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AMENDMENT NO. ____ Calendar No. ____

Purpose: To provide health care for America's children.

IN THE SENATE OF THE UNITED STATES—105th Cong., 2d Sess.

S. 1415

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GPO: 1996 25-891 (mac)

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. TORRICELLI

Viz:

On page 201, between lines 19 and 20, insert the following:

(3) MEDICAID CHILDREN'S ENROLLMENT PERFORMANCE BONUS.—

(A) SET ASIDE OF FUNDS.—Notwithstanding the preceding paragraphs of this subsection, 8 percent of the amount received under this section in a fiscal year shall not be used by a State unless the State satisfies the requirements of subparagraphs (B) and (C).

1902(r)(2) of such Act (42 U.S.C. 1396a(r)(2))) for the child to be eligible for medical assistance under section 1902(l)(2) or 1905(n)(2) (as selected by a State) of such Act (42 U.S.C. 1396a(l)(2), 1396d(n)(2)) for the age of such child; and

(bb) children determined eligible for such assistance, and enrolled in the State plan under title XIX of the Social Security Act, in accordance with the requirements of paragraphs (1) and (2) of section 1931(b) of such Act (42 U.S.C. 1396u–1(b)).

(II) PROCEDURES DESCRIBED.—The streamlined procedures described in this subclause include—

(aa) using shortened and simplified applications for the children described in subclause (I);

(bb) eliminating the assets test for determining the eligibility of such children; and

(cc) allowing applications for such children to be submitted by mail or telephone.

(ii) CONTINUOUS ELIGIBILITY FOR CHILDREN.—The State provides (or demonstrates to the satisfaction of the Secretary that, not later than fiscal year 2001, the State shall provide) for 12-months of continuous eligibility for children in accordance with section 1902(e)(12) of the Social Security Act (42 U.S.C. 1396a(e)(12)).

(iii) PRESUMPTIVE ELIGIBILITY FOR CHILDREN.—The State provides (or demonstrates to the satisfaction of the Secretary that, not later than fiscal year 2001, the State shall provide) for making medical assistance available to children during a presumptive eligibility period in accordance with section 1920A of the Social Security Act (42 U.S.C. 1396r–1a).

(iv) OUTSTATIONING AND ALTERNATIVE APPLICATIONS.—The State complies with the requirements of section 1902(a)(55) of the Social Security Act (42 U.S.C. 1396a(a)(55)) (relating to outstationing of eligibility workers for the receipt and initial processing of applications for medical assistance and the use of alternative application forms).

(v) SIMPLIFIED VERIFICATION OF ELIGIBILITY REQUIREMENTS.—The State demonstrates to the satisfaction of the Secretary that the State uses only the minimum level of verification requirements as are necessary for the State to ensure accurate eligibility determinations under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(C) REPORT ON NUMBER OF ENROLLMENTS RESULTING FROM OUTREACH.—A State shall annually report to the Secretary on the number of full year equivalent children that are determined to be eligible for medical assistance under the State plan under title XIX of the So-

cial Security Act and are enrolled under the plan as a result of—

(i) having been provided presumptive eligibility in accordance with section 1920A of such Act (42 U.S.C. 1396r–1a);

(ii) having submitted an application for such assistance through an outstationed eligibility worker; and

(iii) having submitted an application for such assistance by mail or telephone.

(D) PROCEDURE FOR REDISTRIBUTION OF UNUSED SET ASIDES.—The Secretary shall determine an appropriate procedure for the redistribution of funds set aside under this paragraph for a State for a fiscal year that are not used by the State during that fiscal year because the State did not satisfy the requirements of subparagraphs (B) and (C) to States that have satisfied such requirements for such fiscal year and have fully expended the amount of State funds so set aside.

(E) OFFSET OF FEDERAL EXPENDITURES.—The amount allocated to the State Litigation Settlement Account for a fiscal year shall, in addition to any reductions required

under the third sentence of section 451(a), be further reduced by the additional estimated Federal expenditures that will be incurred as a result of increased State expenditures resulting from the application of this paragraph.

(F) APPLICATION OF RESTRICTION ON SUBSTITUTION OF SPENDING.—The provisions of subsection (c) of this section apply to this paragraph in the same manner and to the same extent as such provisions apply to the program described in paragraph (2)(G) of this subsection.

(B) DEMONSTRATION OF IMPLEMENTATION OF OUTREACH STRATEGIES.—A State shall demonstrate to the satisfaction of the Secretary that the State has a commitment to reach and enroll children who are eligible for but not enrolled under the State plan through effective implementation of each of the following outreach activities:

(i) STREAMLINED ELIGIBILITY PROCEDURES.—

(I) IN GENERAL.—The State uses streamlined procedures described in subclause (II) for determining the eligibility for medical assistance of, and enrollment in the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) of—

(aa) children in families with incomes that do not exceed the effective income level (expressed as a percent of the poverty line) that has been specified under such State plan (including under a waiver authorized by the Secretary or under section

Dear State Health Official:

The Department of Health and Human Services (DHHS) issued a letter on January 23, 1998 regarding outreach opportunities to improve enrollment of uninsured children in Medicaid or CHIP. In that letter, DHHS described the requirement under the State Children's Health Insurance Program (CHIP) to ensure that children found through screening to be eligible for Medicaid are enrolled in Medicaid. This letter provides additional guidance on the Medicaid "screen and enroll" requirement in the CHIP law under section 2102(b)(3)(B).

"Screen and Enroll" requirement

The "screen and enroll" requirement is critical to ensuring that children are covered by the appropriate program. One of the principles of the CHIP legislation is that coverage should be extended to uninsured children and that CHIP programs should not supplant existing public or private coverage. ~~Although~~ States electing to expand Medicaid only through under CHIP are exempt ~~[as long as Medicaid is all they do]~~ from this requirement because eligibility for regular Medicaid will be determined as part of the eligibility process for the CHIP expansion. States ~~using CHIP funds to~~ establish separate, non-Medicaid health insurance programs must screen all applicants for Medicaid eligibility and enroll them in Medicaid if they are eligible. This requirement ensures that any child applying for CHIP who is found through screening to be eligible for either CHIP or Medicaid will be enrolled in the right program.

The simplest way to meet the "screen and enroll" requirement is to use a joint application form. A State would review the joint application and determine CHIP or Medicaid eligibility concurrently, without requiring the family to submit additional information. Medicaid enrollment can be accomplished without referring the family to another office or completing another application. A number of States with separate CHIP programs are using or are planning to use a joint application form. (Note: DHHS has developed a model application for CHIP and Medicaid. Please see the form in the September 10, 1998 eligibility letter on the HCFA website at www.hcfa.gov.)

The following are three examples of States using a joint application:

- **Joint application / State agency determines eligibility:**

  Oregon uses this approach. The State has developed a joint application for Medicaid and CHIP, and State workers will determine eligibility for both programs. The State will conduct a full Medicaid eligibility determination to determine whether the child is Medicaid eligible. If the child is eligible for Medicaid, she or he is enrolled in that program. If the child does not meet the Medicaid eligibility criteria, the State further screens the application to see if the child meets CHIP criteria. If so, the child is enrolled in CHIP.

- **Joint application / Private entity performs "initial processing":**

  Connecticut uses this approach. The State has developed a two-page application for its "HUSKY" program, which IS USED TO DETERMINE ELIGIBILITY for both Medicaid and CHIP. The State contracts with an independent entity to PERFORM INITIAL MEDICAID SCREEN AND MAKE FINAL ELIGIBILTIY DETERMINATION FOR NONMEDICAID PROGRAM limited eligibility and enrollment functions. When the contractor receives an application for HUSKY and the child appears to be Medicaid eligible, it will send the application to the appropriate Department of Social Services office for a final eligibility determination BASED ON THAT APPLICATION.

  Florida is another example of a State using this approach. When the joint application for the MEDICAID AND THE Healthy Kids program is received, HEALTHY KIDS staff (PRIVATE CONTRACTOR) screen it for Medicaid eligibility. Children appearing to be Medicaid eligible are immediately forwarded to the Department of Children and Families for a final Medicaid eligibility determination. THE DCF WORKER IS CO-LOCATED IN SAME OFFICE AS DCF WORKER, CUTS DOWN TIME DELAY. These applications are not processed for Healthy Kids eligibility until they have been deemed ineligible for Medicaid.

If a State chooses to use separate applications for its Medicaid and CHIP programs, it is still required to implement mechanisms that ensure that Medicaid eligible children applying for CHIP are enrolled in the Medicaid program. [If separate applications are used, procedures are needed to assure compliance with the "screen and enroll" requirement. These procedures cannot place the entire burden for application on the family. They must include reasonable actions on the part of the State to ensure enrollment into Medicaid.] [At a minimum,] State screening processes should assure that all children who are potentially eligible for Medicaid under the poverty-level-related groups are identified. The State may initially use a gross income test that compares total family income to the applicable Medicaid standard. The initial gross income test would immediately identify children whose family income is low enough that Medicaid eligibility would be almost certain. A second test would be needed, however, to detect those children whose gross family income exceeds the Medicaid standard but who are Medicaid-eligible when income disregards are applied. Without this second test, the State would not be meeting its responsibility to ensure that children eligible for Medicaid are identified and enrolled in Medicaid. IN ADDITION TO SCREENING PROCESS, STATES WILL NEED TO ESTABLISH PROCEDURES TO ENSURE THAT MEDICAID ELIGIBLE CHILDREN ARE ENROLLED IN MEDICAID. [__]

In general, [we believe that] using separate applications for CHIP and Medicaid provides fewer safeguards for ensuring that children are enrolled in the appropriate program. If a State is using separate applications for its Medicaid and separate, non-Medicaid CHIP programs, special attention will be paid during the review process to WHATEVER procedures established by the State in order to ensure that the "screen and enroll" requirements are met. IN ADDITION, STATES USING SEPARATE APPLICATIONS SHOULD BE MONITORING THE SUCCESS OF THEIR SYSTEMS IN ENROLLING MEDICAID ELIGIBLE CHILDREN.

Refusal to Apply for Medicaid or Failure to Complete the Application Process

Some States have raised the concern that the screen and enroll procedure may cause families to [refuse to apply for Medicaid] ~~or~~ fail to complete the application process BECAUSE THEY REFUSE TO APPLY FOR MEDICAID, leaving some children uninsured. States should make every effort to ensure that a decision by a family not to apply for Medicaid or not to complete the application process is an informed one. ~~FAMILIES MAY NOT KNOW THAT THEY DO NOT HAVE A CHOICE ABOUT WHICH PROGRAM TO APPLY TO~~. The screen and enroll procedures must provide the family with full and complete information about Medicaid, including the early prevention, screening, diagnosis and treatment benefits, the prohibition against cost sharing, and the differences between Medicaid and the State's CHIP program. The process must ensure that the family understands the consequences of not applying for Medicaid or failing to complete the application process. ~~REFER TO RECENT GUIDANCE~~ ABOUT IMPO~~RTANCE OF OUT~~REACH AND MEDICAID STREAMLINING PROCESS AND RELUCT~~ANCE COULD~~ BE ALLEVIATED. ~~Families should be informed that~~ they do not in particular, that they do not have a choice of choosing CHIP when medicaid eligible

We believe that Congress intended that children eligible for Medicaid be enrolled in the Medicaid program. If a child is found through a State screening process to be eligible for Medicaid and his or her family does not apply for Medicaid or fails to complete the application process for any reason, the child cannot be enrolled in CHIP. E~~nrollment in CHIP c~~an occur only after a full Medicaid determination shows that the child is ineligible for Medicaid. ~~CLARIF~~Y ~~THAT WE DON'T NEED TO DO THAT FOR ALL K~~IDS. State has expanded through a Non-Medicaid program when

If you have any questions about how to fulfill the CHIP "screen and enroll" requirements, or any other part of this guidance, please contact your HCFA Regional Office.

GARY LOCKE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 753-6780 • TTY/TDD (360) 753-6466

cc Mickey
Bill W
Chris J
Jean L
Cynthia R
Mona P.

October 9, 1998

Washington CHIP fix

Erskine Bowles
Chief of Staff
The White House
1600 Pennsylvania Ave. N.W.
Washington, D.C. 20500

Dear Erskine:

I respectfully request the President's support for an amendment to the continuing resolution that would permit Washington State to use its Children's Health Insurance Program [CHIP] funds at an enhanced matching rate for children under 200 percent of the federal poverty level [FPL] who are new to the Medicaid program.

During the past year, the state of Washington and a coalition of children's advocates have worked, with the support of all of our delegation, to develop a finely tuned amendment to the CHIP. This amendment is intended to correct an inequity in the legislation that penalized states that had taken the initiative to expand children's coverage under Medicaid to children with family incomes at or above 200 percent of the FPL prior to the enactment of CHIP.

Under our proposed amendment, Washington, Hawaii, Minnesota and Vermont would be able to claim enhanced federal matching payments for a group of optionally categorically needy children. For Washington State, the federal matching rate would increase to 67 percent, from 52 percent. We would only claim from the state's CHIP allotment for the difference between the Medicaid and CHIP matching rates. We structured the amendment in this way to preserve CHIP funds for other states whose CHIP expenditures may exceed their allotments in the future.

