1999 QUARTER=3

STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
ARIZONA	291,328	37,941	4,544	885,447	3.0	0
CALIFORNIA	0	0	0	7,894,508	.	0
FLORIDA	1,688,904	185,910	121,764	4,691,700	2.8	0
GEORGIA	716,167	38,329	163,063	1,718,646	2.4	0
ILLINOIS	769,297	30,454	39,367	2,235,101	2.9	0
INDIANA	289,184	32,907	12,084	819,548	2.8	0
IOWA	111,224	10,522	12,985	308,877	2.8	0
KANSAS	110,239	10,866	7,408	312,288	2.8	0
LOUISIANA	383,415	52,301	983	1,068,700	2.8	0
MAINE	79,041	4,508	6,023	196,266	2.5	0
MARYLAND	274,855	23,388	13,028	777,629	2.8	0
MASSACHUSETTS	383,774	22,619	25,342	1,083,959	2.8	0
MICHIGAN	625,988	75,228	115,427	1,793,709	2.9	0
MISSISSIPPI	237,413	7,340	28,579	707,134	3.0	0
MISSOURI	366,157	59,359	11,549	1,042,284	2.8	0
NEBRASKA	104,760	16,828	16,169	300,138	2.9	0
NEVADA	60,410	5,578	9,829	168,340	2.8	0
NEW JERSEY	345,652	14,940	18,908	997,440	2.9	0
NEW YORK	1,267,691	67,068	97,122	3,647,202	2.9	0
NORTH CAROLINA	507,162	64,356	58,752	0	0.0	0
NORTH DAKOTA	22,236	1,846	3,102	60,474	2.7	0
OHIO	579,219	50,674	76,720	1,619,398	2.8	0

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----- FISCAL YEAR=1999 QUARTER=3 -----
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STATE	UNDUP # EVER ENROLLED	UNDUP # NEW ENROLLEES	UNDUP # DISENROLLEES	# MEMB MOS ENROLLMENT	AVG # MOS ENROLLMENT	UNDUP # EVER ENROLLED FOR YEAR
OREGON	186,902	23,123	24,560	514,166	2.8	0
PENNSYLVANIA	701,959	22,646	66,058	2,025,312	2.9	0
RHODE ISLAND	56,995	4,635	2,863	168,331	3.0	0
SOUTH DAKOTA	19,869	2,934	2,875	54,246	2.7	0
TEXAS	1,178,158	119,898	134,220	3,237,433	2.7	0
UTAH	95,208	12,517	14,764	259,455	2.7	0
VIRGINIA	302,152	39,126	25,978	845,766	2.8	0
WEST VIRGINIA	163,155	7,766	0	477,347	2.9	0
WISCONSIN	228,159	21,022	16,941	636,523	2.8	0

CHIP Quarterly Statistical Report Tracking Chart

Last updated: 9/20/99

This chart represents all CHIP and Medicaid quarterly statistical reports that have been entered into the HCFA Statistical Information Management System (SIMS) by State and Region. In cases where States fax central office hard copy statistics, we enter the data into SIMS for the States. All possible quarters of CHIP operation are listed since beginning of program. Shaded boxes indicate the program was not operational at that time so quarterly statistical reports were not required.

STATE	TYPE OF PGM	DATE IMPLEMENTED	FY 98 Q1 (Oct.-Dec.)	FY 98 Q2 (Jan.-Mar.)	FY 98 Q3 (Apr.-June)	FY 98 Q4 (July-Sep.)	FY 99 Q1 (Oct.-Dec.)	FY 99 Q2 (Jan.-Mar.)	FY 99 Q3 (Apr.-June)	FY 99 Q4 (July - Sept.)
Region I										
CT	Combo	7/1/98				✓ S-CHIP	✓ S-CHIP	✓ S-CHIP	✓ S-CHIP	
MA	Combo	10/1/97 M-CHIP 7/1/98 S-CHIP	✓ Medicaid ✓ M-CHIP	✓ Medicaid ✓ M-CHIP	✓ Medicaid ✓ M-CHIP	✓ Medicaid ✓ M-CHIP ✓ S-CHIP	✓ Medicaid ✓ M-CHIP ✓ S-CHIP	✓ Medicaid ✓ M-CHIP ✓ S-CHIP	✓ Medicaid ✓ M-CHIP ✓ S-CHIP	
ME	Combo	7/1/98 M-CHIP 8/1/98 S-CHIP				✓ Medicaid ✓ S-CHIP ✓ M-CHIP	✓ Medicaid ✓ S-CHIP ✓ M-CHIP	✓ Medicaid ✓ S-CHIP ✓ M-CHIP	✓ Medicaid ✓ S-CHIP ✓ M-CHIP	
NH	Combo	5/1/98 M-CHIP 1/1/99 S-CHIP			✓ Medicaid ✓ M-CHIP	✓ Medicaid ✓ M-CHIP	✓ Medicaid ✓ M-CHIP	✓ M-CHIP	✓ M-CHIP	
								✓ S-CHIP	✓ S-CHIP	
RI	M-CHIP	5/1/98	✓ Medicaid ✓ M-CHIP	✓ Medicaid ✓ M-CHIP	✓ Medicaid ✓ M-CHIP	✓ Medicaid ✓ M-CHIP	✓ Medicaid ✓ M-CHIP		✓ Medicaid ✓ M-CHIP	
VT *	S-CHIP	10/1/98								

Region II											
NJ	Combo	3/1/98		✓Medicaid ✓ S-CHIP ✓ M-CHIP	✓Medicaid ✓ S-CHIP ✓ M-CHIP	✓Medicaid ✓ S-CHIP ✓ M-CHIP	✓Medicaid ✓ S-CHIP ✓ M-CHIP	✓Medicaid ✓ S-CHIP ✓ M-CHIP	✓Medicaid ✓ S-CHIP ✓ M-CHIP		
NY	S-CHIP	4/15/98			✓Medicaid ✓S-CHIP	✓Medicaid ✓S-CHIP	✓Medicaid ✓S-CHIP	✓Medicaid ✓S-CHIP	✓Medicaid ✓S-CHIP		
PR	M-CHIP	1/1/98									
VI *	M-CHIP	4/1/98									
Region III											
DC	M-CHIP	10/1/98					✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP			
DE	S-CHIP	1/1/99						✓S-CHIP	✓S-CHIP		
MD	M-CHIP	7/1/98				✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP		
PA 2\	S-CHIP	5/28/98	✓Medicaid	✓Medicaid	✓S-CHIP ✓Medicaid	✓S-CHIP ✓Medicaid	✓S-CHIP ✓Medicaid	✓S-CHIP ✓Medicaid	✓S-CHIP ✓Medicaid		
VA	S-CHIP	10/22/98					✓Medicaid ✓S-CHIP	✓Medicaid ✓S-CHIP	✓Medicaid ✓S-CHIP		
V (ombo)	M-CHIP S-CHIP	7/1/98 4/1/99				✓M-CHIP	✓M-CHIP	✓M-CHIP	✓M-CHIP ✓S-CHIP		
									✓Medicaid		

Region IV										
AL	Combo	2/1/98 M-CHIP 9/1/98 S-CHIP					✓S-CHIP	✓S-CHIP	✓S-CHIP	
FL	Combo	4/1/98 Phase 1 7/1/98 Phase 2			✓Medicaid ✓S-CHIP ✓M-CHIP	✓Medicaid ✓S-CHIP ✓M-CHIP	✓Medicaid ✓S-CHIP ✓M-CHIP	✓Medicaid ✓S-CHIP ✓M-CHIP	✓Medicaid ✓S-CHIP ✓M-CHIP	
GA	S-CHIP	11/1/98					✓S-CHIP	✓S-CHIP ✓Medicaid	✓S-CHIP ✓Medicaid	
KY	Combo	7/1/98 M-CHIP 7/1/99 S-CHIP				✓M-CHIP				
MS 6\	Combo	7/1/98 M-CHIP 1/1/99 S-CHIP			✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	
NC	S-CHIP	10/1/98					✓S-CHIP	✓S-CHIP	✓S-CHIP ✓Medicaid	
TN	M-CHIP	10/1/97								
SC *	M-CHIP	8/1/98								

Region V											
IL	M-CHIP	1/5/98		✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP ✓S-CHIP	✓Medicaid ✓M-CHIP ✓S-CHIP	✓Medicaid ✓M-CHIP ✓S-CHIP		
IN	M-CHIP	10/1/97	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP		
MA	Combo	5/1/98 S-CHIP 5/1/98 M-CHIP	✓Medicaid	✓Medicaid	✓Medicaid ✓S-CHIP ✓M-CHIP	✓Medicaid ✓S-CHIP ✓M-CHIP	✓Medicaid ✓S-CHIP ✓M-CHIP	✓Medicaid ✓S-CHIP ✓M-CHIP	✓Medicaid ✓S-CHIP ✓M-CHIP		
MD	M-CHIP	10/1/98									
MI	M-CHIP	1/1/98		✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP		
VA	M-CHIP	4/1/99							✓Medicaid ✓M-CHIP		
Region VI											
AR 5\	M-CHIP	10/1/98					✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP		
LA	M-CHIP	11/1/98					✓M-CHIP		✓M-CHIP ✓Medicaid		
NM	M-CHIP	3/31/99									
OK * 1\	M-CHIP	12/1/97									
TX	M-CHIP	7/1/98				✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP		

Region VII											
IA	M-CHIP (Combo)	7/1/98				✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP ✓S-CHIP	✓Medicaid ✓M-CHIP ✓S-CHIP		
KS	S-CHIP	1/1/99						✓Medicaid ✓S-CHIP	✓Medicaid ✓S-CHIP		
MO	M-CHIP	9/1/98				✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP		
NE	M-CHIP	5/1/98			✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP		
Region VIII											
CO *	S-CHIP	4/22/98			✓S-CHIP	✓S-CHIP	✓S-CHIP	✓S-CHIP	✓S-CHIP		
MT	S-CHIP	1/1/99						✓S-CHIP	✓S-CHIP		
ND	M-CHIP	10/1/98					✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP		
SD	M-CHIP	7/1/98				✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP	✓Medicaid ✓M-CHIP		
WY	S-CHIP	12/99 implement									
UT	S-CHIP	8/3/98				✓Medicaid ✓S-CHIP	✓Medicaid ✓S-CHIP	✓Medicaid ✓S-CHIP	✓Medicaid ✓S-CHIP		
AS **	M-CHIP	4/1/99									
AZ	S-CHIP	11/1/98				✓S-CHIP	✓Medicaid ✓S-CHIP	✓Medicaid ✓S-CHIP	✓Medicaid ✓S-CHIP		

CA 7\	Combo	3/1/98 M-CHIP 7/1/98 S-CHIP		✓Medicaid	✓Medicaid ✓ M-CHIP	✓Medicaid ✓ M-CHIP ✓ S-CHIP	✓Medicaid ✓ M-CHIP ✓ S-CHIP	✓Medicaid ✓ M-CHIP ✓ S-CHIP	✓Medicaid ✓ M-CHIP ✓ S-CHIP	
GU **	M-CHIP	10/1/97								
HI	M-CHIP	1/3/00								
NV	S-CHIP	10/1/98					✓Medicaid ✓S-CHIP	✓Medicaid ✓S-CHIP	✓Medicaid ✓S-CHIP	
Region X										
AK	M-CHIP	3/1/99						✓M-CHIP	✓M-CHIP	
ID	M-CHIP	10/1/97	✓M-CHIP	✓M-CHIP	✓M-CHIP	✓M-CHIP	✓M-CHIP	✓M-CHIP	✓M-CHIP	
W'A	S-CHIP	1/1/00								
CR	S-CHIP	7/1/98				✓S-CHIP ✓Medicaid	✓S-CHIP ✓Medicaid	✓S-CHIP ✓Medicaid	✓S-CHIP ✓Medicaid	

1 Date implemented is date children began receiving services under the State's initial approved CHIP plan. Dates obtained from Division of Integrated Health Systems project officers and are more recent than State CHIP fact sheets on the web. States w/ combo programs have both implementation dates listed. Implementation dates of more minor amendments are not listed.

Notes:

- * Denotes States that have written HCFA and/or the Dept. letters expressing difficulty in meeting the reporting requirements.
- * Territories cannot access their CHIP allotments until Medicaid funding is exhausted. We will explore the feasibility of more flexible reporting requirements for Territories.
- 1\ Oklahoma currently is only capable of sending monthly aggregate statistical data. State wrote us a letter explaining same.
- 2\ Although PA had a CHIP plan implemented during the last month in quarter 3 of FFY 1998, enrollment did not begin until July 1998 (4th quarter). Therefore, CHIP enrollment for 3rd quarter FFY 1998 is zero.
- 4\ Minnesota was able to provide (the RO) monthly aggregate (unduplicated) enrollment numbers, while the State continues working to produce complete statistical reports.

- 5\ Arkansas submitted forms 64.21E and 64EC for M-CHIP and regular Medicaid, but is only able to report aggregate Aduplicated@ counts.
- 6\ Although approved, Mississippi has not yet begun to enroll children in its S-CHIP program.
- 7\ California able to report complete 21E (S-CHIP) form, but only is able to submit line item#4 - A number of member months of enrollment@ - for M-CHIP and regular Medicaid.

***CHIP Enrollment as of 3rd Quarter FY 99 (6/30/99)**

Reported Data

Data reported to HCFA by States through 8/30/99 indicate a total enrollment in CHIP (S-CHIP plus M-CHIP) as of 6/30/99 of about 1.2 million (1.35 million ever-enrolled in the third quarter of FY 1999 less 0.12 million disenrollees for the quarter.)

Limitations

It is important to note that the reported data is subject to limitations arising from

- o *Missing data.* Five states with implemented programs have not reported any data on CHIP enrollment since their programs began.
- o *Incomplete data.* Six other States have reported data in the past but are missing data for the third quarter of FY 1999.
- o *Anomalous data.* A number of additional States have reported data which results in incompatible enrollment counts over time or unreasonable average months of enrollment, turnover rates, or enrollment growth rates.

For the most part, the states exhibiting these problems are small. Nevertheless, in view of these limitations, the 1.2 million reported enrollment for 6/30/99 should be considered provisional, pending addressing these issues.

