

S Chip Expansion under Title XXI

Amended XXI Statute

SUBTITLE J--STATE CHILDREN'S HEALTH INSURANCE PROGRAM

CHAPTER 1--STATE CHILDREN'S HEALTH INSURANCE PROGRAM

SEC. 4901. ESTABLISHMENT OF PROGRAM.

(a) ESTABLISHMENT- The Social Security Act is amended by adding at the end the following new title:  
TITLE XXI--STATE CHILDREN'S HEALTH INSURANCE PROGRAM

SEC. 2101. PURPOSE; STATE CHILD HEALTH PLANS.

(a) PURPOSE- The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Such assistance shall be provided primarily for obtaining health benefits coverage through--

(1) obtaining coverage that meets the requirements of section 2103, or

(2) providing benefits under the State's medicaid plan under title XIX,

or a combination of both.

(b) STATE CHILD HEALTH PLAN REQUIRED- A State is not eligible for payment under section 2105 unless the State has submitted to the Secretary under section 2106 a plan that--

(1) sets forth how the State intends to use the funds provided under this title to provide child health assistance to needy children consistent with the provisions of this title, and

(2) has been approved under section 2106.

(c) STATE ENTITLEMENT- This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under section 2104.

(d) EFFECTIVE DATE- No State is eligible for payments under section 2105 for child health assistance for coverage provided for periods beginning before October 1, 1997.

SEC. 2102. GENERAL CONTENTS OF STATE CHILD HEALTH PLAN; ELIGIBILITY; OUTREACH.

(a) GENERAL BACKGROUND AND DESCRIPTION- A State child health plan shall include a description, consistent with the requirements of this title, of--

(1) the extent to which, and manner in which, children in the State, including targeted low-income children and other classes of children classified by income and other relevant factors, currently have creditable health coverage (as defined in section 2110(c)(2));

(2) current State efforts to provide or obtain creditable health coverage for uncovered children, including the steps the State is taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs and health insurance programs that involve public-private partnerships;

(3) how the plan is designed to be coordinated with such efforts to increase coverage of children under creditable health coverage;

(4) the child health assistance provided under the plan for targeted low-income children, including the proposed methods of delivery, and utilization control systems;

(5) eligibility standards consistent with subsection (b);

(6) outreach activities consistent with subsection (c); and

(7) methods (including monitoring) used--

(A) to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan, and

(B) to assure access to covered services, including emergency services.

(b) GENERAL DESCRIPTION OF ELIGIBILITY STANDARDS AND METHODOLOGY--

(1) ELIGIBILITY STANDARDS--

(A) IN GENERAL- The plan shall include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. Such standards may include (to the extent consistent with this title) those relating to the geographic areas to be served by the plan, age, income and resources (including any standards relating to spenddowns and disposition of resources), residency, disability status (so long as any standard relating to such status does not restrict eligibility), access to or coverage under other health coverage, and duration of eligibility. Such standards may not discriminate on the basis of diagnosis.

(B) LIMITATIONS ON ELIGIBILITY STANDARDS- Such eligibility standards--

(i) shall, within any defined group of covered targeted low-income children, not cover such children with higher family income without covering children with a lower family income, and

(ii) may not deny eligibility based on a child having a preexisting medical condition.

(2) METHODOLOGY- The plan shall include a description of methods of establishing and continuing eligibility and enrollment.

(3) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH

COVERAGE PROGRAMS- The plan shall include a description of procedures to be used to ensure--

(A) through both intake and followup screening, that only targeted low-income children are furnished child health assistance under the State child health plan;

(B) that children found through the screening to be eligible for medical assistance under the State medicaid plan under title XIX are enrolled for such assistance under such plan;

(C) that the insurance provided under the State child health plan does not substitute for coverage under group health plans;

(D) the provision of child health assistance to targeted low-income children in the State who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c)); and

(E) coordination with other public and private programs providing creditable coverage for low-income children.