The group of children for whom we can claim the enhanced match is defined as the number of optionally categorically needy children above the state's federal fiscal year (FFY) 1997 level, adjusted over time for growth in the state's total children population. By enacting the amendment, we estimate that Washington could save approximately $12 million over the four-year period from FFY 1998 through FFY 2001.

Our delegation's strategy is to include this amendment in the continuing resolution currently being developed. Enactment of this amendment would substantially increase our chances of obtaining authorization from the Washington State Legislature to expand CHIP coverage to new

groups of uninsured children, and would provide much needed funding to help support our commitment to health coverage for low-income families in Washington State.

Our understanding is that White House Domestic Policy staff are comfortable with the substance of our amendment. However, there is a greater political issue involved at this point. White House staff and national children's advocacy organizations are concerned about opening up the CHIP statute this year. They fear that amending the statute to address Washington State's concerns could lead to efforts that could weaken or fundamentally alter the nature of the CHIP program. For example, we understand that Wisconsin is seeking a CHIP amendment that would allow it to use its CHIP allotment to cover adults, as well as children, in low-income families.

Washington State's amendment is clearly distinguishable from that proposed by Wisconsin. Our amendment would use CHIP funds exclusively for coverage of children who would be uninsured, but for the availability of Medicaid coverage. In other words, these are the very children that Congress sought to cover upon enactment of CHIP. We are asking for the same relief that other states, such as Tennessee, Rhode Island and Arkansas, have already obtained for their expansions of Medicaid children's coverage. We agree that if additional amendments are proposed by other states that would have the effect of significantly weakening the CHIP law and enactment of our amendment is conditioned upon inclusion of such additional amendments, it would be reasonable for the White House to oppose inclusion of our amendment in the continuing resolution.

We greatly appreciate your consideration of our request.

Sincerely,

Gary Locke
Governor

cc: Joe Dear, Chief of Staff, Office of the Governor
Lyle Quasim, Secretary, Department of Social & Health Services

Congress of the United States
Washington, DC 20515

October 12, 1998

The Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, SW.
Washington, D.C. 20201

Dear Madam Secretary:

Last year, Congress created the Children's Health Insurance Program (CHIP) to provide health insurance coverage for children in low-income families. The Health Care Financing Administration has done an admirable job in working with states to implement this program expeditiously. We hope that you will continue to adhere to the principle of this program: providing meaningful, affordable health insurance coverage to uninsured, low-income children.

To date, HCFA has approved more than 41 state CHIP plans. But, few of these programs are actually to the point of enrolling new children. It will take time for states to implement this new program. For that reason, we are concerned that some states are asking to spend their CHIP allotment on populations other than children. We believe that it is too early to allow states to diverge from the clear intent of the CHIP program and provide coverage for populations that are not eligible for CHIP as defined in the statute. Congress developed CHIP standards such as eligibility requirements in order to achieve the program's goal -- to reach the maximum number of children with a limited amount of funding.

We are particularly concerned about the use of section 1115 demonstration authority within the CHIP program. Using section 1115 waiver authority to allow states to cover other populations with CHIP funds would circumvent Congressional intent of the new law. In addition, applying section 1115 demonstration waivers to CHIP at this early stage of the program would prevent Congress, HCFA, and the states from ever being able to assess the impact and success or failure of the CHIP program in reaching the uninsured children that are targeted in this legislation.

Section 1115 demonstration authority was intended to allow states to experiment with new approaches to achieving the goals of an established program. By their nature, section 1115 demonstrations are time-limited and require a baseline experience that permits comparisons and an evaluation of results. The CHIP program is barely a year old. Most states only have a few months of experience in their new programs and no program data with which to compare its effectiveness to alternative approaches.

We hope that you will continue your commitment to upholding the principles of CHIP and will continue to work toward reaching the 10 million uninsured children in the country with the funding that was designated for this purpose. We request that the intent of the CHIP program and the intent of section 1115 demonstration waivers not be undermined by using flexibility inappropriately.

Sincerely,

John D. Dingell
Member of Congress

Orrin G. Hatch
U.S. Senator

Henry A. Waxman
Member of Congress

Daniel Patrick Moynihan
U.S. Senator

J. Robert Kerrey
U.S. Senator

Fax to Cindy Mann, plain paper Fax cover, and say Closet fold / Comments by COB, from me + you.

Dear State Health Official:

improve enrollment of [Double space between sentences]

408-1056

The Department of Health and Human Services issued a letter on January 23, 1998 regarding outreach opportunities to uninsured children. In that letter, DHHS described the requirement under the State Children's Health Insurance Program (CHIP) to ensure that children found through screening to be eligible for Medicaid are enrolled in Medicaid. This letter provides additional guidance on the Medicaid "screen and enroll" requirement in the CHIP law under section 2102(b)(3)(B).

"Screen and Enroll" requirement

The "screen and enroll" requirement is critical to ensuring that children are covered by the appropriate program. One of the principles of the CHIP legislation is that coverage should be extended to uninsured children and that CHIP programs should not supplant existing public or private coverage. Although States electing to expand Medicaid under CHIP are exempt from this requirement because eligibility for regular Medicaid will be determined as part of the eligibility process for the CHIP expansion, States using CHIP funds to establish separate, non-Medicaid health insurance programs must screen all applicants for Medicaid eligibility and enroll them in Medicaid if they are eligible. This requirement ensures that any child applying for CHIP ~~who is found through screening to be eligible for Medicaid will be enrolled in Medicaid~~. who is eligible for either CHIP or Medicaid gets enrolled in the right program.

The simplest way to meet the "screen and enroll" requirement is to use a joint application form. A State would review the joint application and determine CHIP or Medicaid eligibility concurrently, without requiring the family to submit additional information. Medicaid enrollment can be accomplished without referring the family to another office or completing another application. A number of States with separate CHIP programs are using or are planning to use a joint application form. (Note: DHHS has developed a model application for CHIP and Medicaid. Please see the form in the September 10, 1998 eligibility letter on the HCFA website at www.hcfa.gov.)

The following are two ~~models that~~ examples of using a joint application: States ~~might consider in developing an effective "screen and enroll" procedure~~:

- **Joint application / State agency determines eligibility:** ~~A State develops a single application for determining eligibility for both Medicaid and CHIP~~. The State uses the same State agency staff to determine eligibility for both ~~programs~~. Medicaid + CHIP using a joint application.

  Oregon uses this approach. The State has developed a joint application for Medicaid and its non-Medicaid CHIP, and State workers will determine eligibility for both programs. The State ~~will~~ conducts a full Medicaid eligibility determination to ~~discern~~ determine whether the child is Medicaid eligible. If the child is eligible for Medicaid, she or he ~~will be~~ is enrolled in that program. If the child does not meet the Medicaid eligibility criteria, the State ~~will~~ further screens the application to see if the child meets CHIP criteria. If so, the child ~~will be~~ is enrolled in CHIP.

- **Joint application / Private entity performs "initial processing":** A State develops a single application for determining eligibility for both programs. In this case, a private entity (paid with CHIP funds) screens for potential eligibility for Medicaid and determines eligibility for CHIP. If the screen indicates the child is likely to be Medicaid eligible, Medicaid agency staff will make the final eligibility determination for Medicaid.

  Connecticut uses this approach. The State has developed a two-page application for its "HuskyCare" program, which screens for both Medicaid and CHIP eligibility. The State contracts with an independent entity to provide limited eligibility and enrollment functions. When the contractor receives an application for HuskyCare and the child appears to be Medicaid eligible, it will send the application to the appropriate Department of Social Services office for a final eligibility determination.

  Florida is another example of a State using this approach. When the joint application for the Healthy Kids program is received, enrollment staff will screen it for Medicaid eligibility. Children appearing to be Medicaid eligible are immediately forwarded to the Department of Children and Families for a final Medicaid eligibility determination. These applications will not be processed for Healthy Kids eligibility until they have been deemed ineligible for Medicaid.

If a State chooses to use separate applications for its Medicaid and CHIP programs, it is still required to implement mechanisms that ensure that Medicaid eligible children applying for CHIP are enrolled in the Medicaid program. If separate applications are used, procedures are needed to assure compliance with the "screen and enroll" requirement. These procedures cannot place the entire burden for application on the family. They must include reasonable actions on the part of the State to ensure enrollment into Medicaid. At a minimum, State screening processes should assure that all children who are potentially eligible for Medicaid under the poverty-level-related groups are identified. The State may initially use a gross income test that compares total family income to the applicable Medicaid standard. The initial gross income test would immediately identify children whose family income is low enough that Medicaid eligibility would be almost certain. A second test would be needed, however, to detect those children whose gross family income exceeds the Medicaid standard but who are Medicaid-eligible when income disregards are applied. Without this second test, the State would not be meeting its responsibility to ensure that children eligible for Medicaid are identified and enrolled in Medicaid.

In general, we believe that using separate applications for CHIP and Medicaid provides fewer safeguards for ensuring that children are enrolled in the appropriate program. If a State is using separate applications for its Medicaid and separate, non-Medicaid CHIP programs, special attention will be paid during the review process to the referral and enrollment procedures established by the State in order to ensure that the "screen and enroll" requirements are met.

Refusal to Apply for Medicaid or Failure to Complete the Application Process

Some States have raised the concern that the screen and enroll procedure may cause families to refuse to apply for Medicaid or fail to complete the application process, leaving some children

uninsured. States should make every effort to ensure that a decision by a family not to apply for Medicaid or not to complete the application process is an informed one. The screen and enroll procedures must provide the family with full and complete information about Medicaid, including the early prevention, screening, diagnosis and treatment benefits, the prohibition against cost sharing, and the differences between and advantages of Medicaid over the State's CHIP program. The process must ensure that the family understands the consequences of not applying for Medicaid or failing to complete the application process.

We believe that Congress intended that children eligible for Medicaid be enrolled in the Medicaid program. It is the Department's policy that if a child is found through a State screening process to be eligible for Medicaid and his or her family does not apply for Medicaid or fails to complete the application process for any reason, the child cannot be enrolled in CHIP. Enrollment in CHIP can occur only after a full Medicaid determination shows that the child is ineligible for Medicaid.

[Redundant]

When the family applies for Medicaid, the State should afford a reasonable opportunity to complete the application and should offer whatever assistance it can in helping the family obtain required documentation and complete the application. Simplifying and shortening the process should help reduce situations where families fail to complete the applications.

If you have any questions about how to fulfill the CHIP "screen and enroll" requirements, or any other part of this guidance, please contact your HCFA Regional Office.

FAX COVER SHEET

OFFICE OF LEGISLATION

Number of Pages:_____ Date: _____

To: Deborah Adler
Kate Kirchgraber

From: Jennie Bonny

Fax: _____

Fax: 202-690-8168 or 205-5157

Phone: _____

Phone: _____

REMARKS: KY CHIP info

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

March 10, 1999

Note to Robin Bowen

Subject: Coverage of Children of State Employees Under CHIP

Attached is a paper describing the chronology of HCFA's decision making process on the coverage of children of State employees under the Children's Health Insurance Program (CHIP) plus a further explanation of the differences between Arkansas and Kentucky State employee coverage. I believe that these are consistent with what Mike Hash and Debbie Chang explained to you last week. If you have further questions, please contact me at 690-7762.

Don

Don Johnson
Ofice of Legisaltion

Attachment

Coverage of Children of State Employees
Under Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) statute, Title XXI of the Social Security Act (Act), primarily provides for funding child health assistance for children who are uninsured. The provisions of the CHIP statute demonstrate that Congress and the Administration did not want to "crowd out" existing resources by displacing current coverage or substituting Federal dollars for private and public dollars already spent on coverage. The first protection against such crowding out is that children with other health insurance coverage are excluded from the definition of a targeted low income child. Only targeted low income children are eligible under either a separate CHIP program or a CHIP-related Medicaid expansion (under Title XIX of the Act).

Under the CHIP statute, there is an additional exclusion from the definition of targeted low income child for children of public agency employees who are eligible for health benefits coverage under a State health benefits plan. This exclusion is contained in section 2110(b)(2)(B) of the Act, and applies to separate CHIP programs. The Medicaid definition of optional targeted low income children (who may be eligible in a CHIP-related Medicaid expansion) does not refer to this exclusion. Instead, the Medicaid definition at section 1905(u)(2) of the Act refers only to section 2110(b)(1) of the Act.

The wording of the CHIP exclusion for public agency employees includes any "child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State." This means that even if the child is eligible and offered coverage but the family does not accept or take the coverage, the uninsured child is not eligible for CHIP.

We have interpreted "State health benefits plan" to include only situations in which the State makes available an actual "benefit," in the form of a subsidy to cover part or all of the cost of coverage for a dependent child in the family. (North Carolina and Mississippi meet this standard and, therefore, they can cover such children in their separate CHIP program.) A subsidy is present whenever the State contribution for health coverage could exceed the minimum amount necessary for coverage of the employee alone, because that contribution is then available to cover part or all of the cost of dependent coverage. (Arkansas and Kentucky are in this situation and therefore, they cannot cover such children in their separate CHIP program. See further explanation of these States in Attachment A) This applies regardless of whether the State offers a defined benefit plan or a defined contribution applicable to a range of optional benefits.