HCFA, Office of the Actuary, 9/7/99

THE PRESIDENT HAS SEEN

9-23-99

99 SEP 19 PM5:55

THE WHITE HOUSE
WASHINGTON

September 13, 1999

MEMORANDUM FOR THE PRESIDENT

FROM:

CHARLES M. BRAIN *CMB*

SUBJECT:

CONGRESSIONAL CORRESPONDENCE

Attached for your signature is a letter to Senator Edward M. Kennedy (D-MA), in response to his August 5 correspondence regarding efforts to enroll more children in the Children's Health Insurance Program (CHIP). Additionally, attached for your review is a copy of the Senator's incoming letter.

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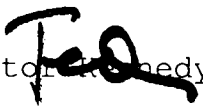
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improve - over
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we showed & can do
that will completely
achieve goal?*

Be

THE WHITE HOUSE

WASHINGTON

Dear Senator  Kennedy,

Thank you for your recent letter regarding how to enhance our current efforts on children's health insurance outreach. As always, I appreciate your steadfast leadership in ensuring that all Americans have access to adequate health care coverage.

I certainly agree with you that the back-to-school time period offers a great opportunity to launch new efforts to identify and enroll eligible children in both Medicaid and CHIP. To that end, I have planned several efforts to take advantage of this opportunity to insure children. As you know, last month at the National Governors Association's (NGA) annual conference, I announced that the Department of Education and the National Association of Elementary School Principals sent letters to nearly 16,000 school superintendents and 27,000 elementary school principals asking them to commit to conducting on-site education and enrollment of uninsured children. Additionally, beginning in late September, the Departments of Health and Human Services and Education will hold regional meetings to bring together state officials, school systems, and groups to promote local school based outreach efforts. These meetings will lay the foundation for a national conference on school-based health insurance outreach, currently scheduled for mid-November. I will ensure that your ideas get incorporated into these efforts to institutionalize enrolling children in health insurance.

Our work to insure children is not limited to schools. We are continuing our public-private "Insure Kids Now" campaign to engage a range of citizens and organizations in outreach. At the NGA conference, I encouraged states to step up their outreach efforts, and I announced that the United Way will join the Departments of Justice and Health and Human Services to conduct aggressive community-based outreach in over 20 vulnerable cities. This joint action follows similar efforts by foundations, corporations, health care providers, consumer advocates and others in the private sector that include placing the toll-free number -- 1-877-KIDS NOW (1-877-543-7669) -- on corporate products and airing public service announcements on TV and radio. Also, my Federal Interagency Task Force on Children's Health Insurance Outreach implemented over 150 new activities to educate Federal workers and families nationwide about the availability of

The Honorable Edward M. Kennedy
Page Two

Medicaid and CHIP. These activities include distributing hundreds of thousands of posters to health centers, providers, and Federal grantees nationwide; launching the new "insurekidsnow.gov" website; and providing thousands of employees with information, such as the new toll-free number, on their wage and earning statements. The second report by the Task Force is due out shortly, with a new set of actions to promote outreach.

We are also continuing to focus on outreach to legal immigrant children. Our public charge policy, which clarifies that the receipt of Medicaid or CHIP will not affect immigration status, has been well received not only by the immigrant community, but by public health experts, providers, and state and local governments. We have begun to publicize this clarification to eliminate the fear that previously deterred so many members of the immigrant community from applying for benefits for themselves and their children. To this end, INS and HHS together with members of your staff are currently designing an outreach campaign to further educate providers, immigration officials, and the immigrant community about our current policy on public charge.

Finally, I think it is essential to ensure that there are no barriers to enrollment. In the near future, my Administration will be conducting comprehensive, on-site reviews of state Medicaid enrollment and eligibility processes to assess compliance with current law and to develop recommendations for improvements. As part of these reviews, HHS officials will stress the need for accurate and timely state data submissions. We are committed to ensuring that any barriers to enrollment and access to quality care that may exist as part of the state TANF, Medicaid, and CHIP are eliminated.

Once again, thank you for taking the time to share your thoughts on this issue, which is so important to me. For your review, I am enclosing a summary of our recent activities on outreach.

Sincerely,

A handwritten signature in black ink, appearing to read "Bill", is written below the word "Sincerely,".

The Honorable Edward M. Kennedy
United States Senate
Washington, D.C. 20510

THE CLINTON ADMINISTRATION'S COMMITMENT TO PROVIDING HEALTH INSURANCE TO CHILDREN

THE IMPORTANCE OF CHILDREN'S HEALTH OUTREACH. Over 11 million children in America are uninsured. Nearly 90 percent of these children have parents who work, but do not have access to or cannot afford health insurance. Over 4 million of these uninsured children are already eligible for Medicaid. However, many families are not aware that their children are eligible for Medicaid, and others have difficulty filling out the application. Similar problems could undermine the new Children's Health Insurance Program's goal to enroll millions of uninsured children.

INTENSIVE PUBLIC-PRIVATE OUTREACH EFFORTS TO IDENTIFY AND ENROLL ELIGIBLE CHILDREN. The President, Vice President, and First Lady have unveiled several public-private initiatives to identify and enroll eligible uninsured children in either Medicaid or CHIP, including:

Launching a new nationwide "Insure Kids Now" Outreach Campaign. This campaign will engage a broad-based, bipartisan, public-private coalition to use a variety of means to educate and assist families in insuring their children. Initial activities include:

- Unveiling the "1-877-KIDS NOW" Hotline. Together with members of the National Governors Association, the President unveiled 1-877 KIDS NOW, a toll free number developed by the NGA in partnership with Bell Atlantic and the Administration, to provide state-specific information about Medicaid and CHIP to families in all 50 states. Families calling this number will receive information about eligibility criteria, benefits, and how to apply for coverage.
- Running public service announcements on national television and radio about Insure Kids Now. NBC, ABC, Univision, Turner Entertainment, the National Association of Broadcasters, and Viacom/Paramount have begun to air public service announcements providing information about the importance of health insurance and promoting the Insure Kids Now number. Radio ads on Insure Kids Now will also be aired nationwide, starting with California, Utah, Colorado, Alabama, Arkansas, Illinois, Ohio, and North Carolina.
- Printing the Insure Kids Now toll free number on commonly used products. Building on a series of commitments made in 1998, K-Mart, General Motors, the American Dental Hygienists Association, and American Medical Response have pledged to put the new toll-free number on grocery bags, toothbrushes, diaper boxes, pharmaceutical products, child safety seats, and schoolbuses.
- Reaching out to enlist every school in the country in a back-to-school children's health outreach campaign. The President announced that the Department of Education and the National Association of Elementary School Principals will send letters to all 15,725 school superintendents and 27,000 elementary school principals asking them to get involved in children's health outreach. The letters include information on how schools can target and help enroll these children and a pledge form to document their commitments.

- Collaborating with the United Way of America, DOJ, and HHS in targeting 21 key cities in conducting outreach campaigns. The President announced that in September 1999, the United Way of America, HHS, DOJ, and Education will launch intensive outreach efforts that include: providing information in orientation packets; including CHIP information with school lunch applications; and hosting outreach events at school and community events. HHS will invest \$1 million in a radio campaign to promote the Insure Kids Now toll-free number.

Releasing an Executive Memorandum ordering Federal Agencies to conduct new outreach activities. In an Executive Memorandum dated June 23, 1998, the President ordered the Departments of Health and Human Services, Treasury, Agriculture, Education, Labor, Housing and Urban Development, Interior, and the Social Security Administration to enact over 150 initiatives designed to help enroll millions of uninsured children in Medicaid or the new Children's Health Insurance Program (CHIP). The Task Force has begun new outreach efforts include launching the new "insurekidsnow.gov" website; distributing 145,000 posters to over 20,000 health centers, providers, and other grantees; and providing 92,000 USDA employees with information about outreach, including the new toll-free number, on their wage and earning statements.

New actions to assure families access to Medicaid, CHIP, and other benefits. On May 25, 1999, the Administration unveiled new regulations assuring families that enrollment in Medicaid or the new Children's Health Insurance Program (CHIP) and the receipt of other critical benefits, such as school lunch and child care services, will not affect their immigration status. The new regulation, effective immediately, clarifies a widespread misconception that has deterred eligible populations from enrolling in these programs and undermined the public health. In addition, Federal agencies will send guidance to their field offices, program grantees and to work with community organizations to educate the public about this new policy.

Reviewing Medicaid eligibility and enrollment processes in every state and promoting best practices. On August 9, 1999, the President instructed HCFA to launch comprehensive, on-site reviews of state Medicaid enrollment and eligibility processes. These reviews, conducted by HCFA regional office staff, will include interviews with state officials and case file checks to assess compliance with current law and to develop recommendations for improvements. The review teams will also highlight best practices for ensuring that eligible families get Medicaid. These efforts build on recently released guidance encouraging states to reach out to children who are no longer eligible for cash assistance but are still eligible for Medicaid or CHIP.

Investing in new children's health insurance outreach. The President has included a \$1 billion, 5-year initiative to fund outreach to enroll uninsured children in Medicaid and the new Children's Health Insurance Program (CHIP) in his FY 2000 budget. These new funds will enable States to simplify enrollment systems, launch ad campaigns, educate community volunteers, outstation eligibility workers, and conduct outreach campaigns to identify and enroll uninsured children in both Medicaid and CHIP.

EDWARD M. KENNEDY
MASSACHUSETTSTHE PRESIDENT HAS BEEN
8-10-99
United States Senate

WASHINGTON, DC 20510-2101

August 5, 1999

The Honorable William Jefferson Clinton
President of the United States
The White House
Washington, DC 20500

Dear Mr. President:

I have spoken to you several times about a cause that is close to both of our hearts—guaranteeing health insurance coverage for all children. As you know, the vast majority of uninsured children today are eligible for either Medicaid or CHIP, but too many are not participating.

A recent report by the Kaiser Family Foundation found that CHIP enrollment has increased dramatically in the last six months—to 1.3 million—but is still only a fraction of those eligible. This school year will be the first full year in which the program is fully operational in all states. The back-to-school period offers a unique opportunity for a new initiative on enrollment in both CHIP and Medicaid, and can be the launching pad for a major effort for the entire upcoming year.

Under your leadership, the Executive Departments and Agencies have made significant efforts to enroll more children, and your staff have been working effectively on this issue. Here are some suggestions for the next few months:

- Appoint a high level White House coordinator, whose responsibility is to work with the Executive Branch, the states, the Congress, and voluntary agencies and organizations to enroll children in CHIP and Medicaid and to assure that enrolled children receive needed health services. This coordinator should have the same stature as the Director of the White House Office of National AIDS policy or the Y2K coordinator.
- Use the occasion of your address to the National Governor's Association on Sunday to urge greater efforts by states to enroll uninsured children. Many states are making worthwhile efforts, but the gap between what has been done and what could be done is still too wide. The practices that would have the greatest potential impact to encourage enrollment of children include presumptive eligibility for both programs, and assigning eligibility workers to schools, health centers, churches, day care centers, pre-schools, and other organizations.
- Use a Saturday radio address to encourage parents to enroll their children in CHIP and Medicaid as they prepare to go back to school.

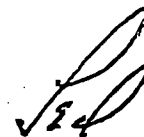
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Page 2

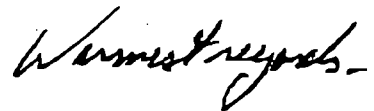
- Encourage coordination of enrollment for school lunch programs and CHIP and Medicaid. Participation in school lunch programs is high, and the eligibility largely overlaps.
- Launch a campaign, working with the INS and voluntary organizations with ties to the immigrant community, to assure immigrant populations that enrolling their children in CHIP will not affect their immigration status. The INS agrees that this is the case, but a greater effort must be made to publicize this point and reassure parents, since a substantial proportion of uninsured children come from this community.
- Direct the Departments of HHS and Education and other appropriate agencies to hold joint regional conferences around the country this month, to bring together state officials, school systems and groups, advocates and others to launch an enrollment effort tied to back to school events. Governors and other local leaders should be asked to address these conferences as a way of strengthening their commitment to this goal. For school systems, the objective should be a system in which determining children's insurance status and enrolling them if they are uninsured is as routine as verifying that they have required vaccinations.
- HHS needs to insist that states provide better and more timely data on the progress of enrollments. Only with better data will it be possible to identify the trouble spots that need special attention.

I hope these suggestions are helpful. I was delighted with the focus you put on uninsured children in your recent press conference. The coming weeks offer an unparalleled opportunity to bring the goal of universal health insurance for children closer to reality.

Respectfully,



Edward M. Kennedy



Examples of Creative and Successful School-based Outreach Strategies That Governors Could Replicate

District of Columbia: A poster/poetry contest helped to raise awareness about need for and availability of health insurance. Application boxes are provided in principals' offices, and training is provided for selected school staff. Enrollment at events such as report card parent/teacher conferences is an effective strategy -- one such event resulting in 400 approved applications.

Idaho: The Hospital Consortium of North Idaho partners with 12 school districts in five counties as part of a federally funded demonstration project. As part of the project, the shared school nurse provides information about health coverage to families, and works with local Medicaid staff to ensure that families' applications are processed appropriately.

Illinois: Chicago Public Schools identified more than 200,000 children without health insurance, of whom more than 100,000 should be eligible for KidCare. The KidCare Enrollment Campaign has evolved into an innovative and aggressive school-based outreach campaign at over 600 public schools. Enrollment for health insurance at the time of report-card pick up was the focus of the successful campaign. Chicago Public Schools' experience provides important lessons on the need for public-private partnerships, and for cooperation across state agencies.

Nevada: Experience in Nevada shows that 70% of CHIP applicants learn about the program through the school system. Coordination with school lunch programs, athletic programs and parent-teacher conferences helps to spread the word about CHIP. School principals became effective leaders to coordinate school outreach efforts.

Massachusetts: Teenagers and their families, working with Health Care for All, helped to organize the Coaches' Campaign to focus on enrolling children who want to participate in school sports. Coaches learn about opportunities for health coverage for students during Red Cross CPR training for coaches and other school athletic staff.

Minnesota: Assistance with completion of Medicaid applications is available to families of new students at the Welcome Center operated by the Minneapolis Public Schools. During peak registration months of August and September, a Medicaid eligibility worker is outstationed at the Welcome Center.

Nebraska: In Nebraska, community health centers are permitted to enroll children who are presumed to be Medicaid eligible. Staff of Panhandle Community Services health center attended a parent information night at a Scotts Bluff elementary school and was able to directly enroll children by assisting parents to fill out Medicaid applications on site.