(4) NONENTITLEMENT- Nothing in this title shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan.

(c) OUTREACH AND COORDINATION- A State child health plan shall include a description of the procedures to be used by the State to accomplish the following:

(1) OUTREACH- Outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in, such a program.

(2) COORDINATION WITH OTHER HEALTH INSURANCE PROGRAMS- Coordination of the administration of the State program under this title with other public and private health insurance programs.

SEC. 2103. COVERAGE REQUIREMENTS FOR CHILDREN'S HEALTH INSURANCE.

(a) REQUIRED SCOPE OF HEALTH INSURANCE COVERAGE- The child health assistance provided to a targeted low-income child under the plan in the form described in paragraph (1) of section 2101(a) shall consist, consistent with subsection (c)(5), of any of the following:

(1) BENCHMARK COVERAGE- Health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in subsection (b).

(2) BENCHMARK-EQUIVALENT COVERAGE- Health

benefits coverage that meets the following requirements:

(A) INCLUSION OF BASIC SERVICES- The coverage includes benefits for items and services within each of the categories of basic services described in subsection (c)(1).

(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE- The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages.

(C) SUBSTANTIAL ACTUARIAL VALUE FOR ADDITIONAL SERVICES INCLUDED IN BENCHMARK PACKAGE- With respect to each of the categories of additional services described in subsection (c)(2) for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package.

(3) EXISTING COMPREHENSIVE STATE-BASED COVERAGE- Health benefits coverage under an existing comprehensive State-based program, described in subsection (d)(1).

(4) SECRETARY-APPROVED COVERAGE- Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population of targeted low-income children proposed to be provided such coverage.

(b) BENCHMARK BENEFIT PACKAGES- The benchmark benefit packages are as follows:

(1) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE-

The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

(2) STATE EMPLOYEE COVERAGE- A health benefits coverage plan that is offered and generally available to State employees in the State involved.

(3) COVERAGE OFFERED THROUGH HMO- The health insurance coverage plan that-

(A) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act), and

(B) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

(c) CATEGORIES OF SERVICES; DETERMINATION OF ACTUARIAL VALUE OF COVERAGE-

(1) CATEGORIES OF BASIC SERVICES- For purposes of this section, the categories of basic services described in this paragraph are as follows:

(A) Inpatient and outpatient hospital services.

(B) Physicians' surgical and medical services.

(C) Laboratory and x-ray services.

(D) Well-baby and well-child care, including age-appropriate immunizations.

(2) CATEGORIES OF ADDITIONAL SERVICES- For purposes of this section, the categories of additional services described in this paragraph are as follows:

(A) Coverage of prescription drugs.

(B) Mental health services.

(C) Vision services.

(D) Hearing services.

(3) TREATMENT OF OTHER CATEGORIES- Nothing in this subsection shall be construed as preventing a State child health plan from providing coverage of benefits that are not within a category of services described in paragraph (1) or (2).

(4) DETERMINATION OF ACTUARIAL VALUE- The actuarial value of coverage of benchmark benefit packages, coverage offered under the State child health plan, and coverage of any categories of additional services under benchmark benefit packages

and under coverage offered by such a plan, shall be set forth in an actuarial opinion in an actuarial report that has been prepared-

(A) by an individual who is a member of the American Academy of Actuaries;

(B) using generally accepted actuarial principles and methodologies;

(C) using a standardized set of utilization and price factors;

(D) using a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan;

(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

(5) CONSTRUCTION ON PROHIBITED COVERAGE- Nothing in this section shall be construed as requiring any health benefits coverage offered under the plan to provide coverage for items or services for which payment is prohibited under this title, notwithstanding that any benchmark benefit package includes coverage for such an item or service.

(d) DESCRIPTION OF EXISTING COMPREHENSIVE STATE-BASED COVERAGE-

(1) IN GENERAL- A program described in this paragraph is a child health coverage program that-

(A) includes coverage of a range of benefits;

(B) is administered or overseen by the State and receives funds from the State;

(C) is offered in New York, Florida, or Pennsylvania; and

(D) was offered as of the date of the enactment of this title.