In other words, if the family must pay the full cost of coverage for dependents, then effectively no benefit is available, and children in the family could be eligible for a separate CHIP program. On the other hand, if the State makes available a subsidy for the cost of coverage beyond the amount needed to cover the cost of the employee alone, then a subsidy would be available for dependent coverage, and children in the family would not be eligible.

As noted above, in defining the population included in CHIP-related Medicaid expansions, the definition of an "optional targeted low income child" in section 1905(u)(2) of the Act does not refer to 2110(b)(2)(B) of the Act, where the public agency employee eligibility exclusion is contained. Instead, the Medicaid definition refers only to section 2110(b)(1). The Department has interpreted this to mean that this exclusion does not apply to Medicaid expansion programs.

Attachment A

Kentucky and Arkansas Differences

This is a explanation of the difference between the state employee health benefits plans in Kentucky and Arkansas. Although both states do not qualify for our "state work exception," each state fails to qualify for a different reason.

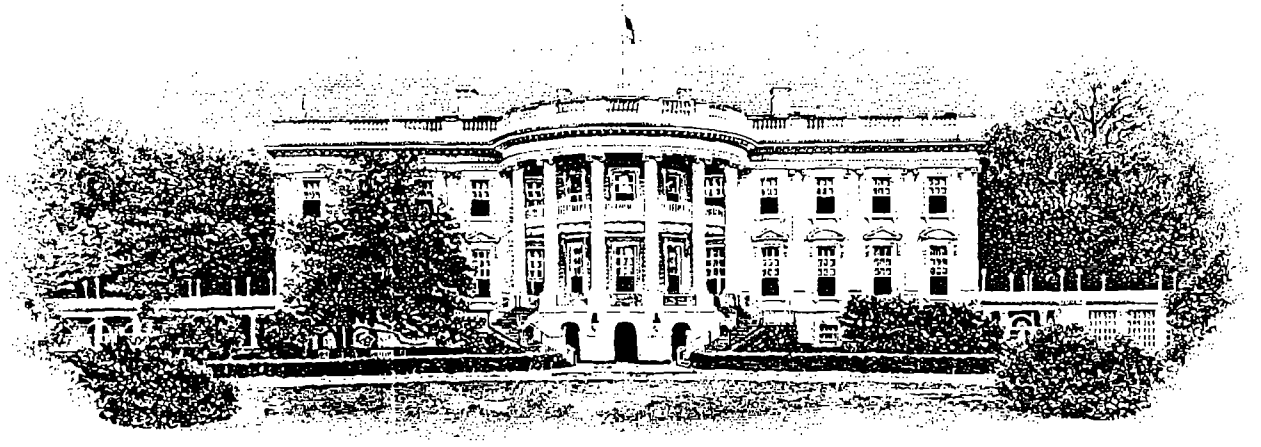
Kentucky: The State makes a defined contribution for state employee health insurance coverage. The state does not change the contribution it makes if a state worker purchases dependent coverage. Under most circumstances, a flat contribution would allow a state to qualify for our state worker exception. There is a two-part reason why Kentucky does not qualify for our exception: (1) some individual insurance coverage options are cheaper than the defined contribution ($203 in 1999); and (2) state workers have flexible spending accounts which give those employees the flexibility to take any money remaining after the purchase of individual coverage and spend it on other benefits (such as dependent coverage). This 'left over' money constitutes a "benefit" that is available.

Arkansas: The State does **not** make a defined contribution for its state employee health benefits coverage. Instead, workers who cover dependents receive considerably higher state contributions than workers who only cover themselves. The rates are as follows:

Insurance Category	**State Contribution (1998)**
Employee Only	$159
Employee + Spouse	$246
Employee + Child	$216
Employee + Family	$363

Therefore, Arkansas clearly offers a dependent coverage benefit to its state employees which does not allow it to qualify for our exception.

THE WHITE HOUSE
OFFICE OF INTERGOVERNMENTAL AFFAIRS



FAX COVER SHEET

To: Devorah Adler

From: Todd Blidaar

Date: _____ **No. of Pages:** _____

Phone: _____ **Fax:** 65557

Phone: 202/456-2896 **Fax: 202/456-2889**

Message: _____

To:

The Honorable Paul Patton

Dear Governor Patton:

Upon further review of the Kentucky health care system it is our opinion that dependents of state employees should be eligible to participate in the Kentucky Children's Health Insurance Program (KCHIP).

The original findings of the Health Care Financing Administration of HHS questioned the eligibility of the dependents of state employees on the grounds that the State contributed to dependent health care coverage. With your urging we reevaluated the historic materials on the Kentucky employee health benefits plan and have found that the State has only provided coverage for the employee and offered employees the option to purchase dependent coverage at the group rate, but without a state contribution.

It is our opinion that Kentucky should be treated like Mississippi and North Carolina for purposes of determining CHIP eligibility for dependents of state employees. It should also be noted that Kentucky is unique in how they have structured their health contribution and we are not of the opinion that by accommodating Kentucky's unique situation any other states would be affected.

We continue to support your efforts to provide health insurance to children in your state and hope this proves helpful in clearing up the confusion with committee staff.

Sincerely,

(Yet-to-be- determined White House Official)

Office of Legislation

HCFA
MEDICARE • MEDICAID

Number of Pages: _____ Date: 10/23/98

To: Jeanne / Deborah
Kate

From: Jennie

Fax: _____

Phone: _____

Fax: _____

Phone: _____

REMARKS: Thanks for reviewing!

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

DRAFT 10/23/98

Dear State Health Official:

The Department of Health and Human Services (DHHS) issued a letter on January 23, 1998 regarding outreach opportunities to uninsured children. In that letter, DHHS described the requirement under the State Children's Health Insurance Program (CHIP) to ensure that children found through screening to be eligible for Medicaid are enrolled in Medicaid. This letter provides additional guidance on the Medicaid "screen and enroll" requirement in the CHIP law under Section 2102(b)(3)(B).

"Screen and Enroll" requirement

The "screen and enroll" requirement is critical to ensuring that children are covered in the appropriate program. One of the principles of the CHIP legislation is that coverage should be extended to uninsured children and that it should not supplant existing coverage. This requirement ensures that any child applying for CHIP who is found through screening to be eligible for Medicaid will be enrolled in Medicaid.

States that establish separate CHIP programs are required to include in their Title XXI State plan a description of procedures that will be used to ensure that children found eligible for Medicaid through intake screening or follow-up are enrolled in Medicaid. In our letter of January 23, 1998, we set forth the following minimum guidelines for State screening processes to identify children who are potentially eligible for Medicaid.

~~At a minimum~~, State screening processes should assure that all children who are potentially eligible for Medicaid under the poverty-level-related groups are identified. The State may initially use a gross income test that compares total family income to the applicable Medicaid standard. The initial gross income test would immediately identify children whose family income is low enough that Medicaid eligibility would be almost certain. A second test would be needed, however, to detect those children whose gross family income exceeds the Medicaid standard but who are Medicaid-eligible when income disregards are applied. Without this second test, the State would not be meeting its responsibility to ensure that children eligible for Medicaid are identified and enrolled in Medicaid. ~~(Some States have used this technique with simplified Medicaid applications.) Screening is not required for States that elect to expand Medicaid under CHIP because the child's eligibility for regular Medicaid will be determined as part of the State's process for determining eligibility for the CHIP expansion.~~

We indicated that the State's procedures for enrolling children found potentially eligible for Medicaid through screening had to involve more than a simple referral. We also stated that we would provide additional guidance on options for meeting the "screen and enroll" requirement.

The simplest way to meet the "screen and enroll" requirement is to use a joint application form. A State would screen the joint application for Medicaid eligibility and determine CHIP eligibility consecutively without asking the family for additional information. Medicaid enrollment can be accomplished without referring the family to another office or completing another application. A number of States with separate CHIP programs are using or are planning to use a joint application form. (Note: DHHS has developed a model application for CHIP and Medicaid. Please see the form in the September 10, 1998 eligibility letter on the HCFA website at www.hcfa.gov.)

move to insert

~~States also have the option of using separate application forms for CHIP and Medicaid~~. If separate applications are used, procedures are needed to assure compliance with the "screen and enroll" requirement. These procedures cannot place the entire burden for application on the family. They must include reasonable actions on the part of the State to assure enrollment into Medicaid. In general, ~~we believe~~ that using separate applications for CHIP and Medicaid provides fewer safeguards for ensuring that children are enrolled. States that choose this option might want to determine how well the system works by analyzing the number of children enrolled in Medicaid compared to the number who were screened as being potentially eligible for Medicaid.

three examples of States using a joint application:

The following are ~~several models that States might consider in developing an effective "screen and enroll" procedure~~:

- **Joint application/State agency determines eligibility:** ~~A State develops a single application for determining eligibility for both Medicaid and CHIP. The State uses the same State agency staff to determine eligibility for both programs~~.

  Oregon uses this approach. The State will use a joint Medicaid/CHIP application, and the same State workers will determine eligibility. The State will first determine if an applicant under the age of 19 meets Medicaid eligibility criteria. If the child is eligible for Medicaid, the child will be enrolled in that program. If the child does not meet Medicaid eligibility criteria, the State will further screen the application to see if the child meets CHIP criteria. If so, the child will be enrolled in CHIP.

- **Joint application/Private entity performs "initial processing:"** ~~A State develops a single application for determining eligibility for both programs. In this case, a private entity (paid through CHIP) screens for potential eligibility for Medicaid and determines eligibility for CHIP. If the screen indicates the child is likely to be eligible for Medicaid, Medicaid agency staff will make the final eligibility determination for Medicaid~~.

  Connecticut is one example of this approach. The State has developed a two-page double-sided application for "Husky," which ~~includes both Medicaid and its CHIP program.~~ ~~The State contracts with an entity, which is responsible for certain eligibility and enrollment functions, to be a single point of entry servicer (SPES). When the SPES receives an application for Husky and the child appears likely to be eligible for Medicaid,~~

insert (3)

insert (4)

the SPES will send the application to the appropriate Department of Social Services (DSS) office for Medicaid processing. The family will not have to fill out a second application at the local DSS office if it has already filled out a request for Husky at the SPES.

Florida is another example. When the joint application for medicaid and "Healthy Kids" is received, enrollment staff will screen it. Applications of children who appear to be eligible for Medicaid will be immediately forwarded to the Department of Children and Families (DCF) for full determination of Medicaid. Staff of the DCF will be co-located on the premises of the Healthy Kids Corporation. These applications will not be processed for Healthy Kids until they have been deemed ineligible for Medicaid.

Insert (A)

- **Separate application/Co-location of CHIP and Medicaid eligibility workers:** A State uses separate applications for the two programs, but CHIP and Medicaid eligibility workers are located at the same site. The information from CHIP applications found through screening to be likely eligible for Medicaid will be sent to the Medicaid agency staff for final determination.. The CHIP application, for example, could include a statement that the information will automatically be sent to the Medicaid office to begin the Medicaid application process for children who appear to be Medicaid eligible. If the family chooses not to apply for Medicaid, they should be informed of the implications of not applying for both programs. (Note: There are no State examples of this approach to date.)

- **Separate application/State sends potentially eligible applications to Medicaid:** A State uses separate applications for the two programs. All CHIP applications are screened for Medicaid eligibility. CHIP applications found through screening to be likely to be eligible for Medicaid are sent to the Medicaid agency for an eligibility determination. The date of the Medicaid application is the date the applicant filed for CHIP. The information already supplied for CHIP does not have to be supplied again by the applicant. If additional information is needed from the applicant, however, the State contacts the applicant to send or bring in the required documentation (e.g., signature). The CHIP application is not processed unless the applicant is found ineligible for Medicaid.

  Montana uses this strategy. All applications for CHIP are screened for Medicaid eligibility. On the fifth working day after receipt of a complete CHIP application, the family is notified that the children are eligible or ineligible for CHIP. If the children are potentially eligible for Medicaid, information from the CHIP application is transferred to the Medicaid application and forwarded to the county public assistance offices to begin the Medicaid application process (unless the family indicates that it does not want this information forwarded). Children who are potentially Medicaid eligible are sent a CHIP denial letter and a full Medicaid application form. If a family is subsequently found ineligible for Medicaid, the family must send the Medicaid denial letter to the CHIP program in order to have CHIP eligibility determined.

Refusal to Apply for Medicaid or Failure to Complete the Application Process

{Note: We are still considering whether to include this section or just keep as our internal policy. We would appreciate your input.} Some States have raised a concern that in the screen and enroll process some families may refuse to apply for Medicaid or fail to complete the application process leaving the children uninsured. We believe that Congress intended that children eligible for Medicaid be enrolled in Medicaid. It is HCFA's policy that if a child is found through a screening process to be eligible for Medicaid and his or her family either refuses to apply for Medicaid or fails to complete the Medicaid application process for any reason, the child cannot be enrolled in CHIP. Enrollment in CHI can occur only after a full Medicaid determination shows that the child is ineligible for Medicaid.