South Carolina: About two thirds of all CHIP applications originate in schools. School employees involved in the outreach effort included school nurses, athletic directors and guidance counselors. An incentive program encouraged applications with five dollars paid to each child with a completed application, and pizza parties for the schools with the most applications.

Utah: Families can apply for Medicaid at Edison Elementary School in Salt Lake City. After the Utah Department of Health discovered at an Edison school health fair that many students were suffering from untreated health conditions, a Medicaid eligibility worker was outstationed at the school five days a week. The worker also provides information in six other schools on parent teacher nights and to school counselors.

X Washington: Seattle schools are organizing multiple approaches to increase enrollment of eligible children in Medicaid. School nurses and family support workers trained by the Washington Health Foundations's Child Health Access Program assist families with Medicaid applications. Families learn about the program from school-based promotional materials including letters, posters and activity at school events. Linkage with school-lunch program and other strategies for making insurance application a part of school routine are being explored.

West Virginia: Teaming up with community health centers provides additional resources for enrollment. New River Health Association operates four school-based health clinics and provides assistance to other school-based clinics in West Virginia. Health center staff provides families with application forms and offers assistance with the application process.

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United States Senate

WASHINGTON, DC 20510-2101

August 5, 1999

cc: Stein
Jennings

The Honorable William Jefferson Clinton
President of the United States
The White House
Washington, DC 20500

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advocates have privacy concerns

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Respectfully,



Warmest regards

Edward M. Kennedy

HHS told him we'd do as part of POTUS event in fall.

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District of Columbia: A poster/poetry contest helped to raise awareness about need for and availability of health insurance. Application boxes are provided in principals' offices, and training is provided for selected school staff. Enrollment at events such as report card parent/teacher conferences is an effective strategy -- one such event resulting in 400 approved applications.

Idaho: The Hospital Consortium of North Idaho partners with 12 school districts in five counties as part of a federally funded demonstration project. As part of the project, the shared school nurse provides information about health coverage to families, and works with local Medicaid staff to ensure that families' applications are processed appropriately.

Illinois: Chicago Public Schools identified more than 200,000 children without health insurance, of whom more than 100,000 should be eligible for KidCare. The KidCare Enrollment Campaign has evolved into an innovative and aggressive school-based outreach campaign at over 600 public schools. Enrollment for health insurance at the time of report-card pick up was the focus of the successful campaign. Chicago Public Schools' experience provides important lessons on the need for public-private partnerships, and for cooperation across state agencies.

Nevada: Experience in Nevada shows that 70% of CHIP applicants learn about the program through the school system. Coordination with school lunch programs, athletic programs and parent-teacher conferences helps to spread the word about CHIP. School principals became effective leaders to coordinate school outreach efforts.

Massachusetts: Teenagers and their families, working with Health Care for All, helped to organize the Coaches' Campaign to focus on enrolling children who want to participate in school sports. Coaches learn about opportunities for health coverage for students during Red Cross CPR training for coaches and other school athletic staff.

Minnesota: Assistance with completion of Medicaid applications is available to families of new students at the Welcome Center operated by the Minneapolis Public Schools. During peak registration months of August and September, a Medicaid eligibility worker is outstationed at the Welcome Center.

Nebraska: In Nebraska, community health centers are permitted to enroll children who are presumed to be Medicaid eligible. Staff of Panhandle Community Services health center attended a parent information night at a Scotts Bluff elementary school and was able to directly enroll children by assisting parents to fill out Medicaid applications on site.

South Carolina: About two thirds of all CHIP applications originate in schools. School employees involved in the outreach effort included school nurses, athletic directors and guidance counselors. An incentive program encouraged applications with five dollars paid to each child with a completed application, and pizza parties for the schools with the most applications.

Utah: Families can apply for Medicaid at Edison Elementary School in Salt Lake City. After the Utah Department of Health discovered at an Edison school health fair that many students were suffering from untreated health conditions, a Medicaid eligibility worker was outstationed at the school five days a week. The worker also provides information in six other schools on parent teacher nights and to school counselors.

X Washington: Seattle schools are organizing multiple approaches to increase enrollment of eligible children in Medicaid. School nurses and family support workers trained by the Washington Health Foundations's Child Health Access Program assist families with Medicaid applications. Families learn about the program from school-based promotional materials including letters, posters and activity at school events. Linkage with school-lunch program and other strategies for making insurance application a part of school routine are being explored.

West Virginia: Teaming up with community health centers provides additional resources for enrollment. New River Health Association operates four school-based health clinics and provides assistance to other school-based clinics in West Virginia. Health center staff provides families with application forms and offers assistance with the application process.

• 100% states don't comply
w/ SSN # requirements.

Proposals for Joint USDA/HHS Efforts to Promote Working Families Participation in Food Stamps and Medicaid

Making it Easier for Families to Access Assistance

Issue joint HHS/USDA guidance on the opportunities for coordinating Medicaid and Food Stamp application and enrollment simplification activities. Both USDA and HCFA should adopt a single common message about Medicaid/CHIP, Food Stamps and child care being important work support programs. The agencies, for example, could encourage states to take a joint Medicaid/Food Stamp application from a family before interviewing or discussing the TANF program with a family as an effort to ensure that families' application for these programs does not get delayed due to TANF pre-application requirements. Any such guidance needs to have specific examples of what kinds of activities are useful and examples of states that are conducting them. Many of the items to follow could be included in such a guidance.

Design and promote a short model joint Medicaid-Food Stamp application. Shorter applications make it easier for families to apply from outside the welfare office and for community groups to help families apply. Unfortunately, many states have joint food stamp/Medicaid applications that are 15 -25 pages long. By contrast 46 states have shortened their health program-only applications to improve access to the program. USDA and HCFA could disprove those who claim a short process is impossible by developing an optional model short/simplified application. In addition, the agencies could offer to assist states looking to simplify their applications and procedures but that are unclear about how best to do so. The agencies could promote existing state applications that defy the norm with respect to simplicity and access. In addition, food stamp and Medicaid rules differ in some areas with respect to the protections and rights they offer applicants and recipients. By developing a model joint application, USDA and HHS could capitalize on each of the program's strengths.

Encourage and promote state activities to take Medicaid/food stamp applications outside of the welfare office (with simplified applications) Allowing working families to apply for health care outside of the welfare office has been considered essential to expanding enrollment in health care. Working families will often find it easier and preferable to access alternative sites such as health clinics, Head Start programs, child care sites, schools, and Medicaid/CHIP outreach sites. States should be encouraged to expand Medicaid/CHIP outstationing efforts to include Food Stamps. Medicaid outstationed workers could be trained to take both food stamp and Medicaid applications. In addition to this effort, states should be encouraged strongly to expand welfare office hours.

Issue joint HHS/USDA guidance on Access Issues Affecting Immigrants and Non-English Speakers

SSN Requirements. HCFA has issued guidance explaining that Medicaid law prohibits states from asking, let alone requiring SSN's from a non-applicant parent. This effort has been useful in the effort in encouraging states to remove

inappropriate SSN questions from Medicaid and CHIP-only applications. Joint applications for Medicaid/Food stamp/cash assistance continue to be problematic because states believe that they must ask for SSN's as a part of the food stamp application. Food Stamps law gives families the option not to provide an SSN if they do not have one. FNS should issue guidance to states clarifying this policy. State demands for a parent's SSN (due to QC concerns), although unnecessary, has a significant chilling effect on immigrants participation in both programs due to concerns around public charge and confidentiality. Also, to the extent that families apply for Medicaid in the welfare office via a common application, unless the SSN "requirement" is fixed for Food Stamps it will adversely affect Medicaid enrollment.

Foreign Language Requirements. Community groups continue to raise concerns about problem non-English speakers encounter when attempting to apply for Medicaid and Food Stamps. HCFA/ACF/FNS could issue joint guidance regarding the rules on access to the assistance programs for non-English speakers. While these rules have been on the books for years, it would be useful to remind states and the communities of the rights non-English speakers have when attempting to apply for assistance. Food stamp rules are particularly strong in this area.

Retaining Eligible Families on the Programs

Issue joint HHS/USDA guidance clarifying the rules on certification periods. Some states may be under the false impression that they must align Medicaid and food stamp certification periods. Since states have been setting short certification periods for working families, this has a negative impact on the Medicaid retention. Working families fail to show up for recertification interviews and lose not just Food Stamps but Medicaid as well. At a minimum, HCFA and FNS should clarify that this practice is unnecessary and highly detrimental to Medicaid enrollment and retention. USDA could go to remind states that they now have many options to lengthen certification periods and to ease the burdens of the certification process in the Food Stamp program. In addition, the guidance could discuss the problems with using a Medicaid application filed outside the welfare system as an excuse to shorten a family's certification food stamp period for quality control purposes.

Develop USDA "Enough is Enough" policy with respect to Verification and Promote in Coordination with HCFA's Flexible Policy on Verification. Medicaid does not require states to verify a family's income. Food Stamps, however, encourages detailed verification of all information in order to assure payment accuracy. In order to bring the program's closer together, USDA should establish an "enough is enough" policy on verification. This would declare states will not be held liable for QC errors for information that was verified in certain specific (highly reliable) ways even if it later proves to be wrong. This would be analogous to procedures that already exist for SAVE and for expedited issuance and has not led to any noted abuse. This would be limited to extremely reliable pieces of verification (e.g. computerized wage stubs covering an entire month or relatively recent state wage information. In this case it would avoid the state having to call the employer to verify

wages.) HCFA and USDA could jointly promote state flexibility on verification as an important method of simplifying and streamlining the program.

Joint HHS and USDA State Reviews. HHS and USDA are both undertaking special efforts to review state agencies and state welfare offices with respect to client access issues. Many of these concerns are exactly the same for each program (are applications available, are applications processed regardless of TANF pre-application requirements, are state computer systems programmed appropriately to deal with on-going food stamp and medicaid eligibility when a family leaves the TANF program, are notices understandable and accurate.) It would be useful for the regional offices to coordinate state reviews and to share findings with each other.

HHS and USDA could jointly promote positive state policies and practice that seek to proactively education low-income families about their eligibility for Medicaid and food stamps once they leave TANF. This includes good simple notices to families, including Medicaid and Food stamp eligibility rules as a part of TANF orientation programs and sending education materials to families on TANF once they get a job.

Agenda

928,000

240,000 CHIP

1.1 million for MC

2nd quarter
new enrollees

A. DATA

quarterly
4 elements

1. unduplicated # kids ^{ever} enrolled
2. unduplicated # kids new enrolled
3. disenrolled
4. total # months of enrollment
- 5.
6. ever enrolled for entire

HCFA

1. # enrolled ever
2. # MC spillover
3. quarterly enrollment

allotment
draw down #?

JML says no phone calls
JML says letter?

B. \$500M find

HCFA -
no state by state?

Smarteam

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Estimate

Marcia Brand
 HCFA
 5600 Fishers Lane
 Parklawn Building, Room 115
 Rockville, MD 20857

Date
 Number
 Revision
 AE/Team
 Client PO
 Due Date:

08/11/99
 HQF09182
 Original
 DC

Name/Title: Insure Kids Now Buscards
Desc/Specs: Production and printing fees for 3,980 "Insure Kids Now" Buscards.

Description	Estimate:
Account Management	\$ 250.00 *
Production	\$ 25.00 *
Creative Services Subtotal:	\$ 775.00
Digital Color Prints	\$50.00 *
Messenger Service	\$50.00 *
Direct Costs Subtotal:	\$ 100.00
Buscard Printing - 1,320 each of 3 sizes <i>Printing full-color posters at 28" x 11", 42" x 11" and 56" x 11" on 16pt stock with overall varnish. Delivery in 12-16 working days.</i>	\$ 14,350.00 *
Printing Services Subtotal:	\$ 14,350.00
TOTAL	\$ 15,225.00

Upon acceptance of job description and estimate, please sign below and fax estimate to (202) 518-7046.
 A 1/3 deposit of total job estimate is required for all new accounts or assignments which exceed \$5000.
 Client signature below confirms receipt of, and agreement to, Smarteam's "Standard Terms and Conditions."
 For convenient payment, we now accept VISA, Mastercard, American Express, and Discover cards.

Approvals:

Client: _____ Date: _____

Date: _____

FAX**Health Division**

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

To: Deborah Adler
Fax: 6 5557

From: Lillian

Number of Pages (excluding cover):

Subject: - It may vary from state to state what triggers a bundled rate payment. In NY + NJ, at least, ~~per~~ it depends on whether a child accessed a service that is part of the bundled rate. (see attached)

Voice Numbers:

Health Division (Front Office)	202/395-4922
Health & Human Services Branch	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

DRAFT

NEW YORK'S FEE FOR SERVICE METHODOLOGY

New York has an approved state plan amendments authorizing Medicaid services to be provided by school districts to Medicaid-enrolled special education children who are receiving medical care and treatment as "related services" on a child's Individualized Education Program (IEP).

I. School districts are paid a monthly fee for five Medicaid services listed in the state. Reimbursement is provided for physical therapy, speech pathology, occupational therapy, nursing, and psychological counseling. Every encounter with a child must be documented by the school district. The district is entitled to receive the monthly fee for a particular child once that child has received two services in a month.

OF
SERVICE
TRIGGERS
PAYMENT

The methodology for establishing the monthly fees for physical therapy, occupational therapy and speech pathology services is described in the state plan as follows, and includes the cost of an annual evaluation:

The monthly fee is made up of 1) direct costs, personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting the evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.¹ (Attachment 4.19-B)

The methodology for establishing the monthly fees nursing and psychological counseling services does not include the evaluation as a component and is described in the state plan as follows:

The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components was multiplied by the average monthly frequency to obtain the monthly fee.¹

School district personnel are expected to document medical services for all special education children, but are only reimbursed for the services provided to Medicaid recipients. By agreement with the State Department of Education (SED) and New York City, the Department provides monthly lists of Medicaid enrolled children which are cross checked against special education students prior to a school district submitting a claim to the Department.² In addition, the districts report periodically to the department the actual number of services provided of each discipline to each child for which reimbursement is claimed.

II. School districts are entitled to claim reimbursement for various types of evaluations related the related services included on a special education child's IEP so long as the child is enrolled in Medicaid.