(2) MODIFICATIONS- A State may modify a program described in paragraph (1) from time to time so long as it continues to meet the requirement of subparagraph (A) and does not reduce the actuarial value of the coverage under the program below the lower of-

(A) the actuarial value of the coverage under the

program as of the date of the enactment of this title, or

(B) the actuarial value described in subsection (a)(2)(B), evaluated as of the time of the modification.

(e) COST-SHARING-

(1) DESCRIPTION; GENERAL CONDITIONS-

(A) DESCRIPTION- A State child health plan shall include a description, consistent with this subsection, of the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. Any such charges shall be imposed pursuant to a public schedule.

(B) PROTECTION FOR LOWER INCOME CHILDREN- The State child health plan may only vary premiums, deductibles, coinsurance, and other cost sharing based on the family income of targeted low-income children in a manner that does not favor children from families with higher income over children from families with lower income.

(2) NO COST SHARING ON BENEFITS FOR PREVENTIVE SERVICES- The State child health plan may not impose deductibles, coinsurance, or other cost sharing with respect to benefits for services within the category of services described in

subsection (c)(1)(D).

**(3) LIMITATIONS ON PREMIUMS AND COST-SHARING-**

**(A) CHILDREN IN FAMILIES WITH INCOME BELOW 150 PERCENT OF POVERTY LINE-** In the case of a targeted low-income child whose family income is at or below 150 percent of the poverty line, the State child health plan may not impose--

(i) an enrollment fee, premium, or similar charge that exceeds the maximum monthly charge permitted consistent with standards established to carry out section 1916(b)(1) (with respect to individuals described in such section); and

(ii) a deductible, cost sharing, or similar charge that exceeds an amount that is nominal (as determined consistent with regulations referred to in section 1916(a)(3), with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable).

**(B) OTHER CHILDREN-** For children not described in subparagraph (A), subject to paragraphs (1)(B) and (2), any premiums, deductibles, cost sharing or similar charges imposed under the State child health plan may be imposed on a sliding scale related to income, except that the total annual aggregate cost-sharing with respect to all targeted low-income children in a family under this title may not exceed 5 percent of such family's income for the year involved.

**(4) RELATION TO MEDICAID REQUIREMENTS-** Nothing in this subsection shall be construed as affecting the rules relating to the use of enrollment fees, premiums, deductions, cost sharing, and similar charges in the case of targeted low-income children who are provided child health assistance in the form of coverage under a medicaid program under section 2101(a)(2).

**(f) APPLICATION OF CERTAIN REQUIREMENTS-**

**(1) RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS-**

**(A) IN GENERAL-** Subject to subparagraph (B), the State child health plan shall not permit the imposition of any preexisting condition exclusion for covered benefits under the plan.

**(B) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE-** If the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the plan may permit the imposition of a preexisting condition exclusion but only insofar as it is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and title XXVII of the Public Health Service Act.

**(2) COMPLIANCE WITH OTHER REQUIREMENTS-** Coverage offered under this section shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

**SEC. 2104. ALLOTMENTS.**

**(a) APPROPRIATION; TOTAL ALLOTMENT-** For the purpose of providing

allotments to States under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated--

- (1) for fiscal year 1998, \$4,295,000,000;
- (2) for fiscal year 1999, \$4,275,000,000;
- (3) for fiscal year 2000, \$4,275,000,000;
- (4) for fiscal year 2001, \$4,275,000,000;
- (5) for fiscal year 2002, \$3,150,000,000;
- (6) for fiscal year 2003, \$3,150,000,000;
- (7) for fiscal year 2004, \$3,150,000,000;
- (8) for fiscal year 2005, \$4,050,000,000;
- (9) for fiscal year 2006, \$4,050,000,000; and
- (10) for fiscal year 2007, \$5,000,000,000.