The State's enrollment procedures must be designed to assure that a decision by a family not to apply for Medicaid or not to complete the application process is an informed. The procedures must provide for giving the family full and complete information about Medicaid, including the benefit package for children, the prohibition against cost-sharing for children and, as appropriate, the advantages of Medicaid over the State's CHIP program. The procedures must ensure that the family understands the consequences of not applying for Medicaid or completing the application.

If the family applies for Medicaid, the State should afford a reasonable opportunity to complete the application and should offer whatever assistance it can in helping the family obtain required documentation and complete the application. Simplifying and shortening the process should help reduce situations where families fail to complete the applications.

If you have any questions about this guidance, please don't hesitate to contact your HCFA Regional Office.

Sincerely,

Sally K. Richardson
Director

WELFARE TO WORK		
As a result of welfare reform, many people are leaving welfare rolls. Although federal legislation supposedly ensures that families continue to receive Medicaid—at least for a transitional period—when they return to work, dramatic drops in Medicaid caseloads suggest that a large number of people are not getting these benefits.		
Yes	**No**	**My state . . .**
		Allows families to retain Medicaid even if they lose TANF for failing to meet work requirements.
		Provides outreach to families leaving the TANF rolls to inform them of their continuing eligibility for Medicaid.
		Provides outreach to low-income working families about the possible eligibility of family members—parents and children—for Medicaid.
		Provides automatic Medicaid eligibility for TANF recipients.
		Has increased the earnings "disregards" (i.e., the amount of money that does not have to be included in the total when determining income for eligibility) for working families.
		Processes Medicaid applications from families who are diverted from applying for TANF. Some states attempt to divert persons from the welfare rolls by providing emergency assistance, requiring job searches, or requiring families to search for other means of support before filing a TANF application. These families may be eligible for Medicaid immediately.

For more information about the issues discussed above, contact:
Families USA, 1334 G Street, N.W., Washington, DC 20005.
Phone: (202) 628-3030.
Fax: (202) 347-2417.
E-mail: info@familiesusa.org

Families USA FOUNDATION
The Voice for Health Care Consumers

Medicaid Checklist

How Consumer-Friendly Is Your State's Medicaid Program?

Is your state doing everything it can to protect consumers under Medicaid managed care? to ensure that seniors who are eligible for assistance with Medicare premiums and cost-sharing get help? to ensure that persons leaving the welfare rolls still get Medicaid benefits? This checklist will help you assess your state's efforts.

If you answer "No" to any of the questions below, your organization may want to lead a campaign to improve your state Medicaid program. If you do want to do a Medicaid campaign, feel free to contact Families USA for help—we may be able to provide you with written and/or technical assistance on the issue.

Medicaid Managed Care

States are moving or have already moved large numbers of consumers into Medicaid managed care plans. Managed care is a complicated system. Consumers need to know a good deal about gaining access to services, what to do when a service is denied, and even basic information on how managed care is intended to work.

ENROLLMENT		
Yes	**No**	**My state is . . .**
		Ensuring that at least 75% of Medicaid managed care enrollees choose their own managed care plan, decreasing the number of default or automatic assignments. When fewer than 75% of beneficiaries select their plan, the states should extend the time for beneficiaries to choose plans and should take other corrective action.
		Coordinating its Medicaid and CHIP enrollment effort. Coordination of enrollment for both Medicaid and CHIP will insure that applying for health coverage is family-friendly and that persons eligible for either program are enrolled—not referred to another department. Many families will be making the transition from welfare to work; they may continue to qualify for Medicaid or they may move to CHIP. Coordinated enrollment efforts are both cost-effective and in the best interests of children.
		Using either an Enrollment Broker or agency staff to provide educational information about managed care and about the participating providers. Managed care is very different from traditional health insurance. Consumers have the right to receive understandable information prior to or at the time of enrollment. A neutral entity—not a managed care plan—should provide assistance with the enrollment and disenrollment process to all eligible consumers.
		Providing clear information regarding each plan and participating providers of the plan.
		Making sure that when beneficiaries are automatically assigned to plans and providers, every effort is made to ensure continuity with their previous providers, both in making assignments and when the beneficiary is choosing a provider within the plan.

Families USA • 1334 G Sti • Washington, DC 20005 • (202) 628- 30 • e-mail: info@familiesusa.org

COMPLAINTS AND GRIEVANCES

Yes	No	My state is . . .
		Establishing a centralized grievance/hearing system that is consumer-friendly. For example, Tennessee's system records all grievances centrally, so that the 90-day time limit to a fair hearing decision begins running as soon as a beneficiary makes a complaint and the state has records of all complaints.
		Establishing an expedited grievance and hearing system. State standards should require that expedited grievances be resolved within 24 hours of the call.
		Ensuring that managed care plans routinely notify beneficiaries in plain language of their right to continued services pending a hearing whenever the plans reduce or terminate benefits.

ACCESS TO PROVIDERS

Yes	No	My state is . . .
		Establishing and monitoring: ■ ratios of full-time-equivalent providers to patients. ■ waiting times for emergency, urgent, sick, and routine care appointments.
		Maintaining state standards that address both specialty and primary care.
		Ensuring that traditional providers continue to receive contracts and adequate reimbursements under Medicaid managed care.
		Overseeing the development and operation of transportation systems that meet the needs of managed care consumers. Particular attention should be given to rural and medically under-served areas. People must be able to get to all of the medical services they need, and states or their contractors must offer transportation assistance to families so that children can get to health screening and treatment appointments.

CHRONIC AND DISABLING CONDITIONS

Yes	No	My state is . . .
		Considering the distinct needs of the individual (if the state is enrolling persons with special needs). Persons with special needs, their families and advocates need to be involved in the managed care planning process. States should write detailed contracts concerning the types of services that must be offered and requiring coordination with various public agencies. States should use risk-sharing arrangements and adjusted capitation rates to ensure that adequate resources are available to serve persons with special needs.
		Defining "Medically Necessary" (in contracts with managed care plans) to include services that prevent conditions from worsening and that maximize functioning. In managed care, one crucial issue is what is defined as "medically necessary." Services and treatments that the plan does not consider to be medically necessary will be denied. States need to assume responsibility for establishing a strong definition.

		Assuring that network providers are in compliance with the Americans with Disabilities Act (ADA) regulations.

QUALITY ASSURANCE

Yes	No	My state is . . .
		Adopting standards for immunization rates, EPSDT compliance, and clinical care—particularly for prevalent conditions such as asthma, hypertension, HIV, and diabetes; monitoring compliance with these standards; and sanctioning plans that don't meet the standards.
		Collecting encounter data as another means for evaluating managed care.
		Collecting data on grievances at the plan level, complaints to the state and/or its hotline, and fair hearing requests.
		Developing a plan to resolve problems, based on the findings from audits and quality reviews.
		Providing consumers and advocates with access to information regarding quality.
		Reviewing plans' reports on utilization, HEDIS, and financial information specifically for their Medicaid products as another means of monitoring quality.

Other Medicaid Issues

QMB/SLMB FOR LOW-INCOME MEDICARE BENEFICIARIES

Medicare buy-in benefits were created by Congress to help low-income Medicare beneficiaries pay their share of Medicare premiums, and, in some instances, deductibles and copayments. The programs for Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualified Individuals (QI-1 and QI-2) are administered by state Medicaid agencies. Nationally, fewer than half of the persons eligible for these benefits actually receive them.

Yes	No	My state . . .
		Uses a simplified Medicaid application process and short application form for QMB/SLMB.
		Has established QMB/SLMB income standards for families of three or more rather than applying SSI income standards for two persons to larger households.
		Entered into a Part A Buy-In agreement with HCFA so that people can enroll in the QMB program at any time during the year. Without such an agreement, persons who must buy Part A may be denied QMB participation for as long as 16 months.
		Pays cost-sharing up to the full Medicare rate and pays Medicare copayments for QMBs enrolled in Medicare managed care.

Families USA
FOUNDATION
The Voice for Health Care Consumers

MEMORANDUM

To: Medicaid Advocacy Network
From: Jeff Kirsch, Field Director
Subj: New State Medicaid Program Evaluation Tool
Date: October 14, 1998

Families USA has produced a new tool to help you assess your state Medicaid program and find out quickly if there are ways you can work to improve it. The "Medicaid Checklist" (copy enclosed) can help you identify weaknesses in your state Medicaid program: Is your state coordinating Medicaid and CHIP enrollment? Establishing a consumer-friendly, centralized complaint/grievance system? Using a simplified application process for low-income Medicare beneficiaries (QMBs) who want to apply for assistance?

If you answer "No" to any of these or other questions on the Medicaid Checklist, your organization may want to spearhead an effort to correct these problems. Let us know if you do: we may be able to provide you with assistance. You can contact us by calling 1-800-593-5041, ext. 3631 (for Jeff Kirsch) or by sending e-mail to: jkirsch@familiesusa.org. We also urge you to check out the *Medicaid Clearinghouse* on the World Wide Web. You can get there via our home page: www.familiesusa.org.

Also, a reminder: If you need another copy of one of our Medicaid *Guides*, please let us know. The *Guides* cover the issues of enrollment and marketing in managed care, appeals and grievances, access to providers in Medicaid managed care, cost-sharing, and the needs of people with disabilities or chronic conditions in Medicaid managed care.

To Your Health!

1334 G Street, NW • Washington, DC 20005 • 202-628-3030 • Fax 202-347-2417
E-Mail: info@familiesusa.org Web site: www.familiesusa.org

South Dakota

CSDR00024
Michael Penticoff 605/734-5511
Mid Dakota Hospital
300 South Byron Blvd..
Chamberlain, SD 57325
FY97 $122,000 FY98 $100,000 FY99 $80,000

The area covered by the Mid-Dakota Hospital project is over 3,900 square miles and has a population of only 12,434. The project covers 4 counties in South Dakota with two American Indian Reservations included. The primary focus of the project is to enhance the Emergency Medical Services System. There are 5 area emergency service providers participating in this project which will initiate enhanced medical services training to hospital and emergency personnel, provide more up-to-date medical equipment on the ambulances, and provide community accident prevention information. The project will use the current area resources and build on them to increase their EMS volunteer staff numbers and educational level to provide more timely emergency service with better medical outcomes for the population of this frontier area. The network includes the hospital and 5 separate ambulance services.

Tennessee

CSDR00034
George Austin 901/658-3100
Bolivar General Hospital
650 Nuckolls Road
Bolivar, TN 38008
FY97 $188,325 FY98 $188,717 FY99 $194,425

This project is providing programs in Hardeman county in rural west Tennessee to deal with the issues of lack of prenatal care, infant death rate, teenage pregnancy and sexually transmitted diseases. The target population of pre-teen and teens are white and African American. Workshops will be implemented for pre-teen and teens (girls ages 9 through 17 and boys ages 10 through 13) and their parents on issues surrounding health, sexuality, personal hygiene. The second component of this project is an adaptation of the Healthy Start Hawaiian home visiting program. This program will identify mothers at high risk for s tress and being overburdened, to help reduce the incidence of child abuse and neglect, increase immunization rates for young children, ensuring prenatal care and detecting and remedying developmental delays in young children. The network members include Bolivar General Hospital, health department, community health center, legal services, social services, and school system.

CSDR00007
Connie Sharp
Columbia Area Mental Health
P.O. Box 513
Hohenwald, TN 38462
615/796-5916

FY97 $192,420 FY98 $182,500 FY99 $182,500

This project is designed to provide mental health treatment, alcohol and drug abuse treatment and other supportive services for the unmet needs of the low income residents of Lewis County, one of the poorest counties in Tennessee. The supportive services include transportation, ambulatory equipment and emergency assistance for low-income elderly, and for pregnant teenagers, transportation and housing assistance. The target population for the project are the low income residents of the country who are ineligible for these services under local managed care plan. The majority of the county population is Caucasian with a small percentage of African Americans and Hispanics. The network members include Columbia Area Mental Health Center, drug abuse treatment center, community home health agency, the Home Ties Program and county school system.

Texas

CSDR00018
David Shaw
Pecos County Memorial Hospital
Sanderson Hwy.
P.O. Box 1648
Fort Stockton, TX 79735
915/336-2241 Ext. 111

FY97 $199,954 FY98 $198,771 FY99 $198,336

The Pecos County Memorial Hospital will serve as lead agency in the formation of a vertically integrated network (Trans-Pecos Primary Care Initiative Network) that will provide primary care to the target population in the upper Rio-Grande Valley of Texas along the Texas-Mexico border. Over 90% of the health care providers in this three county area will participate in the network including: federally qualified health centers, public health departments, outpatient mental health services, school districts, a state university, WIC and two hospitals. The population to be served includes children, families, adults, 45 migrant farm families, as many as 5,000 uninsured Hispanics, 1,760 seniors and about 11,400 tourists and visitors who travel through the area each year. The target area has one of the highest poverty levels in Texas with 32% of the children living below poverty and over 40% of the Hispanic population living below the poverty level. The counties also face the problems of illicit drug trafficking from Mexico and a border black-market economy. A primary problem is the population go into Mexico for medicinal drugs that don't need a prescription and are cheaper to purchase which leads to self-medication with poorer health outcomes. The focus areas of the project are adolescent health and school populations, training for local health professionals and school personnel in district/disease prevention and health promotion, ambulatory and mental health care, enhanced EMS services, and increased access through outreach and transportation.