The methodology for establishing the fees for psychological, audiological³, medical and special medical evaluations is described in the state plan as follows, and fees have been developed by the Department for New York City and "rest of state" school districts:

¹ The direct and indirect costs were obtained from survey information from the school districts. Average monthly frequency is obtained from an analysis of related services included in a sample of IEPs.

² Outside of New York City the SED provides school districts with the names of those special education children who are enrolled in Medicaid.

³ Although this service is authorized by the state plan, the Department has not yet developed a fee for this service, and is not presently reimbursing school districts for this cost.

The fee is fee-for-services and is made up of 1) direct costs, personal service costs and other than personal services costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee.

The specialized medical evaluation fee is reimbursable only when the service is provided by a physician specialist subsequent to and upon the written recommendation of the provider of a medical evaluation.

III. School districts are also reimbursed for service coordination and case management for a target group under Social Security Act 1915(g). Five categories of service coordination have been approved by HCFA in the state plan. The Department has developed fee-for-services fees for four of the categories for New York City and "rest of state." A monthly fee for ongoing service coordination has been developed for the "rest of state" category.

100 11 99 12.02 NU.002 P.04

SCHOOL BASED MEDICAL SERVICES OVERVIEW OF NEW JERSEY PRACTICES

Special Education School Districts:

Reimbursement for school based rehabilitative services is on a fee-for-service basis. The fee-for-service is a cost based, bundled rate. The fee reimburses the provision of covered components of rehabilitative services included in the Individual Education Plan (IEP). The fees each reimburse a single day of service regardless of the extent of services provided during that day. Assessment and evaluation services are reimbursed through a separate, single fee.

The fees for school based rehabilitative services vary according to the location where the service is provided. These various locations include in-district, out-of-district, non-public schools, and state operated facilities. Additionally, two separate fees cover transportation services. These fees are for in-district medical transportation and specialized medical transportation.

Early Intervention:

Reimbursement for early intervention multi-disciplinary rehabilitative services is on a fee-for-service basis. The fee-for-service is a cost based, bundled rate. The fee reimburses the provision of covered components of rehabilitative services included in the Individualized Family Service Plan (IFSP). The fees each reimburse a single day. Evaluation services are reimbursed through a separate, single fee.

Procedures:

New Jersey uses a contractor for the preparation and submission of claims for school based services. These claims are processed through the State's Medicaid Management Information System (MMIS). The State's contractor coordinates the collection of eligibility and service delivery data with the local education agencies. The contractor maintains a registry of Medicaid eligible students as provided by the local education agencies. Each month the contractor provides a turn-around document that the local education agencies use to record the delivery of services to Medicaid eligible students. The completed turn-around documents, properly certified, are used by the contractor to prepare and submit Medicaid claims for MMIS processing.

Eligibility:

All claims for school based medical services must reflect the delivery of service to a Medicaid eligible beneficiary. Medicaid eligibility for these students is determined through county welfare agencies or other established eligibility

processed such as SSI. These eligibility determinations are independent of the local education agencies and the State's contractor. When the contractor submits claims they are checked on the State's eligibility system to ensure that the client was Medicaid eligible at the time of service.

Services:

The rates for school based services include speech-language therapy, occupational therapy, physical therapy, audiology services, psychological counseling, psychotherapy and nursing services, excluding private duty nursing. The rates, except assessment and evaluations, reflect a day that any of these services were provided regardless of the number or extent of services provided.

Documentation:

In addition to the Medicaid student registrations and the turn-around documents, the local education agencies are required to maintain each student's IEP and documentation of the delivery of services by an appropriate practitioner. The State's contractor has supplied tracking logs and assistance to the local education agencies for this purpose.

Methodology:

The States bundled rates are based on actual, total costs incurred by the local education agencies for a base year and are adjusted annually for inflation. The total costs of the local education agencies, including direct service delivery costs and allocated overhead and indirect costs, were divided by total, unduplicated days of service for Medicaid eligible and other students. This results in the calculation of an average cost per school day of special education services to one child. This average cost (or bundled rate) is then multiplied by the number of days in which special education services were provided to a Medicaid eligible child during the month.

Payment is
based on
HOF days
in a month
a child
received
a service X

per client bundled
rate

HUG 11 99 12:04 NO.002 P.06

Massachusetts - School-Based Medicaid Services

Introduction

The State of Massachusetts has used a bundled rate methodology for billing Medicaid school based services since the program was implemented in the fall of 1993. This bundled per diem rate methodology is based upon a statistically valid sample of school district service utilization data extracted from selected special education student's individual educational plans (IEP). The methodology calculates five bundled per diem rates based upon special education student prototypes using the average number of hours of units of Medicaid covered services included in the IEP multiplied by the existing fee for service rate in a non-institutional free standing setting.

Claiming for Medicaid eligibles only

All school districts that participate in the Massachusetts Medicaid School-Based program must prepare and submit claims like any other Medicaid provider. This means following all the rules and regulations contained in Medicaid billing and provider manuals. All claims for Medicaid recipients must be submitted individually for each recipient through the automated Massachusetts Medicaid Information System (MMIS). The MMIS claim edits and eligibility data files used for all other Medicaid provider types to ensure that claims are processed only for Medicaid recipients who are eligible for these services are used for school-based claiming.

Claiming for Medicaid covered services only

The development of the Massachusetts school-based bundled rate methodology incorporated the following Medicaid covered services in the bundled rate: Physical Therapy, Occupational Therapy, Speech Therapy and Mental Health Counseling. These services were included in the bundled rate because all of these services are defined as Medicaid Covered Services in the pertinent sections of the Code of Federal Regulations (CFR) and the All Provider Medicaid Manual. A review of these services in the school setting was conducted to ensure that they were provided in accordance with the Medicaid Provider Manual requirements.

Documentation of services rendered

The Massachusetts Medicaid School-Based program relies upon the existing documentation requirements as established through the Massachusetts Department of Education regulations. These include for each individual special education student: the IEP document which includes both the frequency and the type of Medicaid service that is required to be provided, quarterly progress reports for each student describing progress towards the goals stated in the IEP, annual team meeting and evaluation documentation and individual health provider documentation and scheduling including appointment logs or calendar. Also, Massachusetts State law requires all services included in students IEP must be provided. As part of the rate methodology development, a study was conducted

of a statistically valid sample of IEP's to ensure that services listed in the IEP were actually provided. The results of this study indicated that services required to be provided in the IEP were in fact actually provided.

Methodology

The bundled rate methodology for school based services was developed using actual units of service utilization data from a statistically valid sample of school district IEP's and fee for service rates used by free standing \ non institutional providers. The bundled rates were calculated using 1992 level fee for service rates and have never been updated. As a result, these rates are significantly below what rates would be if current school based costs were used in the rate calculation.

6-557

**Kansas Department of Social and Rehabilitation Services
Division of Adult and Medical Services
Local Education Agency Reimbursement
September 1, 1998**

History <i>A consultant was contracted to determine methods for increasing the Medicaid support of the school districts for health related services included in students' individual education programs (IEP). After analysis of services delivered by the schools, "bundled rates", similar to the diagnosis related groups (DRG) used to pay hospitals, were developed as a reimbursement mechanism for schools. In addition, a data matching process was developed to assist schools in identifying Medicaid eligible students. As a result, reimbursement to all school districts in the state for the 15 month study period increased \$23.6 million over the \$1.5 million already paid. The Governor has included these new revenues in his budget.</i> <i>This is not a new program, but a modification to how reimbursement for medical services is paid.</i>	Outcomes/Expectations/Philosophy - The school district will assure continuation of maintenance of effort requirements and prohibition on supplanting. Medicaid revenues will be used to strengthen special education services. - The school district will bill Medicaid for every Medicaid eligible student who has an IEP and receives any bundled rate service from the school. - The school district will deposit Medicaid payments in the special education account to be used for services identified in the Medicaid bundled rate and included in the IEPs of eligible students. - The school district will maintain a quality assurance process to demonstrate SRS is purchasing quality services based on the needs of the student. Further measures will be developed in collaboration with KSDE's I.D.E.A. reauthorization performance measures. - The school district agrees that assistive technology purchased for a Medicaid eligible student is owned by that student. - The school district will document that bundled rate services are included in the IEP and were provided to Medicaid eligible students consistent with the IEP. - The school district will assure that parents are notified of the bundled rate services being billed to Medicaid.	Disabilities Covered - Behavioral disorder - Deaf - Blind - Hearing impaired - Mental retardation - Severe Multiple impairment - Physical impairment - Other health impairment - Specific learning disability - Speech/Language - Visual impairment - Autism - Traumatic Brain Injury - Special Education - Early childhood - Developmentally Delayed
Quality Assurance - Surveillance and Utilization Review Subsystem (SURS) - Annual external audits of schools - Complaints and grievances: Billing and coverage concerns to: Consumer Assistance Unit at 1-800-766-9012 SRS Ombudsman at (785) 296-4687 IEP related concerns: Call the school district. Kansas Department of Education Student Support Services Team at 1-800-283-9462 Families Together at 1-800-264-6341 Kansas Advocacy and Protection Services at 1-800-432-8276	Services - All medically necessary medical services included on an individual student's IEP are included in the bundled rate, including health screening, vision services, speech/language services, physical therapy, occupational therapy, school nursing services, behavioral rehabilitation services, rehabilitative assistance, and medical transportation. Assistive technology needs of students are included in the bundled rate. All services delivered must be documented. - Claims are filed electronically with the amount of reimbursement based on the student's identified disability. - KAN Be Healthy screening and Skilled Nursing Attendant Care are the only services which will be paid in addition to bundled rate reimbursement.	Eligibility Student - Any Medicaid eligible student with an IEP. - KAN Be Healthy screening is not required. School District - Recipient of tax funds to use for state certified match. - Enrolled as a Medicaid provider with SRS' fiscal agent. - Must obtain parental permission to share the educational record with SRS.



KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

315 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

July 13, 1999

Payment for services covered under the Special Education Funding Partnership Program are made on a monthly blended rate basis. This methodology uses a single monthly payment rate to reimburse districts and cooperatives for the full range of medically necessary medical services authorized as part of an Individualized Education Program (IEP). The blended rates were developed for children with disabilities identified by their primary area of exceptionality established in the IEP process. The primary area of exceptionality was used to reflect the similarities in services provided and costs for children with the same type of exceptionality.

The blended rate methodology is similar to the payment practices used in hospital Diagnosis Related Grouping (DRG) payment systems. This methodology uses actual cost and historical utilization factors to develop a global fee to reimburse providers for the medically necessary services used to treat the child with the diagnosed disability. The blended rate methodology establishes a fixed individual monthly fee based on each diagnosed child's primary area of exceptionality. In other words, the same monthly payment will be made for each similarly identified child based on historical costs and units of service consumed. Appropriate rate setting practices and statistical probability will ensure that, over time, appropriate financial reimbursement will be made.

1. Identified Medicaid reimbursable services delivered by schools
2. Quantify services documented in school records
 - a. By child's primary area of exceptionality
 - b. Medically necessary medical services such as:
 - i. Health screening
 - ii. Vision services
 - iii. Speech/language services
 - iv. Physical therapy
 - v. Occupational therapy
 - vi. School nursing services
 - vii. Behavioral rehabilitation services
 - viii. Rehabilitative assistance
 - ix. Medical transportation
 - x. Assistive technology
 - c. Using random sampling
 - i. Urban/rural split between schools
 - ii. Sponsoring district/interlocal cooperative split
 - iii. Stratified by child's primary area of exceptionality
3. Set blended rate
 - a. Determine average monthly cost of providing each service
 - b. Determine each disability group's service utilization rate (units of service)
 - c. Determine each group member's service cost allocation (service costs for the group)
 - d. Aggregate service costs to blended rate
4. Reimburse schools for services delivered
 - a. Enroll schools as providers
 - b. Schools bill electronically using modified turnaround-document software
 - c. Quality Assurance
 - i. Provider outcomes and expectations
 - ii. Surveillance & Utilization Review Subsystem review
 - iii. Annual independent audit of delivery of services on the IEP
 - iv. Complaints and grievances

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EXECUTIVE ORDER

(Executive Order Number)

WHITE HOUSE COMMISSION ON COMPLEMENTARY AND ALTERNATIVE MEDICINE POLICY

By the authority vested in me as President by the Constitution and the laws of the United States of America, and in order to establish, in accordance with the provisions of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), the White House Commission on Complementary and Alternative Medicine Policy, it is hereby ordered as follows:

Section 1. Establishment. There is established the White House Commission on Complementary and Alternative Medicine Policy ("Commission"). The Commission shall consist of not more than 12 members, including the chair, appointed by the President from knowledgeable representatives in health care practice, and complementary and alternative medicine.

Section 2. Function. The Commission shall report to the President and the Congress regarding legislative and administrative recommendations to assure that public policy maximizes the benefits to Americans of appropriate use of complementary and alternative medicine (CAM). The recommendations shall address the education and training of health care practitioners; coordinated research to increase knowledge about complementary and alternative medicine practices and products; reliable and useful information for health professionals that can be made readily accessible and understandable to the general public; and guidance for appropriate access and delivery of complementary and alternative medicine.

Section 3. Administration. The Department of Health and Human Services shall provide the Commission with administrative services, facilities, staff, and other support services necessary for the performance of its functions. Funds for the operation of the Commission shall

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be provided by the Department of Health and Human Services.

(a) The heads of executive agencies shall, to the extent permitted by law, provide the Commission such information and assistance as it may require for the purpose of carrying out its functions.

(b) Each member of the Commission shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for Level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day during which the member is engaged in the performance of the duties of the Commission. Members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees under subchapter I of Chapter 57 of Title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

© Notwithstanding any other Executive Order, the functions of the President under the Federal Advisory Committee Act, as amended, which are applicable to the Commission, except that of reporting to the Congress, shall be performed by the Secretary of Health and Human Services in accordance with guidelines issued by the Administrator of General Services.

(d) The Commission shall terminate 2 years from the date of this order unless extended by the President prior to such date. OR

The Commission shall terminate 30 days after submitting its report.