**(b) ALLOTMENTS TO 50 STATES AND DISTRICT OF**

**COLUMBIA-**

**(1) IN GENERAL-** Subject to paragraph (4) and subsection (d), of the amount available for allotment under subsection (a) for a fiscal year, reduced by the amount of allotments made under subsection (c) for the fiscal year, the Secretary shall allot to each State (other than a State described in such subsection) with a State child health plan approved under this title the same proportion as the ratio of--

(A) the product of (i) the number of children described in paragraph (2) for the State for the fiscal year and (ii) the State cost factor for that State (established under paragraph (3)); to

(B) the sum of the products computed under subparagraph (A).

**(2) NUMBER OF CHILDREN-**

**(A) IN GENERAL-** The number of children described in this paragraph for a State for--

(i) each of fiscal years 1998 through 2000 is equal to the number of low-income children in the State with no health insurance coverage for the fiscal year,

(ii) fiscal year 2001 is equal to--

(I) 75 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus

(II) 25 percent of the number of low-income children in the State for the fiscal year; and

(iii) each succeeding fiscal year is equal to--

(I) 50 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus

(II) 50 percent of the number of low-income children in the State for the fiscal year.

**(B) DETERMINATION OF NUMBER OF CHILDREN-** For purposes of subparagraph (A), a determination of the number of low-income children (and of such children who have no health insurance coverage) for a State for a fiscal year shall be made on the basis of the arithmetic average of the number of such children, as reported and defined in the 3 most recent March supplements to the Current Population Survey of the Bureau of the Census before the beginning of the fiscal year.

**(3) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN HEALTH COSTS-**

**(A) IN GENERAL-** For purposes of paragraph (1)(A)(ii), the 'State cost factor' for a State for a fiscal year equal to the sum of--

(i) 0.15, and

(ii) 0.85 multiplied by the ratio of--

(I) the annual average wages per employee for the State for such year (as determined under subparagraph (B)), to

(II) the annual average wages per employee for the 50 States and the District of Columbia.

**(B) ANNUAL AVERAGE WAGES PER EMPLOYEE-** For purposes of subparagraph (A), the 'annual average wages per employee' for a State, or for all the States, for a fiscal year is equal to the average of the annual wages per employee for the State or for the 50 States and the District of Columbia for employees in the health services industry (SIC code 8000), as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the fiscal year involved.

**(4) FLOOR FOR STATES-** In no case shall the amount of the allotment under this subsection for one of the 50 States or the District of Columbia for a year be less than \$2,000,000. To the extent that the application of the previous sentence results in an increase in the allotment to a State above the amount otherwise provided, the allotments for the other States and the District of Columbia under this subsection shall be reduced in a pro rata manner (but not below \$2,000,000) so that the total of such allotments in a fiscal year does not exceed the amount otherwise provided for allotment under paragraph (1) for that fiscal year.

**“(c) ALLOTMENTS TO TERRITORIES-**

**“(1) IN GENERAL-** Of the amount available for allotment under subsection (a) for a fiscal year, subject to subsection (d), the Secretary shall allot 0.25 percent among each of the commonwealths and territories described in paragraph (3) in the same proportion as the percentage specified in paragraph (2) for such commonwealth or territory bears to the sum of such percentages for all such commonwealths or territories so described.

**“(2) PERCENTAGE-** The percentage specified in this paragraph for—

- “(A) Puerto Rico** is 91.6 percent,
- “(B) Guam** is 3.5 percent,
- “(C) the Virgin Islands** is 2.6 percent,
- “(D) American Samoa** is 1.2 percent, and
- “(E) the Northern Mariana Islands** is 1.1 percent.