General questions: How long are these workers typically hired for? If it is a few months, that is one thing, but if they are already starting to hire them, these jobs could be a year or two, right? If so, we are kind of asking a low.

Also, can states explicitly disregard a "Census earning" as a category of income?

Finally, it sounds strange that the Census Bureau does not provide them health coverage -- don't all other Federal employees get such coverage?

Dear State Health Official:

I am writing to encourage you to take steps to ensure that ~~persons who are temporarily hired by the Census Bureau to assist in~~ **temporary employment for the** Census 2000 **does not make people lose eligibility** ~~are not made ineligible~~ for Medicaid or **the** ~~separate State~~ Child**ren's** Health Insurance Programs (CHIP) ~~because of the pay they receive from the Census Bureau~~. [

Census 2000 offers a unique work opportunity for welfare recipients **and other unemployed people** to earn money while ~~receiving training and~~ developing work skills that can be ~~a~~ valuable ~~first step toward entering~~ **in** the workforce. [moved from later] The Census Bureau estimates that there may be several million applicants for these temporary Census positions. Under the President's welfare-to-work initiative, the Census Bureau has the goal of hiring 4,000 welfare recipients. ~~There will be a far greater number of persons hired who will not be welfare recipients, but may be enrolled in or eligible for Medicaid.~~

Unfortunately, for some people covered by Medicaid or CHIP, this income can make them ineligible for this health coverage. Although ~~m~~Many welfare recipients may not lose Medicaid because of ~~the protection afforded by~~ the transitional Medicaid benefit ~~in your State. However~~, others may no longer qualify for Medicaid because of temporary Census Bureau earnings. **Children of such workers are vulnerable as well.**

[new paragraph] **Thus, w**~~W~~e encourage you to take advantage of the flexibility that exists under Title XIX and Title XXI~~,~~ of the Social Security Act~~,~~ to disregard Census earnings for the purpose of Medicaid and CHIP eligibility determinations. ~~(A few Medicaid eligibility groups are subject to limits on Federal financial participation).~~ **This will allow workers to take this temporary job without fearing the loss of their own health coverage or that of their children.** Since hiring is already underway, we **would** also encourage you to submit the necessary Medicaid and CHIP State plan amendments so that they can be made effective as soon as possible.

Additionally, t~~T~~his represents **a** ~~another~~ significant outreach opportunity for finding and educating **workers** ~~families~~ and **their** children **about their potential eligibility for**

Medicaid and CHIP~~and potential dual eligibles among this group of applicants~~. The Census Bureau is prepared to work with you in this outreach effort and will be contacting you to discuss **possible options** ~~necessary arrangements~~. We hope that you will join us in meeting this challenge.

Sincerely,

Sally K. Richardson
Director

Caring Program National Update
November, 1998

Alabama	Will continue program; focus on community outreach and education/school programs, supplementing the state's CHIP program. Blue Plan recently awarded the CHIP contract, will be coordinated through the Caring Program. Will combine fundraising/free coverage with state funded Chip program.
California Kids	Will roll kids to state program. Blue Plan is no longer major sponsor. May move toward other benefits (mental health) or daycare or special projects for children in hospitals over extended stays. Will likely offer coverage to children with residency issues, emancipated minors, others ineligible for CHIP.
BCBS Colorado Foundation	Will pull support from Colorado CHIP and fund the Nevada Caring Program Dental Van, other local health charities.
Georgia	State "Peachcare" CHIP program scheduled to begin 1/99. Stopped enrollment Nov. 1. Will pay premium on kids until 3/31. Researching new programs, considering a mobile van program to deliver care to O-5 population in daycare centers, including health education and Medicaid/CHIP enrollment. All plans contingent upon the upcoming merge of Wellpoint/BCBSGA. Admin. Support beyond 1999 questionable.
Idaho	Closed program.
Iowa	Will transition children to Healthy Kids of Iowa. Researching new children's health focus for philanthropy, to include some (if not all): 800 # health referral phone line; mobile health; rural health access—all children's initiatives.
Kansas	Will close program December 31, 1998. Concentrate on transition of kids to the state program for now, may investigate another philanthropic mission.
Louisiana	State will offer CHIP coverage in steps; Caring Program will expand eligibility in to pick up in the interim. Considering a mobile health project once CHIP program is rolled out fully.
Maryland	Will close program; transition kids to state program. Will keep the community grants program.
Massachusetts	Less affiliated with the Blue Plan, though receives admin. support. Ended insurance program before CHIP an issue. Innovative community health programs in low income neighborhoods/hunger projects/health van/healthy communities– deliver direct care to "at risk" children in current Caring Program. May change name to "BCBS-Mass. Health Foundation"
Michigan	Closed program. Kids transferred to "Michild." BCBSMI Foundation/Community grants program still active.
Mississippi	Closed program before CHIP inacted.

Kansas City, MO	Caring Program still in existence interested in another health project – not a key BCBS Plan initiative now.
St. Louis, MO Caring Program	Closing program October 1. Will continue community relations projects via the Plan, but dissolve the 501©3 corporation of the Caring Program.
Montana	Status Quo – General Assembly recently allocated support to the Caring Program. No federal dollars will be drawn down until 2000. Business as usual.
Nevada	Kicking off new "Miles of Smiles" Mobile Dental Van. Funded in part by BCBS Nevada and BCBS Colorado.
North Dakota	Legislation doesn't meet until 1999. Business as usual. Steve Hogburg to leave as Director December 31, 1998.
New Hampshire Healthy Kids	State will run school age children through Healthy Kids – minimal dependence on Philanthropy/Blue Plan. Will become "government contractor"- will administer the outreach and marketing for CHIP (Healthy Kids)
North Carolina	Closed program after transitioning children to CHIP.
Ohio	Closing Caring Program • transitioning kids to state program • Board may decide to create new children's project in support of Federal Maternal & Child Health's "Bright Futures" program, "Operation Smiles" or programming for medically fragile children. Interested in the mobile van project for daycare children.
Oklahoma	Young children will transition to expanded Medicaid program; children age 15-19 are current focus of Caring Program; likely that this group will be picked up by future CHIP programs in Oklahoma; researching other insurance mobile van for day care centers concept.
Pennsylvania Blues	5 "Caring Programs" that receive funding from Commonwealth: Of the 2 that received philanthropic support: Pittsburgh: will focus on "Caring Place" a grieving center for kids. Philadelphia: Creating a "Healthy Futures" program to educate parents and guide them on the use/access of healthcare coverage.
South Dakota	Status quo; dependent upon decision-making in Iowa, where the Blue Plan is predominately in control of S.D. business.
Texas	Will transition children out of Caring Program and into state program this summer; Caring Program will pick up BCBSTX "Care Van" – immunizations for children. Considering other health programs.
Utah	Utah State CHIP plan began in August. Ended insurance program. Interest in maintaining Caring Program investigating other charitable projects. Researching support fitness and health education camps as well as other projects.

West Virginia	West Virginia CHIP plan still in progress. Interest in maintaining Caring Program, investigating other charitable projects. Phase I of CHIP (expansion of Medicaid to 150% of FPL for kids age 1-6). Anticipates Phase II (kids age 6-18) will be effective in early 1999. The specifics are still being developed. Investigating other projects in the interim.
Wyoming	Business as usual. Wyoming will not draw down Title 21 allocations. Caring Program still the only alternative for uninsured children.

November 18, 1998

To: Chris Jennings

From: Ray Hanley

We are preparing to submit our request to HCFA to convert ARKids to SCHIP funding as evidenced by the attached cover letter to Rick Fenton. The one point we are asking HCFA to exercise its waiver authority on is to allow us to keep the reasonable, successful cost sharing schedule. Any help you might offer in helping us obtain the approval on this point would be very much appreciated.

Thanks

Arkansas Department of Human Services
Division of Medical Services
Donaghey Plaza South
P.O. Box 1437
Little Rock, Arkansas 72203-1437
Telephone (501) 682-8292 TDD (501) 682-2117 FAX (501) 682-1197

November 18, 1998

Richard Fenton, Deputy Director
Family and Children's Health Program Group
Health Care Financing Administration
U.S. Department of Health and Human Services
7500 Security Blvd., Mail Box S2-2600-12
Baltimore, Maryland 21244-1850

RE: ARKids First Conversion to SCHIP

Dear Mr. Fenton:

This letter is accompanying the application of Arkansas to convert it's very successful 1115 waiver known as ARKids First to a program eligible for SCHIP funding. As HCFA already knows, ARKids has met the goal of SCHIP, providing a high quality health care program to previously uninsured children. Today, fourteen months after launching the program, ARKids covers some 35,000 children, providing not only a good package of services but also enrollment in the nationally recognized ConnectCare managed care program which won the Ford Foundation Innovations in American Government award in 1997.

We are asking in this application that HCFA exercise it's authority to grant a waiver to allow Arkansas to retain the existing patient cost sharing requirements contained in the previously HCFA approved ARKids 1115 Medicaid waiver when it is converted to SCHIP. These cost sharing amounts are less than, but still similar to those found in the Arkansas State employee's insurance program upon which the ARKids benefits are modeled.

While the existing ARKids cost sharing is higher than specified in SCHIP, necessitating the exercise of HCFA's discretionary authority, the amounts are not at all unreasonable for a excellent benefit, premium free, health care plan targeted to working families above Medicaid income guidelines. Unlike most states we have more than a year's experience with this program and find no evidence that the modest cost sharing has had any adverse impact on access to health services. In point of fact the automatic enrollment in ConnectCare that comes with an approved ARKids application affords the newly covered children with the best access to private sector primary care in the nation when viewed against almost any other states Medicaid program.

In this era of welfare reform President, the congress and the nation's Governors have rightfully touted the new concept of personal responsibility. The ARKids cost sharing is $5 per prescription, $10 for a physician visit and 20% of the first days Medicaid payment for a hospital admission, an average cost of around $150 for the patients share. If the family can't make the payment at the time of service nobody is being turned away, its not at all unreasonable to expect the family to be billed and to pay off the small obligation, even if in installments of $2, $5, etc. when able. In the case of a hospital admission where the cost of care might range from a few hundred dollars up to hundreds of thousands of dollars the families cost sharing for that admission will still only average $150. Without the HCFA waiver we will have to abandon most of this cost sharing which is already in place, accepted by both the covered families and the medical community. This would send the most negative of messages about personal responsibility.

We look forward to obtaining SCHIP approval of the ARKids First program as it represents one of the finest examples of what a successful state and federal partnership can accomplish when we work together.

Sincerely,

Ray Hanley
Director

Enclosure

RH/pw

Cynthia A. Rice 11/17/98 02:06:45 PM

Record Type: Record

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

cc:

Subject: The Fax 67431 is having trouble sending OUTGOING faxes

It's receiving faxes fine, but people can't read the outgoing ones. Essence will investigate

Message Sent To:

Cynthia A. Rice/OPD/EOP
Andrea Kane/OPD/EOP
Christa Robinson/OPD/EOP
Jeanne Lambrew/OPD/EOP
Thomas L. Freedman/OPD/EOP
Mary L. Smith/OPD/EOP
Paul J. Weinstein Jr./OPD/EOP
Teresa M. Jones/OPD/EOP

Test

November 18, 1998

To: Chris Jennings

From: Ray Hanley

We are preparing to submit our request to HCFA to convert ARKids to SCHIP funding as evidenced by the attached cover letter to Rick Fenton. The one point we are asking HCFA to exercise its waiver authority on is to allow us to keep the reasonable, successful cost sharing schedule. Any help you might offer in helping us obtain the approval on this point would be very much appreciated.

Thanks

Arkansas Department of Human Services
Division of Medical Services

Donaghey Plaza South
P.O. Box 1437
Little Rock, Arkansas 72203-1437
Telephone (501) 682-8292 TDD (501) 682-2117 FAX (501) 682-1197

November 18, 1998

Richard Fenton, Deputy Director
Family and Children's Health Program Group
Health Care Financing Administration
U.S. Department of Health and Human Services
7500 Security Blvd., Mail Box S2-2600-12
Baltimore, Maryland 21244-1850

RE: ARKids First Conversion to SCHIP

Dear Mr. Fenton:

This letter is accompanying the application of Arkansas to convert it's very successful 1115 waiver known as ARKids First to a program eligible for SCHIP funding. As HCFA already knows, ARKids has met the goal of SCHIP, providing a high quality health care program to previously uninsured children. Today, fourteen months after launching the program, ARKids covers some 35,000 children, providing not only a good package of services but also enrollment in the nationally recognized ConnectCare managed care program which won the Ford Foundation Innovations in American Government award in 1997.