WILLIAM J. CLINTON

THE WHITE HOUSE,

(Date)

HCFA'S NEW ISSUES LIST CHIP REGULATION

1.	Amendments	457.60
2.	Patients Bill of Rights	457.110
3.	Budget Submission	457.140
4.	Ninety Day Clock	457.160
5.	Covering Children of State Employees	457.310
6.	Screen and Enroll	457.350
7.	Level of Benefits	457.410
8.	Abortions	457.475
9.	Cost Sharing for Native Americans	457.535
10.	Five Percent Cap	457.555
11.	Due Process before Disenrollment	457.570
12.	Evaluation and Monitoring	457.700
13.	Strategic Objectives	457.710
14.	Baseline	457.750
15.	Crowd-out	457.805
16.	Fraud and Abuse	457.900
17.	Privacy Protections	457.995
18.	Family Coverage	457.1010
19.	Enhanced FMAP for Children	433.11

foundations:
RWJ funds
being used
for match
Jim F.
comm based
only →
look at
revenue
stream

in acid exp

→ State

① check w/ VP on TN

② data mty 720.

③ Jeanne → Parkland

④ immigrant NPRM
Cynthia no self declare
exception in reg for regulation

⑤ PBOF

⑥ list of controversial
issues

⑦ no foundation

**Children's Health Insurance Program (CHIP) Regulation
And Related Revisions to the Medicaid Regulation Parts 431, 433, &
435 Implementing the Balanced Budget Act of 1997
May 7, 1999**

The CHIP regulation is based on policies that have been discussed by the Steering Committee, cleared by the Department, White House and OMB, and with the exception of some of the issues described in this document identified as "New Issues", have been released publicly. These policies were released in the form of a State plan application template, five sets of 108 questions and answers, and 20 "Dear State Health Official" letters. On the whole, States, the Hill, and the advocate community are well aware of our policies. The regulation text consists almost entirely of previously released public documents. However, this document identifies and describes those issues that are new, as well as those key issues that may be considered controversial.

Subpart A - Introduction; Definitions and Terms, State Plans for Child Health Insurance Programs and Outreach

Section 457.1 - Program Description

- * This provision gives a general description of the Children's Health Insurance Program.

Section 457.2 - Basis and Scope of Subchapter D

- * This provision describes the authority provided for in Title XXI to set forth State plan requirements, standards, procedures and conditions for obtaining FFP for providing coverage to targeted low-income children.

Section 457.10 - Definitions and Use of Terms

- * This subsection provides the general definitions and terms used throughout this regulation.

Section 457.30 - Basis, Scope and Applicability of Subpart A

- * This provision gives the basis for the provisions governing the administration of a State child health program, the general requirements for a State child health plan, and a description of the process for review of a State child health plan or plan amendment.

Section 457.40 - State Program Administration

- * This provision requires States to implement their program in accordance with the approved plan, approved plan amendments, and statutory and regulatory requirements. This provision specifies that the State plan or plan amendment must be signed by the Governor or designee and must identify the State officials who are responsible for program administration and financial oversight.

Section 457.50 - State Plan

- * This provision describes the State plan, which contains all of the information necessary for HCFA to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

Section 457.60 - Amendments

- * This provision describes the circumstances under which a State must submit a State plan amendment, including budget amendments.

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A. New Issue: We are proposing to require States to submit a plan amendment if the funding source of the State share changes, prior to such change taking effect. This is intended to ensure compliance with our requirement that States only use permissible sources of funding for the State share. This policy has not previously been made public.

B. New Issue: We are proposing that an amended 3 year budget must be submitted, with a plan amendment request, if the plan amendment would make any modifications to the approved budget. States may see this as burdensome since they report expenditures quarterly and we are proposing to request budget information with the annual report. This policy has not previously been made public.

Section 457.65 - Duration of State Plans and Plan Amendments.

- * This provision specifies that the State plan or plan amendment takes effect on the day specified in the plan. It describes the length of time that an amendment may remain in effect prior to being submitted to HCFA. It

specifies the rules applying to amendments that eliminate or restrict eligibility or benefits. It allows the State plan to continue in effect unless and until the State adopts a new plan by obtaining approval of a State plan amendment or the Secretary finds substantial noncompliance of the plan.

A. New Issue: We have not publicly announced our policy that amendments that implement new cost sharing charges, increase existing cost sharing charges or increase the cumulative cost sharing maximum are subject to the rules pertaining to an amendment for a restriction in benefits. We have not imposed this rule on States. To address this concern, we make the distinction that cost sharing is considered a restriction in benefits for purposes of the rules applying to amendments. This may be controversial because we have previously told Pennsylvania that cost sharing is not part of the benefit package for purposes of a grand fathered benefit package because the two issues are addressed separately in the statute.

B. New Issue: We have stated in previous guidance that in the event that the plan is not implemented as it was approved, the federal government would not match the State's prior expenditures. We are further clarifying in the preamble procedures for when a State plan amendment that does not have segregable expenditures and can be identified as beyond the scope of the approved State plan, is not approved as it was implemented. The implementation of such a plan amendment is considered a failure to conduct the State program in accordance with the approved State plan, subject to compliance procedures. In this situation, HCFA may only withhold federal matching funds after following the compliance procedures permitting the State a "reasonable opportunity for correction". This is consistent with the denial of New York's plan amendment, since the unapproved expenditures could be separated from the approved expenditures. Some may find this controversial, since we are applying separate procedures for different types of plan amendments. However, OGC has advised that this is the only policy supported by the statute.

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Section 457.70 - Program Options

- * This provision specifies that a State may obtain health benefits coverage through a Medicaid expansion program, a separate child health program or a combination program.

Section 457.80 - Current State Child Health Insurance Coverage and Coordination.

- * This provision requires a State to describe the extent and manner in which children have creditable health coverage; the current State efforts to provide or

obtain creditable health coverage for children; and the procedures to accomplish coordination between CHIP and other health insurance programs.

Section 457.90 - Outreach

- * This provision requires a State to implement outreach procedures and provides examples of outreach procedures such as public education campaigns and enrollment simplification.

Section 457.110 - Enrollment Assistance and Information Requirements

- * This provision requires States to make accurate, easily understood information available and to provide assistance to families in making informed health care decisions. In particular, we will be requiring States to make benefit and provider information available to children enrolled in CHIP.

New Issue: This is a new requirement to be imposed upon the States, although most States are already doing this. This provision is being implemented pursuant to the *Consumer Bill of Rights and Responsibilities*. While advocates will be in favor of this requirement, States may see it as restricting their flexibility in CHIP and imposing Medicaid managed care requirements on this program.

Section 457.120 - Public Involvement in Program Development

- * This provision requires a State to describe the methods used to involve the public in the design and implementation of the program.

Section 457.130 - Civil Rights Assurance

- * This provision requires a State to assure that it will comply under the plan with all civil rights requirements.

Section 457.135 - Assurance of Compliance with Other Provisions.

- * This provision requires a State to assure that it will comply under Title XXI with certain provisions of Titles XIX and XI of the Social Security Act (as specified in Section 2107(e)).

Item of Potential Controversy: Our “1115 waiver” policy is mentioned in the

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preamble of the CHIP regulation, but we do not discuss it in great detail. The preamble simply states that we have not approved waivers of Title XXI provisions, and invite comments. This was done to be consistent with our current overall guidance on section 1115 where very little guidance has been made available so that we have flexibility to further refine, or even change our policies. Most of the guidance on CHIP has been in the form of individual letters to States or members of Congress, in response to specific requests (e.g. Minnesota, Wisconsin, Washington and Vermont). In the past, we have wanted to preserve the Secretary's full discretion, rather than complicate matters by proposing regulations, which can be difficult to change. In addition, we did not feel prepared to determine what "1 year of program experience plus an evaluation" should mean at this point, so we have asked for comments in the preamble.

We can expect several comments from States on this issue. It is possible that some groups will be upset that we have not developed a clear policy on when we would permit waivers of Title XXI. Hill Democrats and advocates may also raise concerns because allowing States to modify parts of the Medicaid program for children (e.g. allowing cost-sharing for the Medicaid population) contradicts a fundamental principle in their drafting of language to create a two pronged CHIP program, that keeps the full protections of Medicaid in place.

Section 457.140 - Budget

- * This provision requires a State to include a budget in its State plan. It specifies the requirements for the budget.

A. New Issue: We have not publicly announced our requirement that the State must submit its planned expenditures for a three year period and States have done this. While we have requested that States submit a three year budget, we have not previously required three years. This may be controversial because States may see this as burdensome.

B. Item of Potential Controversy: We have publicly announced that we will not approve State plans that have impermissible funding as the State share. The statute requires that States comply with 1903(w), relating to limitations on provider donations and taxes. This may be controversial because, in the review of State plans and plan amendments, we are using a different standard than the Medicaid program. In Medicaid, we focus less on the State's source of funding initially and take action retroactively.

Section 457.150 - HCFA Review of State Plan Material

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- * This provision describes HCFA's authority to review and approve or disapprove State plans and plan amendments. It specifies that the Administrator will designate an official to receive the initial submission of a State plan and an individual to coordinate review for each State that submits a State plan.

Section 457.160 - Notice and Timing of HCFA Action on State Plan Material

- * This provision specifies that the Administrator will provide written notification to the State regarding approval or disapproval of a State plan or plan amendment. In addition, it specifies the rules governing the 90 day review period.

A. New Issue: We have not publicly announced our policy on counting the 90-day clock. However, we have informally specified our policy that States' responses to formal requests for additional information must be received by 5:00 p.m. eastern time on a day prior to non-business day. If not, the review period will not resume until the following business day. This also applies to responses received on non-business days. States may find this controversial because if HCFA sends a State a formal request after 5:00 pm on a non-business day, then the clock stops that day, although in practice, we try not to do this. In addition, we included in the regulation a new policy that if the 90th day would have fallen on a weekend, we will adjust the clock to have the 90th day fall on the next business day.

B. New Issue: We have considered a policy where the 90-day clock applies to Section 1115 waivers of title XXI Medicaid expansions in cases where the expansions were for children only, and for "simple", straightforward changes consistent with title XXI. In cases where more complex issues are involved (e.g., budget neutrality for adults), we have not committed to completing review of the State's application within 90 days. We have not made this policy public to date and have dealt with this issue on a case-by-case basis.

So far, with the two States we have granted Medicaid waivers (MN, MO), we did not need to apply the 90-day clock. We asked the State very early in the process whether the waiver request was "inextricably linked" to the Title XXI plan. If they said yes, we worked with the States so that they did not formally answer the CHIP questions (keeping the clock stopped) until the Section 1115 waiver issues were resolved. If this did not happen, we would ask the State questions related section 1115 waiver specifically on CHIP as a means of stopping the clock. This has not been an issue of controversy thus far, as we have been able to reach compromises with the States. We have also discovered that applying cost-sharing under

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Medicaid is neither a simple nor straightforward issue within the Department, so we would not apply the clock in the future.

This issue is not addressed specifically in the regulation text, but is discussed briefly in the preamble to say that the 90-day clock applies the same as it does in the traditional Medicaid program, implying that the clock does not apply.

Section 457.170 - Withdrawal Process

- * This provision states that the State CHIP plan or amendment can be withdrawn at any time upon written notification to HCFA.

Section 457.190 - Administrative and Judicial Review of Action on State plan material

- * This provision gives States the opportunity to make a request for reconsideration of HCFA's action on a State plan or amendment (within 60 days of receipt) and provides for hearing procedures.

Subpart B - General Administration - Reviews and Audits; Withholding for Failure to Comply; Deferral and Disallowance of Claims; Reduction of Federal Medical Payments *Published in the Federal Register on March 4, 1999.*

Section 457.200 - Program reviews

- * This provision describes the review process of the plan administration which includes review of policies and procedures, on-site review and case records review.

Section 457.202 - Audits

- * This provision describes the OIG audit process of a State operation. It determines whether the program operates in a cost-efficient manner and that funds are properly expended. Audit reports are released to State and Department officials with OIG recommendations; and concurrence or clearance, appeals, and adjustments are considered.

Section 457.204 - Withholding of payment for failure to comply with Federal requirements

- * This provision describes reasons for withholding of payment. Payments will be withheld if the State is in noncompliance with title XXI. Plans will have reasonable opportunity for correction.

Section 457.206 - Administrative appeals under the State CHIP

- * This provision describes the three determinations that are subject to reconsideration upon request by a State: Compliance with Federal requirements; FFP in State CHIP expenditures; and Discretionary grants disputes.

Section 457.208 - Judicial review

- * This provision sets forth the State's right to a judicial review, petition for review, and court action.

Section 457.210 - Deferral of claims for FFP

- * This provision describes that the Regional Administrator or Administrator will defer a claim if they question its permissibility. A written notice will be sent identifying the type, amount, and reason for deferring.

Section 457.212 - Disallowance of claims for FFP

- * This provision explains the notice of disallowance that is sent to the State that includes the date, time, and amount of the claim that was deferred. A State may request reconsideration within 30 days of the disallowance letter.

Section 457.216 - Treatment of uncashed or canceled (voided State CHIP) checks

- * This provision says that if a check remains uncashed beyond 180 days from the date it was issued, it is no longer an allowable program expenditure. The State CHIP agency must refund all FFP that it received for uncashed checks and a claim may be filed if an uncashed check is cashed after the refund is made.
- * This provision says that if the State has claimed and received FFP for the amount of a voided check, it must refund the amount of FFP received.

Section 457.218 - Repayment of Federal funds by installments

- * This provision requires that a State repay the Federal funds by installments if the amount to be repaid exceeds 2.5 percent of the actual annual State share. This provision describes the repayment schedule and process.

Section 457.220 - Public funds as the State share of financial participation

- * This provision describes how public funds may be considered as the State's share in claiming FFP if they are appropriated directly to the CHIP agency. This provision specifies that public funds are not Federal funds and not authorized by Federal law to match Federal funds.

Section 457.222 - FFP for equipment

- * This provision describes how claims for financial participation in the cost of equipment under the State CHIP are determined in accordance with subpart G of 45 CFR part 95.

Section 457.224 - Conditions relating to cost sharing

- * This provision specifies that no FFP is available for cost sharing amounts that beneficiaries should have paid and anything paid for individuals who are not eligible, even when services could have been provided under a State CHIP program.

Section 457.226 - Fiscal policies and accountability

- * This provision requires that a State provide and maintain an accounting system, records for 3 years, and beyond 3 years if audit findings have not been resolved.