**“(3) COMMONWEALTHS AND TERRITORIES-** A commonwealth or territory described in this paragraph is any of the following if it has a State child health plan approved under this title:

- “(A) Puerto Rico.**
- “(B) Guam.**
- “(C) The Virgin Islands.**
- “(D) American Samoa.**
- “(E) The Northern Mariana Islands.**

**“(d) CERTAIN MEDICAID EXPENDITURES COUNTED AGAINST INDIVIDUAL STATE ALLOTMENTS-** The amount of the allotment otherwise provided to a State under subsection (b) or (c) for a fiscal year shall be reduced by the sum of—

**“(1) the amount (if any) of the payments made to that State under section 1903(a) for expenditures claimed by the State during such fiscal year that is attributable to the provision of medical assistance to a child during a presumptive eligibility period under section 1920A, and**

**“(2) the amount (if any) of the payments made to that State under section 1903(a) for expenditures claimed by the State during such fiscal year that is attributable to the provision of medical assistance to a child for which payment is made under section 1903(a)(1) on the basis of an enhanced FMAP under the fourth sentence of section 1905(b).**

**“(e) 3-YEAR AVAILABILITY OF AMOUNTS ALLOTTED-** Amounts allotted to a State pursuant to this section for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year; except that amounts reallocated to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are reallocated.

**“(f) PROCEDURE FOR REDISTRIBUTION OF UNUSED ALLOTMENTS-** The Secretary shall determine an appropriate procedure for redistribution of allotments from States that were provided allotments under this section for a fiscal year but that do not expend all of the amount of such allotments during the period in which such allotments are available for expenditure under subsection (e), to States that have fully expended the amount of their allotments under this section.

**“SEC. 2105. PAYMENTS TO STATES.**

**“(a) IN GENERAL-** Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under this title, from its allotment under section 2104 (taking into account any adjustment under section 2104(d)), an amount for each quarter equal to the enhanced FMAP of expenditures in the quarter—

- “(1) for child health assistance under the plan for targeted low-income children in the form of providing health benefits coverage that meets the requirements of section 2103; and**
- “(2) only to the extent permitted consistent with subsection (c)—**

- “(A) for payment for other child health assistance for targeted low-income children;**
- “(B) for expenditures for health services initiatives under the plan for improving the health of children (including**

**targeted low-income children and other low-income children);**

**“(C) for expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and**

**“(D) for other reasonable costs incurred by the State to administer the plan.**

**“(b) ENHANCED FMAP-** For purposes of subsection (a), the ‘enhanced FMAP’, for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 30 percent of the number of percentage points by which (1) such Federal medical assistance percentage for the State, is less than (2) 100 percent; but in no case shall the enhanced FMAP for a State exceed 85 percent.

**“(c) LIMITATION ON CERTAIN PAYMENTS FOR CERTAIN EXPENDITURES-**

**“(1) GENERAL LIMITATIONS-** Funds provided to a State under this title shall only be used to carry out the purposes of this title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

**“(2) LIMITATION ON EXPENDITURES NOT USED FOR MEDICAID OR HEALTH INSURANCE ASSISTANCE-**

**“(A) IN GENERAL—**Except as provided in this paragraph, payment shall not be made under subsection (a) for expenditures for items described in subsection (a) (other than paragraph (1)) for a fiscal year to the extent the total of such expenditures (for which payment is made under such subsection) exceeds 10 percent of the sum of—

- “(i) the total of such expenditures for such fiscal year, and**
- “(ii) the total expenditures for medical assistance by the State under title XIX for which Federal payments made under section 1903(a)(1) are based on an enhanced FMAP described in section 2105(b) for such fiscal year.”**

**“(B) WAIVER AUTHORIZED FOR COST-EFFECTIVE ALTERNATIVE-**

The limitation under subparagraph (A) on expenditures for items described in subsection (a)(2) shall not apply to the extent that a State establishes to the satisfaction of the Secretary that—

- “(i) coverage provided to targeted low-income children through such expenditures meets the requirements of section 2103;**
- “(ii) the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under section 2103; and**
- “(iii) such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923.**

**“(3) WAIVER FOR PURCHASE OF FAMILY COVERAGE-** Payment may be made to a State under subsection (a)(1) for the purchase of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children only if the State establishes to the satisfaction of the Secretary that—

**“(A) purchase of such coverage is cost-effective relative to the amounts that the State would have paid to obtain comparable coverage only of the targeted low-income children involved, and** **“(B) such coverage shall not be provided if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage.**

**“(4) USE OF NON-FEDERAL FUNDS FOR STATE MATCHING REQUIREMENT-**

Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of non-Federal contributions required under subsection (a).