We are asking in this application that HCFA exercise it's authority to grant a waiver to allow Arkansas to retain the existing patient cost sharing requirements contained in the previously HCFA approved ARKids 1115 Medicaid waiver when it is converted to SCHIP. These cost sharing amounts are less than, but still similar to those found in the Arkansas State employee's insurance program upon which the ARKids benefits are modeled.

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We look forward to obtaining SCHIP approval of the ARKids First program as it represents one of the finest examples of what a successful state and federal partnership can accomplish when we work together.

Sincerely,

Ray Hanley
Director

Enclosure

RH/pw

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

PHONE: (202)690-6102 FAX: (202)690-6167

Date: _____

From: Rob Stewart To: Devorah Adler

Division: _____ Division: _____

City & State: _____ City & State: _____

Office Number: _____ Office Number: _____

Fax Number: _____ Fax Number: _____

Number of Pages + cover 5

REMARKS: _____

Gary - Close Hold

State of Wisco
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

November 20, 1998

Nancy-Ann Min DeParle, Administrator
Health Care Financing Administration
Department of Health and Human Services
200 Independence Avenue, Room 314G
Washington, D.C. 20201

Dear Ms. DeParle:

In a letter dated August 19, 1998, you suggested a proposed approach to implement Wisconsin's BadgerCare program, which would extend health care coverage to low-income families with children in families that have income under 185% of the federal poverty level. Our fundamental concern with your proposal, which allowed the State to "roll back" eligibility, has always been that some families would lose health care. Our attached proposed modification addresses this significant concern, and is designed to protect families who will be enrolled in BadgerCare.

Specifically, your letter indicated that the State could limit its financial liability for BadgerCare by adjusting income eligibility as enrollment and State budget considerations permit. Although current federal provisions allow the State to roll back eligibility criteria under Medicaid, this action would mean that some families enrolled in BadgerCare would be terminated from the program at their next redetermination. For some families, this redetermination would not occur for 12 months; for other families it could be much sooner depending on the date they were determined eligible for BadgerCare. In any case, families who continue to play by the rules on the date they were enrolled would no longer be eligible for BadgerCare.

To address this issue, the attached proposal outlines a process to modify the eligibility redetermination for families enrolled in BadgerCare to assure that existing families enrolled in BadgerCare remain eligible if they continue to meet the income eligibility criteria in effect on the date they were enrolled. We believe this modification provides more stability and certainty for families with children who are enrolled in BadgerCare, while assuring the state an opportunity to maintain a balanced budget for BadgerCare.

In addition to this issue, I again bring to your attention four outstanding issues relating to our January 23, 1998, BadgerCare waiver request for which we have not yet received a response from your agency. These issues include: (a) tribal cost sharing; (b) budget neutrality; (c) the cost-effectiveness methodology for covering families under Title XXI; and (d) the coverage of child welfare parents under Title XIX. Resolution of these issues is also critical for approval of BadgerCare.

1 West Wilson Street • Post Office Box 7850 • Madison, WI 53707-7850 • Telephone (608) 266-9622

Assuming positive review of our proposals regarding budget neutrality, cost effectiveness and coverage of child welfare parents, our question to you is: can BadgerCare be approved with the modifications attached to your proposal?

Thank you, in advance, for your assistance in resolving these issues. I look forward to hearing from you soon.

Sincerely,

Joe Leean
Secretary

Attachment

HOW BADGERCARE CAN BE APPROVED WITHIN STATE AND FEDERAL LAW

Creating BadgerCare: Wisconsin would file a Title XIX Section 1115 waiver and a Title XXI state plan amendment for BadgerCare. It would expand coverage in families with income up to 185 percent of poverty through a Section 1931 expansion; once eligible, families may remain on BadgerCare if income is no more than 200 percent of poverty. Under Title XXI, enhanced Federal matching payments would be claimed only for the children covered through this expansion or parents eligible through family-based employer insurance. Both of these applications will be approved by December 31, 1998.

Controlling BadgerCare: Because of the State law non-entitlement requirement, Wisconsin would decide on an enrollment "trigger." This is the number of families that the State anticipates that it can enroll within the State budget appropriation. Three actions would happen if the number of families enrolled in BadgerCare hits this trigger:

1. **End New Enrollment.** An amendment to the Medicaid 1115 program would be approved to change the enrollment threshold to accommodate new enrollment. This would mean that no new applications would be approved above the new threshold, although the applications would be kept on a waiting list in the event that additional State funds are appropriated.

2. **Continue Eligibility for Existing Enrollees.** To provide continuity of care to people already enrolled in BadgerCare, an amendment would be approved to permit ongoing eligibility for families who continue to meet BadgerCare eligibility criteria in effect on the date they were enrolled. Thus, families would be required to report significant changes that may affect eligibility within 10 days and to undergo a redetermination for BadgerCare every 12 months, but if a family continues to meet the eligibility criteria on the date they were enrolled, they would not be terminated from BadgerCare.

3. **Additional Funds for Coverage.** If the State did approve additional funds, HCFA would approve an additional amendment to reopen enrollment. Depending on the amount of additional funding authorized, the State would amend the eligibility criteria for BadgerCare to ensure enrollment of additional low-income families up to the new income threshold authorized for BadgerCare.

Maintaining Current Medicaid Program: Wisconsin would maintain its Medicaid entitlement for children, parents and pregnant women eligible through our existing mandatory and optional AFDC and OBRA criteria. To ensure the enrollment of low-income families and children in the appropriate program, the application and eligibility determination process for Medicaid and BadgerCare will be coordinated, with those eligible for the state's Medicaid entitlement enrolled in that program.

FAX COVER SHEET

TO: Jeanne Lambrew
RE: Dear State Letter on Financial and FFY 1998 Annual Reporting
PAGES: 10 (including cover sheet)

FROM: Debbie Chang
PHONE: 410/786-0587

Dan Aibel

① Reg
② 2000 data
③ editorializing.

MEMORANDUM

TO: Sally Richardson
Kate Kirshgraber
Jeanne Lambrew

FROM: Debbie Chang

DATE: December 1, 1998

RE: Dear State Financial Letter

Attached is a final version of the Dear State Letter on quarterly expenditure and financial/statistical and FFY 1998 annual reporting. The strikeouts and redlines include initial edits from both OGC, to assure that we were in compliance with FACA rules on public discussion and decision-making, and the White House. The bolded sections include additions made by HCFA to reflect expectations for FFY 1998 annual reporting for CHIP. We are working to circulate this draft immediately to expedite the release of this letter by Thursday of this week.

DRAFT – 12/1/98

December XX, 1998

Dear State Official:

The Balanced Budget Act of 1997 (BBA) and subsequent amendments established the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. Under these provisions, States may extend health insurance coverage to uninsured children through a separate State CHIP program, a CHIP Medicaid expansion, or a combination of both programs effective as of October 1, 1997.

According to Title XXI, "A State child health plan shall include 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 the Secretary may require in order to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under this title." Title XXI requires States to submit annual reports in January of each year as well as to report expenditure and financial/statistical data on a quarterly basis. This letter and attachments are intended to provide guidance to States for the purpose of program monitoring and evaluation and also for the submission of their Federal Fiscal Year (FFY) 1998 annual reports. ~~requirements. These reporting requirements were developed in consultation with States through the National Governor's Association (NGA), the National Conference of State Legislatures (NCSL), the American Public Human Services Association (APHSA), the General Accounting Office, and the Congressional Research Service.~~ **In addition, we will be working with States to further discuss reporting data for FFY 1999 and beyond, including Title XXI requirements for program evaluation. We will be providing additional information on reporting and evaluation.**

are they reporting or not?

In order to receive federal matching funds, States should have been reporting quarterly expenditures made, for any period the State's program was in operation, in quarterly reports submitted within 30 days after the end of each quarter. HCFA expects that further financial and statistical data will be submitted in the same quarterly cycle on a regular basis. HCFA requests that States which did not submit quarterly reports or data submit prior period information by January 30, 1999. In preparing financial and statistical data, States should review the guidance in Attachments 1 and 2 and include data on age and service delivery, numbers of children enrolled in CHIP, and countable income levels.

Attachment 1: Description of Program Indicators

Attachment 1 describes program indicators for monitoring program performance, including **expenditure and** enrollment data, other CHIP program indicator data, **and** baseline estimates of uninsured children in a State. ~~, and a description of indicators related to the Government Performance and Results Act (GPRA) goal concerning decreasing the number of uninsured children.~~

→ say at outset we plan to require in Reg.

According to Title XXI, States' annual reports shall "assess the operation of the State plan under this title in each fiscal year, including the progress made in reducing the number of uncovered, low-income children [for which States will have to establish a baseline estimate]; and report to the Secretary, by January 1 following the end of the fiscal year on the result of the assessment." Recognizing that many States are currently developing reporting mechanisms, for administrative ease, States may submit fiscal year 1998 annual reports along with their quarterly financial and statistical reports submitted by January 30, 1999. Guidance for FFY 1998 annual reports is outlined in Attachment 1.

Attachment 2: Enrollment Data

Attachment 2 contains the forms and instructions for enrollment data reporting. These instructions include descriptions of ~~describe~~ the requested reporting ~~requirements~~ and instructions for States on accessing the online reporting system. Three forms are included on which States may ~~will~~ report the enrollment data for children in their separate State CHIP ~~stand alone~~ Title XXI program, CHIP related expansion of their Title XIX Medicaid program, and regular Medicaid program. (For your convenience, we also have attached the set of forms in both Excel and WordPerfect formats.)

In general, States should report enrollment data ~~will be reported~~ on a quarterly basis in four age categories for children under age 19 (under 1, 1-5, 6-12, and 13-18) and family income categories related to Federal poverty levels and State cost sharing requirements. States ~~should~~ will report by State-defined countable income and family size and submit their definitions of income and family size.

States should ~~State's~~ report~~ing of~~ enrollment data ~~is required~~ as of the effective date of the States' CHIP program. States may begin reporting this information quarterly upon receipt of this letter. However, we recognize that some States may need more time to develop their reporting capacity. ~~Therefore, if needed, States may wait until January 30, 1999 to begin reporting this information. However,~~ Therefore States may begin reporting this information by January 30, 1999 and States may ~~are required to~~ report previous quarters' data retroactive to the effective date indicated above.

Reports should be sent to your HCFA Regional Office. HCFA staff are available to explain the provisions described in this letter. When ~~these~~ reporting requirements are published in the forthcoming Notice of Proposed Rulemaking, there will be a formal opportunity for input. If you have any questions or require further information, please contact your HCFA regional office, or, as appropriate the contacts indicated in the attachments.

add fact moving towards gross income reporting

Sincerely,

Attachments

cc:

All HCFA Regional Offices
All PHS Regional Offices
HHS Regional Directors

~~Governor's Offices~~
~~All HCFA Regional Offices~~
~~All PHS Regional Offices~~
~~State Health Officers~~

~~Ms. Lee Partridge~~
~~Director, Health Policy Unit~~
~~American Public Human Services Association~~

~~Mr. Nolan Jones~~
~~Director, Human Resources Group~~
~~National Governor's Association~~

~~Ms. Joy Wilson~~
~~Director, Health Committee~~
~~National Conference of State Legislatures~~

~~B Greenberg, R. Strauss~~

ATTACHMENT 1
DESCRIPTION OF CHIP PROGRAM INDICATORS
October 1, 1998

I. OVERVIEW

The Children's Health Insurance Program (CHIP) is the first new Federal-State health insurance program in over 30 years. The law creating CHIP includes specific references to the Secretary's authority to ask States for the data needed to evaluate its effectiveness in achieving its goal of covering low-income, uninsured children. Specific information on the number of children covered by age, income, and type of delivery system is essential to this assessment. At the same time, because ~~since~~ many States are using data and reporting systems already in place for Medicaid, making new data requirements consistent with Medicaid is imperative. The following program indicators were designed to provide the standardized data elements that are ~~minimum data~~ necessary to monitor and evaluate CHIP without overburdening States with new requirements.

II. QUARTERLY REPORTS

A. Expenditure Reporting

States should ~~will be required to~~ report expenditures as of the date of a State's implementation of their approved State child health plan. (Example of the forms were attached to the December 8, 1997 All State letter.)

B. Financial/Statistical Reporting

1. Age and Service Delivery

States should ~~will be required to~~ report on the number of children under 19 years of age who are enrolled (in CHIP, Medicaid-only, and Medicaid-expansion programs) by age break-outs and service delivery categories on a quarterly basis on the HCFA Forms 21-E, 64.21E, and 64EC. In addition, States annually should ~~must~~ report an unduplicated count of children by age break-outs and service delivery categories for each federal fiscal year. (Example of the forms were attached to the December 8, 1997 All State letter.)