Section 457.228 - Cost allocation

- * This provision requires that the State CHIP Agency have an approved cost allocation plan on file with the Department in accordance with the requirements contained in subpart E of 45 CFR part 95.

Section 457.230 - FFP for State ADP expenditures

- * This provision describes that FFP is available for the design and development of mechanized claims processing and information systems for operation of certain systems.

Section 457.232 - Refunding of Federal Share of CHIP overpayments to providers and referral of allegations of waste, fraud or abuse to the Office of Inspector General

- * This provision specifies that payments to the States are reduced or increased to adjust for overpayments or underpayments that have been made. Indications of waste fraud and abuse will be referred promptly to the Office of Inspector General.

Section 457.234 - State plan requirements

- * This provision requires that the State must submit a written statement describing the nature and scope of the CHIP program and conform with requirements of title XXI.

Section 457.236 - Audits

- * This provision requires that the agency assure appropriate audit of records on costs of provider services.

Section 457.238 - Documentation of payment rates

- * This provision requires that the agency maintain documentation of payment rates.

Subpart C -State Plan Requirements: Eligibility

Section 457.300 - Scope and authority

- This provision generally describes Subpart C, which sets forth and interprets eligibility requirements pertaining to a State child health insurance plan.

Section 457.301 -Definitions and use of terms

- * This provision describes the definitions and terms used for purposes of this subpart.

Section 457.305 -State plan provisions

- This provision sets forth the requirement that the State plan must include a description of standards consistent with §457.310 and §457.320 used to determine the eligibility of children for coverage under the State program.

Section 457.310 -Targeted low-income children

- This provision defines Targeted low-income child and the standards to be met in order to qualify as such.

Item of Potential Controversy: Title XXI prohibits the participation of children of employees of public agencies who are eligible to participate in a State health benefit plan. [Section 2110(b)(2)(B)] In cases where there is no employer premium subsidy for any State health insurance coverage option in a public agency, the children could be covered under CHIP.

The regulation will more clearly define the phrase “eligible for health benefits coverage under a State health benefits plan” to mean that a child in such a family who otherwise meets the criteria under the statute, but only has available a *nominal* amount of funds that subsidize health benefits coverage would not be considered to be eligible for State employee health benefits and would therefore, be eligible for CHIP. Since the level of funding available to purchase “health benefits coverage under a State health benefits plan” varies by county, children in some counties might be eligible for CHIP, while children in other counties might be ineligible.

Section 457.320 -Other Eligibility Standards

- This provision sets forth the eligibility standards that may or may not be used when determining eligibility for targeted low income children under the State child health insurance plan.

Section 457.330 -State plan requirement; enrollment of American Indian and Alaska Native children.

- This provision sets forth the requirement that a State must include in its plan a description of procedures to be used to ensure the provision of child health assistance to American Indian and Alaskan Native children

Section 457.340 -Application

- This provision sets forth the application procedures that a State must follow when determining eligibility for targeted low income children under the State child health insurance plan.

Section 457.350 -Eligibility Screening

- This provision sets forth the screening procedures States must follow to ensure that all applicants that are potentially eligible for Medicaid are identified and enrolled in Medicaid if found eligible.

Item of potential controversy: States are concerned that families will not complete the Medicaid application process if they are not immediately found eligible for the State Children's Health Insurance Program and that these children will remain uninsured. Many States have expressed concerns about a negative perception of public assistance programs and the barrier that causes difficulty in getting children enrolled in Medicaid.

Section 457.360 - Facilitating Medicaid Enrollment

- This provision sets for the enrollment procedures that a State must follow when determining eligibility for targeted low income children under the State child health insurance plan.

Section 457.361 - Application for and Enrollment in CHIP

- * This provision sets forth the procedures States must follow to facilitate the application and enrollment process for separate child health programs. States must inform applicants about their rights and obligations under the program as well as the processes for eligibility determinations and effective dates.

Section 457.365 - Grievances and Appeals

- * This provision requires States to provide a process for filing grievances and appeals for denial, suspension or termination of eligibility for the program.

Subpart D - State Plan Requirements: Benefits

Section 457.401 - Basis, Scope and Applicability

- * This provision generally describes Subpart D which sets forth and interprets requirements for health benefits coverage and other child health assistance under a State child health insurance plan.

Section 457.402 - Child Health Assistance and Other Definitions

- * This provision defines child health assistance and health benefits coverage and lists the services available for payment under a State child health plan. The majority of these definitions are consistent with those used in the Medicaid program.

Section 457.410 - Health Benefits Coverage Options

- * This provision lists the four health benefits coverage options from which a State may choose to design its child health assistance program.

Item of potential controversy: The regulation makes clear that there are four possible categories of benefits coverage. It is important to note that during negotiations with States over what their benefits packages would include, it became clear that further description was needed over exactly what each benefit option should mean and what procedures are required to meet that option.

One particular area of concern has been the use of “Secretary approved” coverage. We have determined that those States choosing to use “benchmark - plus” benefit packages must do so under Secretary approved coverage. Even though this may create the appearance of broad Secretarial discretion, we believe that this discretion will be viewed positively overall, because we are allowing flexibility above and beyond a basic minimum level of coverage (the benchmark).

Section 457.420 - Benchmark Health Benefits Coverage

- * This provision describes the various benchmark options from which a State may choose to design its benefit package for targeted low income children.

Section 457.430 - Benchmark equivalent health benefit coverage

- * This provision describes the requirements to which the State must adhere in designing a benchmark equivalent benefit package for its targeted low income children.

Section 457.431 - Actuarial Report for Benchmark-equivalent coverage

- * This provision describes the process requirements in developing an actuarial analysis comparing the actuarial value of coverage of the benchmark package to the State-designed benchmark equivalent benefit package for its targeted

low-income children.

Section 457.440 - Existing Comprehensive State-based Coverage

- * This provision identifies the three existing comprehensive state based programs (New York, Florida, and Pennsylvania) grandfathered-in according to the statute as well as the requirements for any modifications made to those existing programs.

Section 457.450 - Secretary-approved Coverage

- * This provision describes ways a State may define Secretary-approved coverage for its separate State Children's Health Insurance Program. Secretary-approved coverage may include: 1) the same benefits as are provided under the Medicaid State plan, a "Medicaid look-alike" 2) a comprehensive benefit package offered under an 1115 waiver that either offers the full EPSDT benefit or that has been extended to the entire Medicaid population in the State; or 3) a benchmark plan plus any additional benefits.

Section 457.470 - Prohibited Coverage

- * This provision explains that health benefit coverage is not required under the State plan for certain items or services under Title XXI.

Section 457.475 - Limitations on coverage - abortions

- * This provision describes the conditions under which abortion services are permitted under Title XXI and discusses the treatment of managed care entities providing this service under a separate contract.

New Issue: We have received an inquiry from the State of California regarding this issue. The State has proposed to use "firewalls" rather than separate contracts for the provision of abortion services. We have prepared a letter to State Health Officials confirming that this is not permissible and that separate contracts are required. The regulation will likely be the vehicle for announcing this policy for CHIP and may raise concerns with several States.

Section 457.480 - Pre-Existing Condition Exclusions and Relation to Other Laws

- * This provision describes the applicability of the preexisting condition exclusion and the parts of HIPAA, ERISA, the Mental Health Parity Act, and the Newborns and Mothers Health Protection Act that apply to CHIP.

Section 457.490 - Delivery and Utilization Control Systems

- * This provision describes that the State plan must include a description of proposed methods of delivery and utilization control systems to ensure that children receive care that is appropriate and medically necessary.

Section 457.495 - Grievances and Appeals

- * This provision requires States to provide enrollees the opportunity to file grievances and appeals for reductions or denial of services provided for in the benefit package.

Subpart E - State Plan Requirements: Beneficiary Financial Responsibility

Section 457.500 - Basis, Scope and Applicability

- * This provision describes the statutory basis for the cost-sharing provisions for separate child health programs.

Section 457.505 - General State Plan Requirements

- * This provision requires that the State plan specify the amount of cost sharing imposed, the methods (including a description of the public schedule) the State uses to inform the public of the cost sharing amounts, the procedures used to ensure that beneficiaries are not charged cost sharing for well-baby/well-child care when a State purchases family coverage or coverage from an employer sponsored group health plan.

Section 457.510 - Premiums, Enrollment fees, or Similar fees

- * This provision discusses what the State should include in its plan regarding information on premiums, enrollment fees, or similar fees.

Section 457.515 - Co-payments, Coinsurance, Deductibles, or Similar Cost sharing charges

- * This provision discusses what the State should include in its plan regarding information on co-payments, coinsurance, deductibles, or similar cost sharing charges.

Section 457.520 - Cost sharing for well-baby and well-child care.

- * This provision requires that cost sharing not be imposed on beneficiaries for well-baby/well-child care services. This section defines all services considered well-baby/well-child care where a copayment is not allowed.

Section 457.525 - Public schedule

- * This provision requires States to publish a schedule of the cost sharing charges that will be imposed on the beneficiary.

Section 457.530 - General Cost Sharing Protection for Lower Income Children

- * This provision instructs States to not vary premiums, deductibles, coinsurance, co-payments or any other cost-sharing based on family income that favors children from families with higher income over children from families with lower income.

Section 457.535 - Protection to ensure Enrollment of American Indians/Alaska Natives

- * This provision permits States to exclude from cost sharing children who are American Indians as defined by the Indian Health Care Improvement Act of 1976 and Alaskan Natives who are members of a Federally recognized tribe and receive services at IHS facilities and Tribal 638 facilities.

New Issue: The regulation gives States the option to waive cost sharing for these individuals. Some have argued that States should be required to exempt all AI/ANs from cost-sharing, while others are concerned about the precedent of allowing preferential treatment for certain groups. However, we feel that our long standing and unique relationship with the tribes makes this acceptable and most beneficial. We are still discussing the issue of whether to take OCR's recommendation to make this policy a mandate, as they would prefer that if we are going to single out this group of individuals, we should do so uniformly across the States.

Section 457.540 - Cost sharing Charges for Children in Families At or Below 150% of the FPL

- * This provision specifies the maximum allowable cost sharing amounts for children in families with income below 150% of the FPL. The maximum cost sharing amounts are between \$1 and \$5 based on the cost of services provided; and \$15 to

\$19 premium per month based on family size and \$1000/month family income.

Section 457.545 - Cost sharing for children in families above 150 percent of the FPL

- * This provision stipulates that States may impose on a sliding scale, premiums, deductibles, copays, coinsurance or other cost sharing amounts up to the legislative maximum (5% of family income cap) on cost sharing for children in families with income over 150% of the FPL.

Section 457.550 - Maximum Allowable Cost Sharing Charges on Targeted Low-Income Children at or Below 150% of FPL.

- * This provision lays out the requirements for imposing cost sharing. It specifies the frequency and amounts that can be charged and requires that cost-sharing charges cannot exceed 5% of a families annual income.

Section 457.555 - Cumulative Cost Sharing Maximum

- * This provision proposes a cumulative cost sharing maximum on the amount of cost sharing imposed on children in families with income above 150% of the FPL (5% of the family's income), and at or below 150% of the FPL (2.5% of the family's income).

A. *New Issue:* New policy placing a 2.5% cumulative maximum on cost sharing for families below 150% FPL. This issue arose because the statute as written permits families with incomes below 150% FPL to pay as much cost-sharing as those above 150% FPL. After much discussion it was decided that a reasonable cap would be 2.5% of income for lower income families.

Congressional Democrats and advocates are adamant about having cost-sharing relative to the levels of poverty for this population. In addition, this proposed cap will be controversial for those States that have in place a cap that is higher than the 2.5% proposed cap because a State plan change would be needed to comply with the regulations when they become final (CO, FL, KY, UT). Since this policy has not been made public, although States know we are considering this, there has been a question as to whether States with approved plans that cover children at 150% and below will be required to lower the cost-sharing cap to 2.5%, or whether those States with cost-sharing above 2.5% may be grand fathered in, but OGC has said that legally, we could not permit grand fathering.

B. Item of Potential Controversy: It has been our policy that States must have a procedure in place to track the 5% cap on family income and to ensure that families do not pay out-of-pocket for expenses once they have reached the cap. To date, the “shoe-box” approach has been the method of choice for States. This means that the State calculates the dollar amount that represents a family’s cap and then the family collects receipts for each visit/prescription and lets the State know when they reach the cap. Once this occurs, the State puts in place a mechanism to make sure beneficiaries are not billed any further by the plan or providers.

The preamble discusses the “shoe box” approach as the method of choice for tracking against the 5% cap, but solicits comments on additional ideas. There is concern in the advocate community and with some on the Hill that the “shoe box” approach places too much of the burden of tracking expenses on the beneficiary. We commissioned a study through George Washington University to develop alternatives, however the study found no viable alternatives. Instead, the study found that it is unlikely that most families will actually reach the 5% cap within the year, thus diminishing the need for a sophisticated tracking system.

C. Item of Potential Controversy: The statute does not specify whether States should use gross or net family income in calculating the 5% cap, therefore we have not provided any guidance on this issue to date. Virtually all States, however, are using gross income in making these calculations, and we have permitted this so far.

The regulation will clarify that States have the option to use either gross or net family income when calculating the cost-sharing caps. The preamble explains that States have this option, but encourages them to use net income because it is more helpful to the beneficiary as well as being more reasonable. The Hill and the advocates will raise concerns that we are giving States the option to use gross family income in calculating the caps. They will argue that it is much more difficult, even unlikely, that a family would ever reach the cap when gross income is used.

D. New Issue: Under the law, States have the option of counting beneficiary payment of services not covered by CHIP towards the beneficiary’s cumulative cost sharing maximum. However, we cannot require this under the statute. Advocates and the Hill could raise concerns that most States will not choose to do this; and the special needs population will be penalized, as they may need services not included under CHIP, and be required to pay cost-sharing for them.

E. New Issue: While the statute does not allow us to mandate that States apply cost-sharing imposed on adults in CHIP family coverage plans toward the cumulative maximum cap, the regulation proposes that States have the option to do so. This policy has not been released publicly thus far. Advocates may argue that States should be required to count all cost-sharing imposed on a “family” when they are receiving CHIP family coverage because they are likely to reach the cap more quickly.

Section 457.560 - Grievances and Appeals

- * This provision requires States to give enrollees the opportunity to file grievances and appeals for disenrollment based on failure to pay cost sharing.