**“(5) OFFSET OF RECEIPTS ATTRIBUTABLE TO PREMIUMS AND OTHER COST-SHARING-** For purposes of subsection (a), the amount of the expenditures under the plan shall be reduced by the amount of any premiums and other cost-sharing received by the State.

**“(6) PREVENTION OF DUPLICATIVE PAYMENTS-**

**“(A) OTHER HEALTH PLANS-** No payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided child health assistance under the plan.

**“(B) OTHER FEDERAL GOVERNMENTAL PROGRAMS-**

Except as otherwise provided by law, no payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service, as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) shall apply.

**“(7) LIMITATION ON PAYMENT FOR ABORTIONS-**

**“(A) IN GENERAL-** Payment shall not be made to a State under this section for any amount expended under the State plan to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion.

**“(B) EXCEPTION-** Subparagraph (A) shall not apply to an abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

**“(C) RULE OF CONSTRUCTION-** Nothing in this section shall be construed as affecting the expenditure by a State, locality, or private person or entity of State, local, or private funds (other than funds expended under the State plan) for any abortion or for health benefits coverage that includes coverage of abortion.

**“(d) MAINTENANCE OF EFFORT-**

**“(1) IN MEDICAID ELIGIBILITY STANDARDS-** No payment may be made under subsection (a) with respect to child health assistance provided under a State child health plan if the State adopts income and resource standards and methodologies for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX that are more restrictive than those applied as of June 1, 1997.

**“(2) IN AMOUNTS OF PAYMENT EXPENDED FOR CERTAIN STATE-FUNDED HEALTH INSURANCE PROGRAMS FOR CHILDREN-**

**“(A) IN GENERAL-** The amount of the allotment for a State in a fiscal year (beginning with fiscal year 1999) shall be reduced by the amount by which--

**“(i) the total of the State children's health**

insurance expenditures in the preceding fiscal year, is less than

**“(ii) the total of such expenditures in fiscal year 1996.**

**“(B) STATE CHILDREN'S HEALTH INSURANCE EXPENDITURES-** The term ‘State children's health insurance expenditures’ means the following:

**“(i) The State share of expenditures under this title.**

**“(ii) The State share of expenditures under title XIX that are attributable to an enhanced FMAP under section 1905(u).**

**“(iii) State expenditures under health benefits coverage under an existing comprehensive State-based program, described section 2103(d).**

**“(e) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT-** The Secretary may make payments under this section for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and may reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

**“(f) FLEXIBILITY IN SUBMITTAL OF CLAIMS.**—Nothing in this section or subsections (e) and (f) of section 2104 shall be construed as preventing a State from claiming as expenditures in the quarter expenditures that were incurred in a previous quarter.’

**“SEC. 2106. PROCESS FOR SUBMISSION, APPROVAL, AND AMENDMENT OF STATE CHILD HEALTH PLANS.**

**“(a) INITIAL PLAN-**

**“(1) IN GENERAL-** As a condition of receiving payment under section 2105, a State shall submit to the Secretary a State child health plan that meets the applicable requirements of this title.

**“(2) APPROVAL-** Except as the Secretary may provide under subsection (e), a State plan submitted under paragraph (1)--

**“(A) shall be approved for purposes of this title, and**

**“(B) shall be effective beginning with a calendar quarter that is specified in the plan, but in no case earlier than October 1, 1997.**

**“(b) PLAN AMENDMENTS-**

**“(1) IN GENERAL-** A State may amend, in whole or in part, its State child health plan at any time through transmittal of a plan amendment.