2. Countable Income Levels

States also should ~~will be required to~~ report children by income categories. "Income" is defined as the countable income used by the State in eligibility

determinations. Similarly, the State definition of family size should be used. A description of these State definitions must be submitted in a letter accompanying these forms and updated as necessary. The income categories that each State will use depend on whether or not it charges families premiums for participation in CHIP. States that impose premiums at defined levels (e.g., at 185 % and over of FPL) ~~should~~ will report by countable income categories that match their premium categories. States that do not impose premiums and States that use a sliding scale in applying premiums ~~should~~ will report ~~by using~~ two countable income breakouts (based on state-defined household size): up to and equal to 150% of the Federal poverty level (FPL) and over 150 percent of FPL. (Examples of the forms are attached.) This income reporting applies to both the Tittle XXI program and the Medicaid program.

B. Submission Date

~~The s~~Statistical/financial reporting ~~should be for all periods beginning on requirements will become effective as of~~ the date of the implementation of an approved CHIP State Plan ~~and States should submit this data by but States will have until~~ January 30, 1999 ~~to actually submit their statistical data~~.

III. ANNUAL REPORTS

A. Baseline Estimates of the Number of Uninsured Children in a State

One of the key indicators of the success of CHIP will be the number of uninsured children covered by the program. Although it would be preferable to have a single source of this information for all States, this is impossible given the existing data sets and their constraints. Thus, baseline estimates of the number of uninsured children will be determined ~~individually~~ by each State. This section describes the background on the options for baseline estimates and guidance for States in their choices.

Background on data sources: A wide range of options exist for collecting information on the uninsured children in each State. Several States are planning to conduct State-specific surveys but it is unclear how often most of these state-specific surveys will be repeated. Most States will base their estimate on the March supplement to the Current Population Survey (CPS) or on a statistically adjusted CPS. Other surveys such as the Survey of Income and Program Participation (SIPP), the Medical Expenditure Panel Survey (MEPS), the Community Tracking Study, and the National Health Interview Study (NHIS) also provide estimates of the uninsured. However, many of these surveys produce estimates that will not be available without a significant time lag, and several are conducted on an irregular or infrequent basis. The American Public Human Services Association has funded a short paper on CHIP baseline estimate methodology and other

measurement issues by Jim Verdier of Mathematica, which serves as a good resource for States on these issues.

The CPS is the only data source with the capacity to generate annual state-by-state estimates of uninsured children. The CPS is a monthly survey of approximately 57,000 households in the United States. ~~However, CPS state-by-state estimates rely on very small sample sizes and may not be reliable, particularly in the smaller states.~~ Each March, the CPS includes supplemental questions about health insurance status. Specifically, individuals are asked questions about whether they had any of various types of private or public health insurance in the previous year. Individuals who do not report insurance coverage are categorized as having been uninsured.

CPS

~~However, The CPS has a number of limitations. CPS State-by-State estimates rely on small sample sizes and may not be reliable, particularly in the smaller states.~~ Many researchers believe CPS estimates of the number of uninsured are somewhat imprecise because some survey respondents may report coverage status for the prior year while other report their status as of the point in time of the interview. Further, measurement error may be introduced by assessing lack of insurance as a residual when survey respondents indicate they lack specific coverage but are not asked a direct question about their lack of coverage. In addition, questions about coverage generally are difficult for survey respondents to answer. The fact that many Medicaid enrollees are eligible only for intermittent periods may make coverage questions particularly difficult for them to answer. In many cases, identifying insurance coverage through self-reported information is made even more problematic by the tendency of many enrollees to be more familiar with the name of their specific managed care plan and specific Medicaid program ~~name~~ than the more generic term" Medicaid" program. Many of these problems affect other surveys as well.

~~Despite these limitations, the NGA, APHSA and other groups consulted agreed that States should be encouraged to use CPS estimates of the uninsured or to provide a detailed description of the proposed alternative data source and justification. More specifically: with the following qualifications, CPS data will be used to established the initial baseline for the level of low-income children who are uninsured in each State and in the Nation as a whole as well as for obtaining annual estimates of the number of uninsured children:~~

We recognize both the strengths and weaknesses of CPS data. Therefore, States may use the published CPS estimates of the uninsured or an alternative including statistically adjusted CPS data and State-specific surveys. However, if an alternative to the published CPS data is used, then States should provide a justification of the approach and a detailed description of the data sources. More specifically:

- *States ~~may will be permitted to~~ apply appropriate methodologies/techniques to*

adjust and/or explain both the CPS baseline data and annual estimates when they provide a valid justification for this approach e.g., the statistical validity of the CPS data is weak because of small sample sizes).

- *States [redacted] ~~will be permitted to~~ submit other baseline data in accordance with appropriate criteria (e.g., when it is demonstrated that the alternative data has greater validity than the CPS data. However, evaluation of the alternative data will consider how often this data will be available (e.g. annually, periodically, or on a one-time only basis).*

B. Use of Quarterly Data in FFY 1998 Annual Reports

For FFY 1998, States should submit as their annual report quarterly expenditure as well as financial/statistical data. The submission of expenditure and financial/statistical data should encompass quarters represented in FFY 1998 (quarters beginning as early as October 1997 and ending September 30, 1998). States may simply attach these forms to their FFY 1998 annual report.

C. Additional Program Indicator Data

To the extent that it is applicable, States should also provide a brief description of the following items:

- **a description of issues identified that a State has agreed to monitor in its State plan, including an assessment of progress toward the State's identified strategic objectives, performance goals and performance measures;**
- **barriers to effectively implement States' plans that are associated with program design, planning and implementation and the proposed approaches to address such problems;**
- **any need for technical assistance from the Department; and**
- **other areas the State may identify as relevant.**

The inclusion of the descriptive information identified above will promote the initiation of discussion between the States and the Department on problematic issues in implementation, bringing issues to the forefront early in the implementation process and assisting the Department in providing timely technical assistance and establishing additional guidance.

In addition, outreach and crowd-out are two areas of great interest. ~~However, designing standardized data reporting a uniform data collection system to monitor and assess States' success in these areas is difficult. Thus, the States will have to individually report on these two areas.~~ States should consider reporting on a number of structural and process indicators that can be collected through a variety of data collection approaches including

the utilization of administrative data, enrollee mail or telephone surveys, population surveys, disenrollee surveys, surveys of employers, and site visits to eligibility determination locations.

For example, potential crowd out process indicators include: enrollee (or parental) self reported coverage status at enrollment, enrollee self-reported coverage status after disenrollment, self-reports of low income workers and small employers about insurance coverage choices, and site visit interviews with enrollees at eligibility determinations. Potential process indicators for outreach include: proportion of families who know about the CHIP program, application simplification, reduction in documentation and asset test requirements, utilization of mail applications, outstationing of eligibility workers, use of marketing and publicity campaigns, number of requests for CHIP applications, development of private-public outreach partnerships, use of community workers for outreach programs, and providing continuous eligibility for a year.

~~IV. GPRA Goal 8: Decrease the Number of Uninsured Children~~

~~Under the Government Performance and Results Act (GPRA), the major goal for CHIP is to the annual decrease in the number of low-income children less than 19 years of age who lack insurance coverage. Because Since collecting State-specific information is difficult and thus will be done differently across States, the GPRA goal will use a national number for measurement. Specifically, the baseline will be determined by the annual number of children who are uninsured *nationally* as identified by the Current Population Survey (CPS) for FY 99. This method relies on the 1999 CPS survey to create a baseline *national number* and on the annual CPS survey in subsequent years to provide a measurement of the change in the number of uninsured children *nationally*.)~~

~~Other surveys such as SIPP, MEPS, the Community Tracking Study, and NHIS will be used to aid our understanding of the dynamics of insurance coverage. Important information also will be derived from the estimates that each State will submit on the number of uninsured children they have enrolled. The financial/statistical forms that States will be required to submit to HCFA will provide verification of the role of CHIP and Medicaid in giving low income children health insurance coverage. However, CHIP and Medicaid are not the only factors that affect the dynamics of insurance coverage. Other significant determinants are likely to include the effects of economic trends, welfare reform, trends in employer-sponsored coverage, state and private insurance initiatives, and changes in the labor market. Therefore, CHIP and Medicaid enrollment data will provide critical information on the effectiveness of both programs.~~

Gap in health plan angers legislators State employees' children can't get low-cost coverage

Tuesday, December 08, 1998

Louisville Courier Journal - Michael Quinlan The Courier-Journal

FRANKFORT, Ky. -- Key legislators who approved a new plan to provide health insurance to children of the working poor were angry to learn it won't cover children of state employees, some of whom earn as little as $11,112 a year.

Rather than expand Medicaid, for which anyone who meets the income guidelines is eligible, the state Cabinet for Health Services opted to create an insurance system with modest premiums and co-payments -- knowing that federal rules exclude children of state employees.

That outraged legislators, who said Gov. Paul Patton's administration never told them of the exception before the General Assembly approved the plan early this year.

They learned of it last week when cabinet officials announced details of the Kentucky Children's Health Insurance Program, called KCHIP.

"I had no idea that one would preclude state employees," said Sen. Gerald Neal, D-Louisville, who heads the Health and Welfare Committee. "It's very disturbing that we didn't know this. That is a very significant fact that we should have been made aware of."

Some legislators said they might have voted differently had they known that the plan would leave out state employees, along with teachers and other public-school employees.

The state hopes to gain federal permission to cover state employees' children, but it appears the earliest it can ask is next November.

No one is sure how many of the tens of thousands of state employees might have qualified for the inexpensive KCHIP coverage. Eligibility is determined by the family's income and size. A family of four making up to $32,904 would qualify.

But many state employees earn less than $32,904: The median salary of all state employees is $26,574 per year, and the salary scale for full-time workers starts at $11,112.

Had legislators had all the information, said Rep. Steve Nunn, a Glasgow Republican, "It would have made a difference on which approach we took, I feel sure, because Lord knows we have enough state employees at that level that would qualify."

Administration officials said they didn't try to conceal anything and that they assumed legislators

knew of the situation.

Kentucky is putting up $13 million a year of its own to gain $50 million a year from the federal government. The state was trying to insure the most poor children possible with the available money, said Barbara Hadley Smith, a spokeswoman for the cabinet, which designed the plan. The plan is set to begin July 1. Rep. Kathy Stein, D-Lexington, a co-sponsor of the state's plan, said she thinks she was misled. Stein said she initially favored a Medicaid expansion but backed the state's plan because there wasn't enough support for her first choice.

She blamed Health Services Secretary John Morse for failing to fully brief legislators.

Knowing the plan excludes state employees "would have had a major effect on how we looked at that and how we could have lobbied for passage of the bill," Stein said.

Said Senate President Larry Saunders, a Louisville Democrat: "If we had that information, it would have had a bearing. It could have changed the outcome. Any information they knew should have been shared with us."

Smith, the cabinet spokeswoman, said the state created its own plan because legislators had opposed past Medicaid expansions and because it seemed to be the best way to serve the most children.

State employees can purchase health insurance to cover their children through other plans.

But Cindy Akers, 42, who makes $18,500 a year working for the state in Elizabethtown, said those plans are too expensive. If Akers, the mother of two sons, worked anywhere but for the state, she could pay $20 a year for coverage under KCHIP.

The plan available to her, however, "would cost me an extra $100 a month, and I don't have an extra $100 a month," said Akers, a Cabinet for Health Services employee who works with foster parents. "I pray a lot that they don't get sick or hurt, but they do and I end up owing the hospital. I owe $2,000 right now."

Federal money became available to insure poor children last year. Congress gave grants to states to either expand Medicaid or set up alternative systems for working parents who earned too much to qualify for Medicaid but still couldn't afford health insurance for their children. The Patton administration opposed expanding Medicaid, maintaining the state wouldn't have enough money to cover all children who qualified. The administration asked the General Assembly to sign on to the new system of subsidized insurance.

Congress, however, had barred state employees' children from being eligible for state-fashioned alternatives to Medicaid. Congress worried that states would stop spending their own money on health insurance for employees and let the federal dollars take over.

Officials in the Patton administration gambled they could persuade the federal government to make an exception for Kentucky. Although the federal government signed off on KCHIP in November, it hasn't granted any exception thus far.

Both Judith Gambill, president of the Kentucky Education Association, the state's teachers' union, and Charles Wells, a spokesman for the Kentucky Association of State Employees, had been unaware of the KCHIP exclusions. They think many of their members' children would have been eligible for KCHIP, but neither could give a number.

Also caught off guard were two child advocates who lobbied for the Medicaid expansion -- Debra Miller, director of Kentucky Youth Advocates, and Anne Joseph, of the Kentucky Task Force on Hunger. "I certainly think there are some legislators for whom that would have been a powerful argument for looking at a Medicaid expansion," Miller said.

Joseph said, "It would have been a very significant bargaining chip."

Of five members of the House and Senate Health and Welfare Committees interviewed by The Courier-Journal, only Sen. Walter Blevins, D-West Liberty, recalled Morse saying that the plan might not cover the children of state employees.

Smith, the cabinet spokeswoman, said Morse testified during a meeting that there was a question about whether state employees were eligible, but that he was trying to make sure they would be.