Section 457.570 - Due Process

- * This provision requires States to establish a process that gives beneficiaries a reasonable opportunity to pay past due cost-sharing amounts as a “due process” mechanism before disenrollment from CHIP.

New Issue: The statute does not require States to have a protocol to follow prior to disenrolling a beneficiary who has failed to pay cost-sharing. We have proposed that the States have such a process to provide assistance to those beneficiaries who cannot meet their cost-sharing obligations. The preamble language points out specific examples like allowing beneficiaries a grace period prior to disenrollment, or allowing disenrollment only after the beneficiary has established a pattern of failure to make copayments.

We will also specify in the preamble that HCFA will request a copy of this written process once the proposed regulation is published. During the on-site reviews and future cost sharing amendment reviews, HCFA, for plans approved, will target and address problem areas in the State's disenrollment process. When questions are raised regarding the disenrollment policy in future amendments, the State's response will be a part of the State plan. States may object to this level of prescriptiveness as we have not applied a great deal of scrutiny during our initial review of the plans.

Subpart F - Financial Regulation: Allotments and Payments to States -- *Published in the Federal Register on March 4, 1999.*

Section 457.600 - Purpose and basis of this subpart

- * This subpart interprets Section 2104 of the Act which specifies the total allotment amount available to each State for fiscal years 1998 through 2007 and Section 2105 of the Act which specifies the provision for making payment to States.

Section 457.602 - Applicability

- * The provisions of this subpart apply to the 50 states and the District of Columbia, and the Commonwealths and Territories.

Section 457.606 - Conditions for State allotments and Federal payments for a fiscal year

- * This provision requires that a State have a plan submitted in accordance with section 2106 of the Act and that the plan must be approved by October 1, 1999 for fiscal years 1998 and 1999. This provision specifies that after fiscal years 1999, the plan must be approved by end of fiscal year and an allotment is not available prior to the beginning of the fiscal year.
- * Federal payments for States' CHIP expenditures under an approved health plan are limited to the amount of available funds remaining in State allotments in accordance with formulas specified in 457.608 and 457.610.

Section 457.608 - Process and calculation of State allotments for a fiscal year

- * This provision describes the national total allotment amount for each Federal fiscal year. It describes the formula for allotments to the 50 States, the District of Columbia, Commonwealths, and Territories. This provision describes the formula used to calculate the national total allotment for a fiscal year.
 - The amount available for allotment is determined by subtracting certain amounts from the total appropriation specified in section 2104 9 (a) of the Act.
 - The data and methodology used for determining State allotments for a fiscal year are described in this provision.
- * This provision specifies that each approved plan will receive a minimum allotment of \$2 million. If the allotment is below the \$2 million minimum and needs to be

increased, the increase will be offset by reducing the State allotments for the other States in a pro rata manner.

--Final allotments are determined by HCFA based only on those States that have approved State child health plans by the end of fiscal year 1999.

Section 457.610 - Period of availability for State allotments for a fiscal year

- * This provision describes that the final allotment amount for a fiscal year remains available until expended for Federal payments based on claims during a 3-year period of availability.

Section 457.614 - General payment process

- * This provision requires the State to submit quarterly budget estimates and expenditures reports in order for HCFA to advance a grant to a State. In addition, States must track Federal payments claimed quarterly.

Section 457.616 - Application and tracking of payments against the fiscal year allotments

- * This provision describes the categories of payments applied to reduce the State allotments for a fiscal year.

--Payments made to the State for expenditures claimed during the fiscal year under title XIX Medicaid program.

--Coordination and order of payments, and payments against multiple State CHIP fiscal year allotments.

--Principles for applying Federal payments against the allotment must apply to Medicaid expenditures based on the quarter in which the expenditures are claimed by the State. Payments must be applied in a manner that is consistent, effective, and efficient for all States.

Section 457.618 - Ten percent limit on certain Children's Health Insurance Program expenditures

- * This provision describes primary expenditures (expenditures under a plan for targeted low-income children, in form of a standard benefit package), non-primary expenditures (administrative, outreach, and health initiatives), and defines the 10 percent limit calculation.
- * These expenditures are subject to a 10 percent limit, based on the total computable amount of the State's allotment available in the fiscal year. The total computable amount is determined by dividing the States allotment by the State's enhanced matching rate for that fiscal year.

Section 457.622 - Rate of FFP for State expenditures

- * This provision describes the enhanced Federal medical assistance percentage computation. The conditions for availability are; State must have an approved plan, allotment amounts available in the fiscal year and expenditures against a 10 percent limit. The categories for which it is available are; requirements meeting section 2103 of the Act, Initiatives for improving the health of children, and expenditures for outreach activities.
- * This provision describes FFP availability in expenditures for activities defined in sections 2102 (c) (1) and 2102 (c) (2).

Section 457.624 - Limitations on certain payments for certain expenditures

- * This provision sets forth the limitations on certain payments. Abortions are generally not covered but there is an exception. Purchase of family coverage has to be relative to the amounts that the State would have paid for comparable coverage.

Section 457.626 - Prevention of duplicate payments

- * This provision lists the general definitions used in this section. The provision specifies that no payment will be made to a State for child health assistance under the plan to the extent that a health insurer would have been obligated to pay for services.

Section 457.628 - Other applicable Federal regulations

- * This provision describes other regulations including, HHS regulations in sources of Health Care-Related Taxes and Provider-Related Donations, and non-discrimination under programs through HHS including handicap programs.

Section 457.630 - Grants procedures

- * This provision describes the general provisions once HCFA has approved a State plan. Grants are awarded to cover Federal share of expenditures. A State must submit a budget request for the 4 quarters of fiscal year 1998 and 3 quarters of fiscal year 1999. The amount of the grant is based on information submitted to HCFA. This provision specifies the content of award, effect of award, and general administrative requirements.

Subpart G - Strategic Planning, Reporting and Evaluation

Section 457.700 - Basis, Scope and Applicability

- * This subpart sets forth the State plan requirements for monitoring, reporting and evaluation under Title XXI.

Item of Potential Controversy: Our approach has been to work with the states to be flexible in the submission of the annual report and evaluation while trying to establish guidelines that promote a base level of comparability for annual reporting and Year 2000 evaluations -- both of which will become the basis for the Secretary's Report to Congress in 2001. In addition, a State-generated workgroup, with HCFA representation, is working to establish model templates for both future annual reporting and evaluation. States will most likely use such a template, as it will be the only model available to them, so this will help us to get some consistent information in some States.

The regulation text will closely follow the CHIP statute and will not require States to provide much beyond what is prescribed in the legislation, except for the basic information outlined in the December 4 letter. The preamble provides a more in depth discussion of performance measurement and strategic objectives for encouraging States' accountability through data reporting.

While the Congress, the Administration and numerous advocacy and research groups are anxious to learn about the impact of CHIP, the States will be challenged

to respond to the requirements in the law and the regulation given the severe limitations on data and the challenges of Y2K and other impediments to timely reporting. Some States have not been able to meet our deadlines for reporting their first annual report and enrollment information. Also, some of the data we are getting is not consistent with our request. While the regulation is based directly upon the Title XXI statute, which provides broad authority to require specific standardized data, some States have argued that we cannot uphold such requirements.

Section 457.710 - State plan requirements: strategic objectives and performance goals

- * This provision requires that the State child health plan describe the strategic objectives, performance goals, and the performance measures the State has established.

New Issue: The preamble discusses the two general goals for the proposed monitoring provisions. Specifically, monitoring will assure State compliance with both statutory requirements under title XXI and the content of a State's title XXI plan. In addition, monitoring will allow us to track the submission of requested data related to CHIP programs, including enrollment, expenditure, program data, etc., and other efforts related to ultimately ensuring enrollment of eligible children into both CHIP and Medicaid. Expected outcomes of CHIP monitoring include: 1) identifying the need for corrective action, enforcement and improvement within State title XXI programs; 2) recognizing and sharing best practices that may lead to increased enrollment; 3) identifying States' needs for technical assistance; and 4) informing HCFA as we prepare for the Secretary's report to Congress.

The regulation text provides authority for activities such as audits to identify States' noncompliance with the statute and policies outlined in the regulation, as well as with the State plan as approved. The purpose is also to provide States with the opportunity for corrective action as necessary.

In addition, Section 457.200 of the financial regulation outlines HCFA's process for program reviews. In order to determine compliance with Federal requirements for State CHIP programs, HCFA will review State and local administration of State CHIP plans "through the analysis of State's policies and procedures, on-site reviews of selected aspects of agency operation, and examination of samples of individual case records." If it is found that a State program is out of compliance with Federal requirements, a State "must correct its practice accordingly." In addition, the Department's Office of the Inspector General (OIG) will periodically

review State operations to determine the following: 1) whether or not the program is being operated in a cost-efficient manner; and 2) whether funds are being properly expended for the purposes for which they are appropriated. OIG will release reports simultaneously to the States and the Department regarding their findings and recommendations. Section 457.204 outlines the Department's basis for withholding payments to States and additional actions for State noncompliance with Federal regulations.

Section 457.720 - State plan requirement: state assurance regarding data collection, records, and reports

- * This provision requires that the State plan provide an assurance that the State will collect the data, maintain the records, and furnish the reports to the Secretary, at the times and in the standardized format that the Secretary may require.

Section 457.730 - State plan requirement: state annual reports and evaluation

- * This provision requires the State plan to include a description of the State's proposal for submitting annual reports and the state evaluation.

Section 457.735 - State plan requirement: state assurance of the quality and appropriateness of care

- * This provision requires that the State child health plan describe the strategy the State has adopted for assuring the quality and appropriateness of care, particularly with respect to providing well baby care, well-child care, and immunizations and assuring access to covered services, including emergency services. In this section, States must discuss the specific elements of their quality assessment and improvement strategies.

Section 457.740 - State expenditure and statistical reports

- * This provision discusses State expenditure and statistical reporting requirements. States must report CHIP expenditures on a quarterly basis. States also must report the number of children under 19 years of age who are enrolled in separate CHIP, Medicaid-only, and Medicaid-expansion programs by age, countable income (poverty level determined by state-defined countable income and state-defined household size) and service delivery categories on a quarterly basis. In addition, States annually must report an unduplicated count of children by these three categories for each preceding federal fiscal year.

Section 457.750 - Annual Report

- * This provision discusses the type of information that States must provide in the Annual report. The State must provide an assessment of the operation of the State in the preceding federal fiscal year including the progress made in reducing the number of uncovered low-income children and in meeting other strategic objectives and performance goals. In order to report on the progress made in reducing the number of uncovered low-income children, a State must choose a methodology to establish an initial baseline estimate of the number of low-income children.

B. Item of Potential Controversy: States have the option to decide what methodology to use for the baseline estimate of the uninsured but many appear dissatisfied with available data sources. While we have the ability to track changes in baseline at a national level, States may not be comfortable with HCFA determining their State's percent reduction of uninsured children.

To date, we have received baseline estimates from most States. As we did not impose any particular methodology on States, the methodologies used vary substantially across States. For example, most States have submitted baseline estimates using CPS data in various forms (e.g., different survey years, pooled estimates, CPS combined with other survey research, etc.) and others have used either State-based or research-based surveys. States may argue that since there are few reliable and affordable tools accessible to States to develop baseline estimates, tracking this information annually may not make sense.

Section 457.760 - State evaluation

- * This provision discusses the requirement that States submit a comprehensive evaluation by March 31, 2000 that analyzes the progress and effectiveness of their State child health insurance program.

Subpart H - Substitution of Coverage

Section 457.800 - Basis, Scope and Applicability

- * This provision describes Subpart H which sets forth and interprets requirements to prevent substitution of coverage under a State Children's Health Insurance Plan.

Section 457.805 - State Plan Requirements: Private Coverage Substitution

- * This provision explains the requirements for describing reasonable procedures in the State plan that will ensure that no substitution of coverage under a group health plan occurs.

A. Item of Potential Controversy: This regulation text does not set forth our internal policy establishing greater scrutiny at higher levels of income, however we do discuss it in the preamble and solicit comments. We have been applying this standard when reviewing plans, but want to leave room for flexibility.

B. Item of Potential Controversy: There has been a question regarding the application of substitution provisions to the separate Medicaid group of targeted low-income children. Some States have been imposing waiting periods under Medicaid expansions and concerns have been raised that this is in conflict with the entitlement nature of Medicaid.

Section 457.810 - Premium Assistance for Employer-Sponsored Group health Plans: Required Protections Against Substitution

- * This provision describes the requirements for preventing crowd-out in States utilizing employer-sponsored group health plans, including a minimum period of uninsurance (6 months), the minimum employer contribution permitted (60%), and the requirement for an evaluation of the effects of this policy on access to health coverage.

Item of Potential Controversy: Intergovernmental groups and States (e.g., NGA, APHSA) will argue the policy for employer-sponsored coverage is too prescriptive. Some Congressional staff and States believe we do not have statutory authority to impose more stringent requirements on employer-sponsored coverage. Some States have complained about difficulty in meeting the conditions for employer-sponsored coverage (e.g., 6 month waiting period and 60 percent employer contribution.).

Subpart I - Program Integrity and Beneficiary Protections

Section 457.900 - Definitions, Basis, Scope and Applicability

- * Subpart I, Program Integrity and Beneficiary Protections, finds its basis in both Title XIX and Title XI of the Social Security Act, which the Title XXI statute refers to. The CHIP statute emphasizes the importance of maintaining program integrity, but does not prescribe specifically what fraud and abuse protections must be in place. This subpart requires States to have procedures in place and suggests, for purposes of consistency, the Medicaid provisions in this area as a good precedent to follow.

This subpart applies only to States implementing separate State CHIP programs. States that utilize the option to expand existing Medicaid programs must comply with the Medicaid program integrity requirements.

New Issue: This subpart provides the States with flexibility in terms of the type of fraud and abuse protections they choose to implement. However, we have not provided guidance as to our policies on program integrity thus far and we believe that most S-CHIP States have not done a great deal in this area. Therefore, this is a new policy area that may be perceived as somewhat burdensome to these States.

Section 457.902 - Definitions

- * This provision describes the terms relevant to this subpart.

Section 457.910 - State Program Administration and Requirements

- * The State child health plan must provide safeguards necessary to ensure that eligibility is determined and services are provided in an appropriate and efficient manner that serves the best interests of the beneficiaries.

Section 457.915 - Fraud Detection and Investigation

- * The State child health plan must include procedures to ensure program integrity and detection of fraud and abuse. States are also required to have procedures for coordination between the State program integrity unit and the OIG, DOJ, FBI, etc. Although States with separate CHIP plans are not required to use the same procedures specified in the Medicaid regulations, this subsection encourages States to do so.

Section 457.920 - Accessible Means to Report Fraud and Abuse

- * The State agency must facilitate communication between the State and the public in terms of reporting possible fraud or abuse, and for providing information about the issue. This subsection suggests using a toll-free number for this purpose.

Section 457.925 - Preliminary Investigation

- * When a complaint or report is made, the State must conduct a preliminary investigation to determine whether further action is needed.

Section 457.930 - Full Investigation, Resolution and Reporting Requirements

- * States must have procedures for investigation of fraud and abuse, and are encouraged to utilize the Medicaid procedures already provided in regulation, including collaboration with Medicaid Fraud Control Units (MFCUs)

Section 457.935 - Sanctions and Related Penalties

- * Any provider that has been barred from participating in Medicare or Medicaid cannot become a CHIP provider. All corresponding Medicaid disclosure requirements and the related penalties apply.

Section 457.940 - Procurement Standards

- * This provision establishes payment limitations for CHIP services by requiring that States: 1) provide for free and open competition, to the extent possible, in the bidding of contracts for Title XXI services; and/or 2) base Title XXI payment rates on public and/or private payment rates for comparable services. It also permits States to establish higher rates by justifying that such rates are necessary to ensure sufficient provider participation or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services.

New Issue: While our policy basically mirrors the Medicaid regulations that are already in place -- procurement transactions must be “conducted in a manner providing full and open competition” where appropriate, we also agreed to several additional options. The goal is to prevent situations where the State is paying excessively for services. For example, if the State is paying \$100 a day for a service that should only be \$10/day.

Section 457.945 - Certification for Contracts and Proposals

- * Both MCOs and fee-for-service providers must certify the integrity of all information specified by the State.

Section 457.950 - Contract and Payment Requirements Including Certification of Payment-related Information

- * The State must ensure that contracts with managed care entities (MCEs) include enrollment and other required data and the MCE must attest to the accuracy and integrity of enrollee claims and payment data. In addition, the MCE must make that data available to the State upon request.
- * States using fee-for-service must establish procedures to ensure the integrity of provider claims. Fee-for-service providers must provide the State with access to enrollee and payment data upon request by the State.

Section 457.955 - Conditions Necessary to Contract as an MCE

- * This provision requires States to ensure that MCEs have procedures in place to guard against fraud and abuse. States must enforce MCE compliance with all Federal and State standards and must have a mechanism for reporting fraud, abuse or violation of enrollment or payment requirements to HCFA or the Office of the Inspector General. States have authority to inspect or audit the MCE at any time, with reasonable cause.

Section 457.960 - Reporting Changes in Eligibility and Redetermining Eligibility

- * This provision requires States to have procedures designed to ensure that enrollees make accurate reports in circumstances that may affect their eligibility and to conduct redeterminations upon a change in circumstances in a timely manner.

Section 457.965 - Documentation

- * This provision requires States to include in each applicant's record, facts to substantiate eligibility determinations.

Section 457.970 - Eligibility and Income Verification

- * States may use discretion in establishing verification methods, and are encouraged to follow the Medicaid procedures that are in place. This provision also permits States to terminate eligibility for “good cause” reasons, but with written notice of the reasons for termination.

Section 457.975 - Redetermination Intervals in Cases of Suspected Enrollment Fraud

- * This provision gives States flexibility to conduct redeterminations in cases of suspected enrollment fraud at whatever frequency is determined to be in the best interest of the program.

Section 457.980 - Verification of Enrollment and Provider Services Received

- * States must have methodologies in place to verify the accuracy of provider billing and must maintain systems to verify enrollment where enhanced matching is received by the State.

Section 457.985 - Enrollee Rights to Grievances and Appeals

- * This provision requires States and providers to have written procedures in place to give enrollees the opportunity to file grievances, complaints, and appeals, with special emphasis on cases of denial, suspension or termination of eligibility; disenrollment for failure to pay cost sharing; and reduction or denial of services provided for in the benefit package.

In addition, States must inform beneficiaries in writing of their rights. The provision gives States the opportunity to design their own procedures, and suggests use of the Medicaid managed care practices at a minimum, including application of the “gag rule” prohibiting interference with health care professionals’ advice to enrollees; and limitations on physician incentives that have the effect of reducing or limiting services.

Section 457.990 - Privacy Protections

- * States must apply the Medicaid privacy protections to separate CHIP programs. These protections include those pertaining to the protection of enrollee data, medical records and mental health history, and privacy of minors. States must follow the data transmission and other Internet transmission protections and are

encouraged to adopt HCFA's data confidentiality and security policies to safeguard data.

Section 457.995 - Overview of Beneficiary Protections

- * This provision describes all of the sections of the President's directive that are addressed in the CHIP regulation. The sections addressed are as follows: §457.65, §457.110, §457.130, §457.402, §457.525, §457.735, §457.985, and §457.990.

Item of Potential Controversy: We have determined that based on the President's directive, we should include as many protections as possible in this area. This may be controversial with the States because the Title XXI statute does not specifically make reference to these protections.

Subpart J -- Waivers

Section 457.1000 - Basis and Scope

- * This provision lays out the conditions under which States may obtain waivers of the 10 percent cap on administrative expenditures and to provide coverage to entire families.

Section 457.1005 - Waiver for Cost-effective Coverage through a Community-Based Health Delivery System

- * This provision describes the requirements a State must follow to exceed the 10 percent limitation on administrative costs in order to provide child health assistance to targeted low-income children under the state plan through the utilization of cost-effective community-based health care delivery systems.

Section 457.1010 - Waiver for Purchase of Family Coverage

- * This provision describes a waiver which allows the State to provide coverage to an entire family coverage in lieu of individual coverage. To receive payment for purchase of family coverage under the plan, the State must establish that the cost of covering the family is cost effective, meaning it will cost no more than to cover the individual child. The State must also demonstrate that such coverage shall not substitute for other health insurance coverage. When the State applies for the waiver, HCFA will approve the waiver if: 1) the State meets the requirements for substitution of private coverage described in 457.350, 2) meets the requirements

for obtaining health benefits coverage for eligible children as defined in 457.410, 3) meets the standards for imposing cost sharing on beneficiaries and 4) meet the basic requirements for cost-effectiveness. HCFA may withdraw its approval of the waiver if it determines the waiver is no longer cost effective.

Item of Potential Controversy: The only States to receive such a variance thus far are Massachusetts and Wisconsin, using the employer buy-in option. Several other States have shown interest in this option and have asked for greater flexibility. Unfortunately, the statute is very clear and the standards will be too difficult for most States to meet. We will continue to receive pressure from States looking to find more and creative ways to spend their allotments, but some on the Hill are adamant that no flexibility was intended in this area. In addition, we believe that a legislative change would be needed to go beyond the statute to grant variances that will provide more flexibility to cover adults.

Section 457.1015 - Cost Effectiveness

- * This provision describes the waiver requirements for demonstrating cost effectiveness in determining whether to provide family coverage in lieu of individual coverage.

Miscellaneous Issues

Vaccines for Children

- * Non-Medicaid CHIP programs may opt to obtain vaccine at the Federal discount price, plus an amount to cover the costs of administrative overhead and distribution, for the purpose of immunizing CHIP eligible children. This applies to non-Medicaid CHIP programs as well and states may want to use this existing authority given the existence of the VFC program and its potential impact on CHIP. States electing this option must retain overall responsibility for the provision of health services, under the requirements of § 457.405. However, the State may subcontract for any or all other services provided under its CHIP program, including professional services required to immunize eligible children.

Because the Immunization Program of the State Health Department is the CDC grantee, and has sole authority to order and distribute vaccine purchased under the CDC discount contracts, a State CHIP program which opts to obtain these vaccines must negotiate a memorandum of agreement with the Immunization Program to order vaccines and distribute the directly to CHIP providers, and must agree to reimburse the Immunization Program for the cost of each dose of vaccine,

including a pro rata share of administrative overhead and distribution costs. Providers who receive vaccine must agree to comply with reporting and other requirements of the State immunization program, in order to assure that vaccine distributed is accounted for appropriately.

If HCFA establishes that the State has retained overall responsibility for the provision of services and if the State Immunization program has established one price per dose which includes all charges for vaccine, the Immunization Program's administrative overhead and distribution of vaccine, the 10% cap on direct services and administrative costs will not apply.

Item of Potential Controversy: This issue has been and will continue to be controversial with States and the advocate community. The Hill has also taken a strong position on this issue, in favor of our policy.

Disproportionate Share Hospitals (DSH)

- * Title XXI includes a provision that requires States to receive enhanced match for disproportionate share hospital payments under CHIP. We mention this in our letter to the States on financial issues released on December 8, 1997. Although States have the ability to use the CHIP money this way, to date no State has done so.

Because of the concern about this both within HCFA and for some on the Hill, we asked OGC to try to determine whether we have the authority to prohibit States from using CHIP funds for DSH. The General Counsel has told us that this is not possible without a legislative change. We plan on providing technical assistance to Senate Finance Committee staff who are drafting legislation to change this provision.

The CHIP regulation does not address this issue specifically, however it is discussed in the preamble. It notes that we understand that there may be a general concern about the use of title XXI allotment dollars for payment to disproportionate share hospitals and are seeking a legislative change to address this discrepancy. However, until Congress can address this issue in legislation, the law does not allow HCFA to issue a policy that disallows claims for DSH payments related to CHIP Medicaid expansion groups.

Item of Potential Controversy: Some may see the current policy on use of CHIP funds in this way as inappropriate. However, although no State has taken advantage of it, States may oppose a legislative change in policy on the grounds

that it limits flexibility and the ability to spend CHIP dollars as they wish. The advocates may oppose a change in policy as well, arguing that States need increased DSH funding to cover uncompensated care costs. On the other hand, the advocates share our concern that all CHIP dollars will not be going toward the provision of health care services for children.

Related Revisions to Medicaid Regulations - Parts 431, 433, and 435

Section 433.11 - Enhanced FMAP Rate for Children

- * We have made changes to Part 430 of the regulations necessary to incorporate the policies pertaining to FFP that are explained in the CHIP financial regulatory package which is in final clearance.

Item of Potential Controversy: We have proposed (as does the CHIP financial proposed regulation) to make FFP available at the enhanced rate for all Medicaid expansions for children. We considered limiting the availability of enhanced FFP to the new optional group of optional targeted low income children. However, we decided to make enhanced FFP available to States for any expansion for children. That is, enhanced FFP is available for services provided to any child who would not be eligible for Medicaid under the rules in effect on March 31, 1997 and who does not have creditable health insurance, regardless of the eligibility group involved.

This grants flexibility to States and encourages coverage of the maximum number of children. For example, States may expand a group of children whose eligibility is related to the poverty level (e.g., children under age 6 with income at or below 133 percent of the poverty level) and receive enhanced match for those children who do not have insurance and would not have been eligible prior to the expansion. This enables States to expand coverage to children whether or not they have creditable health insurance rather than limiting the expansion to children without insurance as under the new optional targeted low income children's group. (Regular FFP would be available for the children with health insurance and enhanced FFP for those without insurance, all in the same eligibility group.)

We have also required that States maintain a valid method of identifying services provided on behalf of those children who have no insurance and would not be eligible prior to the expansion. Only regular Medicaid FFP will be available if they are unable to separate the children eligible under the old rules from those eligible under the expansion.

Section 435.229 - Optional Targeted Low Income Children

- * These proposed regulations add the new optional group of optional targeted low income children to the existing optional groups. In general, all regular Medicaid rules apply to this group.

Section 435.910 - Use of Social Security Number

- * These proposed regulations explain that a Medicaid identification number other than a Social Security Number may be given to an individual who, because of well established religious objections, refuses to obtain a Social Security Number.

Section 435.1001 - FFP for Administration

- * This provision states that FFP is available for administrative functions such as Medicaid eligibility determinations and redeterminations, and determining presumptive eligibility for children.

Section 435.1002 - FFP for Services

- * This provision makes FFP available for services provided to presumptively eligible children.

Section 435.1100 - Presumptive Eligibility for Children

- * The statute requires that we adapt the language from an already published notice of proposed rulemaking pertaining to presumptive eligibility for pregnant women to implement the new provision related to presumptive eligibility for children. At this point, the majority of States have not yet taken advantage of this option, so we do not have an indication of the overall reaction we will get.

A. Item of Potential Controversy: We have proposed to allow States to establish reasonable methods of limiting the number of periods of presumptive eligibility which will be authorized for a child in a given time frame. The statute is silent on this issue. (Pregnant women were limited to one period of presumptive eligibility per pregnancy.) We stated that because family income and circumstances can change from month to month, we believe it is unreasonable to limit a child to one period of presumptive eligibility in a lifetime. However, it is also unreasonable to provide a child with unlimited periods of presumptive eligibility. The latter would allow continuous coverage of children who never file an application for regular Medicaid and are never determined eligible. It might also result in a parent not

seeking preventive care or establishing a medical home for the child but rather seeking care on an ad hoc basis knowing that the child will be found presumptively eligible.

B. Item of Potential Controversy: We have proposed to require that States provide all services, including EPSDT, to presumptively eligible children. The statute is silent on this issue. (Services provided to presumptively eligible pregnant women are limited by statute.) We considered allowing States to limit the services provided (e.g., provide ambulatory care only). However, we believe that most children will be found retroactively eligible for regular Medicaid and entitled to all services during that period. Therefore, adequate medical care should not be delayed pending the decision on the regular Medicaid application. Another issue that may raise controversy is the fact that once a child is determined to be presumptively eligible, the statute requires that any services provided to that child will be counted against the State's allotment until the final determination of eligibility is completed. So, if the child never follows through with the full application, States can, in effect, be penalized, thus creating a disincentive to use presumptive eligibility.

they have not fixed it
yet. they are trying
to go to Kevin w/ options
next week. At this point,
I will set up a mtg — don't
think it is useful to wait
on them unless you do.

The Kevin mtg has
been pushed back
twice.

Definitely, but
set up, but
we need to
talk to Chris
first.