Smith said legislators received copies of the 20-page federal law, which sets out the provisions exempting state employees. But she acknowledged that no one from her cabinet volunteered the fact that a Medicaid expansion would cover the children of state employees. Rep. Tom Burch, a Bucchel Democrat, said he suspected that information was kept secret to improve the chances of passing the administration's plan.

Morse did tell legislators that if the state expanded Medicaid, it would not be able to offer coverage to children in families with incomes of up to 200 percent of the federal poverty level, as KCHIP does.

Kentucky did expand Medicaid slightly. It used part of the federal money -- $4 million to $5 million -- to provide Medicaid coverage to children age 14 to 18 in families far below the poverty threshold. Younger children in those very poor families -- some with incomes of one-third of the federal poverty level -- were already eligible.

But most of the money went into KCHIP, a program designed to resemble a traditional employer-employee benefit package.

Unlike Kentucky, 28 states chose to use all the federal grant money to expand Medicaid. But not all of them covered children in families with an income that is 200 percent of the poverty level. Some expanded only to 133 percent or 150 percent.

Had Kentucky expanded Medicaid, it probably would have had enough money to cover children only up to 150 percent, according to Miller and Joseph, the advocates.

The federal government has allowed only two states that opted for their own insurance plans, North Carolina and Mississippi, to enroll state employees. That's because neither state contributes anything to family coverage for its employees.

Kentucky contributes $203 a month toward family coverage for state employees, but the amount, in most cases, barely pays for a policy for a single person.

Smith said Morse didn't think he had to stress to legislators that KCHIP wouldn't cover state employees because he believes the federal legislation is unfair and that he could get an exemption, considering Kentucky's low contribution to family plans. "To our point of view it's not acceptable that they will not cover them under the program, and we're going to fight for that," Smith said. "John is planning to go to Washington himself on this."

But under the federal rules, Kentucky is not allowed to ask for a waiver until one year after its plan received federal approval. That will be next November.

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REMARKS:

DRAFT ROLLOUT PLAN FOR WISCONSIN TITLE XXI AMENDMENT & SECTION 1115 DEMONSTRATION

Late Today:

- Heads-up Phone Calls to Hill Staff: Reps. Barrett, Kleczka, Obey. Senators Feingold, Kohl **LEAD: ASL**
- Scheduling of Secretarial Event for Friday -- a call to Governor Thompson with interested members of the Congressional Delegation in attendance. **LEAD: ASL, OS/IGA**

Friday at Designated Time:

Rollout Begins, with:

- Secretarial Calls to Governor, with interested members of the Congressional Delegation in attendance.
- Secretary Leanne **(Nancy-Ann DeParle)**

Followed By Calls/ Faxes to:

- Governor's DC Office **(OS/IGA)**
- Cindy Mann, Center on Budget and Policy Prioities **LEAD: White House**
- Wisconsin Congressional Delegation Staff **(Bonnie Washington and Staff: HCFA/OL)**
- Committee Staff **(ASL)**
- Mayor Norquist **(Lance Simmens)**
- Notification of key advocacy groups:

  Families USA **(HCFA/IGA and HCFA/Baltimore)**
  March of Dimes **(HCFA/IGA and HCFA/Baltimore)**
  CDF **(HCFA/IGA and HCFA/Baltimore)**

  Key State-Based Advocates **(Hannah Rosenthal, RD)**

- Intergovernmental Groups **(OS and HCFA/IGA)**

  NGA
  NCSL
  State Medicaid Directors Association
  State Health Officials Association
  Association of City and County Health Officials

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Gi, Attie

DRAFT
Qs on BadgerCare
CHIP and 1115 waiver

1.Q. Exactly what has HCFA approved for Wisconsin today and how is it different from the plan the agency rejected earlier?

A. Last year, we approved the state's first CHIP plan--a Medicaid expansion for children ages 15-18--and suggested a way for the state to cover adults. We have worked with the state to develop a plan that meets the requirements enacted by Congress. In fact, it's very similar to the proposal we made to the state last year. The plan approved today meets the state's goal of insuring low-income *families* through a state-wide health care delivery system known as BadgerCare. This expansion is different from the state's original proposal because it uses a two-step process to achieve this goal through a new CHIP expansion and a waiver of Medicaid rules.

Phase II of the Wisconsin CHIP program will provide health insurance coverage to children up to age 18 in families with incomes up to 185 percent of the federal poverty level (FPL). The plan approved today builds on Phase One of the state's CHIP plan--a Medicaid expansion that was approved by HHS on May 29, 1998.

As a companion to their CHIP Phase II plan, HHS today also announced the approval of a Medicaid Section 1115 waiver that will allow the state to enroll the parents of CHIP-eligible children in the state's Medicaid program. The state also received approval to use CHIP funds to buy employer-sponsored coverage for families in instances where the cost of the employer coverage is no greater than the cost of covering a child through regular BadgerCare.

In its first proposal, the state had asked to cover both children *and* adults through the CHIP program. This is extremely difficult to accomplish under the federal CHIP statute's cost-effectiveness test (just described above). Since Congress intended CHIP funds only to subsidize insurance for children, we suggested to the state that they could apply the CHIP allotment to an expanded Medicaid program and enroll parents in Medicaid through a Section 1115 waiver. We have worked closely with the state to bring the plan design into compliance with the federal CHIP law and we are pleased with the final design of BadgerCare.

2. Q. How much money is available to the state?

A. When the Department approved the first phase of Wisconsin's CHIP plan, it became eligible to receive as much as $38 million in funds for fiscal year 1998. That same allotment will be applied to this new expansion. HCFA will soon publish state allotments for fiscal year 1999.

3. Q. Will Wisconsin use CHIP dollars to cover adults? Won't this mean less money to help kids?

A. In writing the CHIP law, Congress allowed CHIP funds to be used to cover adults in extremely limited circumstances. Two tests must be met in order for states to cover families as well as children--the plan must not cost more than it would have cost to cover the child alone, *and* it must be designed in such a way to discourage families with coverage from dropping private plans in favor of the federally-supported CHIP program. The cost-effectiveness test is difficult, but not impossible to meet. The easiest way would be if a family has access to employer-sponsored insurance (ESI) that they otherwise cannot afford. If the employer subsidy of that coverage is high enough that the premium cost for the entire family would be no more than the state would have to spend to cover the child alone in a standard CHIP arrangement, then the state can spend CHIP funds to buy that coverage. The ESI plan must meet the benefit requirements established by CHIP. To date, the only state that has met this test and is purchasing ESI is Massachusetts.

4. Q. Will the BadgerCare benefit package always be at the Medicaid level?

A. Yes. Most BadgerCare coverage will be provided through Medicaid. In the event employer coverage is being purchased, the state has a seamless system that will provide any additional benefits needed to bring the plan up to the Medicaid standard.

5. Q. Is Wisconsin's approach unique?

A. Yes. The state has chosen a unique approach that is designed to keep working families together, and to provide incentives for working families to increase their earnings without losing Medicaid coverage. BadgerCare is also designed to strengthen, and work in concert with, the state's successful welfare reform program.

6. Q. The State originally proposed a cap on enrollment because of budgetary concerns, but the federal government said no. Didn't you back down?

A. No, the Department has not changed its position on enrollment caps. Because BadgerCare is financed through Medicaid--an entitlement program--a cap on enrollment is not permitted. While the Department can appreciate the state's wish to limit its financial exposure, adoption of the Medicaid option under CHIP entails a commitment to maintain the entitlement to eligibility that is fundamental to Medicaid--even after the state exhausts its CHIP allotment. HCFA understands the state's budgetary constraints, however. Under Medicaid law, if a state determines that enrollment may exceed its budgetary allowance, it can apply for federal approval to lower the income eligibility level for any new applicants. Wisconsin is free to exercise this option if it feels enrollment will exceed its budget.

7. Q. How does that differ from a cap?

A. The two are very different. Under the enrollment cap, children who are otherwise eligible for Medicaid could be prevented from entering the program because the enrollment cap had been exceeded. Medicaid is an entitlement program and denying care to those legally entitled to it is simply not allowed. If a state changes its enrollment, all children who are eligible under the new income requirements can still enroll. This preserves the entitlement component that is key to Medicaid.

8. Q. Why did HCFA object to the Wisconsin enrollment cap when it has approved caps elsewhere?

A. HCFA has never approved the kind of cap Wisconsin had proposed.

Background: If the question refers to Tennessee, the situation there is not the same. Under Tennessee's Medicaid Section 1115 waiver, a population of people *not otherwise eligible* for Medicaid were added to the Medicaid rolls. HCFA allowed Tennessee to limit that demonstration to a set number of individuals, 1.3 million. The critical difference between the two plans is that Tennessee continues to guarantee Medicaid coverage to those legally entitled to it—those in the demonstration would not otherwise be allowed to participate in Medicaid. In sharp contrast, Wisconsin had proposed to cap enrollment and deny coverage to children who were fully eligible for Medicaid.

9. Q. How will HCFA ensure that beneficiaries won't lose health coverage they are entitled to if the state rolls back eligibility levels?

A. All persons enrolled in BadgerCare will be allowed to remain in the program regardless of any changes in eligibility for *new* applicants. Families can remain in BadgerCare until their income reaches 200 percent of the federal poverty level.

10. Q. Couldn't such a rollback hurt lower-income families in comparison to those with higher incomes?

A. If the state changes the income cut-off for BadgerCare, a currently enrolled family with higher income could be grandfathered into the program while a lower-income family might be denied admission under new, lower eligibility rules. Because federal law allows states to make these kinds of changes HCFA had to approve the state's proposal. States, however, must stay within the federal mandatory minimum income levels of 133 percent of poverty for children from birth to age 5 and 100 percent of poverty for children ages 6-14.

11. Q. This proposal has been under review in various forms since September 1997. What took HCFA so long to approve it?

A. In fact, we approved the first phase of Wisconsin's plan in May 1998 and at that time offered the state an approvable way to cover the adults it wanted to include in BadgerCare. Wisconsin's proposal presented a complex coordination of two programs: a

Section 1115 Medicaid waiver and a Phase II CHIP plan. HCFA staff worked closely with state officials to craft a plan that met the state's coverage goals and stayed within the federal CHIP and Medicaid guidelines.

12. Q. Did HCFA waive provisions of Title XXI in approving BadgerCare?

A. No. All waivers that were granted were waivers of the Medicaid statute, as part of the Section 1115 portion of BadgerCare. The CHIP component of BadgerCare did not require waivers.

13. Q. Under BadgerCare, is it true that children can only enroll if they live with their custodial parent? Does that mean the child has to live in a traditional family?

A. No. Children do not need to be in a traditional family to enroll.

14. Q. Is it true that the federal government forced its program design on the state?

A. No. The BadgerCare program was implemented through a collaborative process. HCFA, state and local officials and members of the state's congressional delegation worked closely together to design a program that both met the state's coverage goals and the federal Medicaid and CHIP laws.

15. Q. Why does Wisconsin need Section 1115 waivers to implement BadgerCare?

A. In order to implement the full BadgerCare program, Wisconsin needed permission to deviate from standard Medicaid practices--permission granted by the Section 1115 waiver. Under the BadgerCare program Wisconsin will be: 1) expanding Medicaid coverage to custodial parents of Medicaid-eligible children; 2) imposing premiums on children above 150 percent of the FPL; 3) obtaining federal matching funds on expenditures resulting from the collection of premiums for the adult expansion population; 4) not providing retroactive eligibility for BadgerCare participants; and 4) using income and resource standards and methods which differ from current Medicaid law.

16. Q. Beyond the enrollment cap issue, what other issues were in contention with the state?

A. In addition to the enrollment cap, Wisconsin wanted to use CHIP dollars to cover adults. The CHIP funds are limited, and Congress provided very limited circumstances when those funds could be spent for adult coverage (see Q. 3). HCFA had to assure that funds spent from the Children's Health Insurance Program were being properly applied and that covering adults doesn't mean less money for children.

17. Q. What were the other significant issues in Wisconsin and how were they resolved?

A In addition to the enrollment cap, HCFA has been concerned about the following issues:

- Premiums: The state had requested federal matching funds for adult premiums under Medicaid. By allocating the premiums separately for adults and children, the state can receive federal matching funds for adult premiums under section 1115 authority. *Resolution:* Following discussions with the state, we came to a mutual agreement on the state's premium allocation methodology.

- Absent Parents: Initially, the state had requested the flexibility to cover absent parents through an 1115 waiver. While we are supportive of the state's goal to cover absent parents, we are concerned that their mechanism for generating savings under the waiver (by claiming Title IV-E targeted case management costs under Medicaid) is not viable. *Resolution:* HCFA and the state agreed to pursue this issue along a separate track so as not to delay the approval of BadgerCare.

- Tribal Cost-Sharing: The state sought a final policy determination on whether or not tribal members could be charged cost-sharing. *Resolution:* The Department is in the process of devising guidance for states regarding cost-sharing options for tribes under title XXI. The state has informed us that they do charge cost-sharing for this group -- which is permissible under the law -- and will continue to do so until they hear otherwise from HCFA.