**“(2) APPROVAL-** Except as the Secretary may provide under subsection (e), an amendment to a State plan submitted under paragraph (1)--

**“(A) shall be approved for purposes of this title, and**

**“(B) shall be effective as provided in paragraph (3).**

**“(3) EFFECTIVE DATES FOR AMENDMENTS-**

**“(A) IN GENERAL-** Subject to the succeeding provisions of this paragraph, an amendment to a State plan shall take effect on one or more effective dates specified in the amendment.

**“(B) AMENDMENTS RELATING TO ELIGIBILITY OR BENEFITS-**

**“(i) NOTICE REQUIREMENT-** Any plan amendment that eliminates or restricts eligibility or benefits under the plan may not take effect unless the State certifies that it has provided prior public notice of the change, in a form and manner provided under applicable State law.

**“(ii) TIMELY TRANSMITTAL-** Any plan amendment that eliminates or restricts eligibility or benefits under the plan shall not be effective for longer than a 60-day period unless the amendment has been transmitted to the Secretary before the end of such period.

**“(C) OTHER AMENDMENTS-** Any plan amendment that is not described in subparagraph (B) and that becomes effective in a State fiscal year may not remain in effect after the end

of such fiscal year (or, if later, the end of the 90-day

period on which it becomes effective) unless the amendment has been transmitted to the Secretary.

**(c) DISAPPROVAL OF PLANS AND PLAN AMENDMENTS-**

**(1) PROMPT REVIEW OF PLAN SUBMITTALS-** The Secretary shall promptly review State plans and plan amendments submitted under this section to determine if they substantially comply with the requirements of this title.

**(2) 90-DAY APPROVAL DEADLINES-** A State plan or plan amendment is considered approved unless the Secretary notifies the State in writing, within 90 days after receipt of the plan or amendment, that the plan or amendment is disapproved (and the reasons for disapproval) or that specified additional information is needed.

**(3) CORRECTION-** In the case of a disapproval of a plan or plan amendment, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such disapproval.

**(d) PROGRAM OPERATION-**

**(1) IN GENERAL-** The State shall conduct the program in accordance with the plan (and any amendments) approved under subsection (c) and with the requirements of this title.

**(2) VIOLATIONS-** The Secretary shall establish a process for enforcing requirements under this title. Such process shall provide for the withholding of funds in the case of substantial noncompliance with such requirements. In the case of an enforcement action against a State under this paragraph, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such an action.

**(e) CONTINUED APPROVAL-** An approved State child health plan shall continue in effect unless and until the State amends the plan under subsection (b) or the Secretary finds, under subsection (d), substantial noncompliance of the plan with the requirements of this title.

**SEC. 2107. STRATEGIC OBJECTIVES AND PERFORMANCE GOALS; PLAN ADMINISTRATION.**

**(a) STRATEGIC OBJECTIVES AND PERFORMANCE GOALS-**

**(1) DESCRIPTION-** A State child health plan shall include a description of--

- (A)** the strategic objectives,
- (B)** the performance goals, and
- (C)** the performance measures,

the State has established for providing child health assistance to targeted low-income children under the plan and otherwise for maximizing health benefits coverage for other low-income children and children generally in the State.

**(2) STRATEGIC OBJECTIVES-** Such plan shall identify specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children.

**(3) PERFORMANCE GOALS-** Such plan shall specify one or more performance goals for each such strategic objective so identified.

**(4) PERFORMANCE MEASURES-** Such plan shall describe how performance under the plan will be--

- (A)** measured through objective, independently verifiable means, and
- (B)** compared against performance goals, in order to determine the State's performance under this title.

**(b) RECORDS, REPORTS, AUDITS, AND EVALUATION-**

**(1) DATA COLLECTION, RECORDS, AND REPORTS-** 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.

**(2) STATE ASSESSMENT AND STUDY-** A State child health plan shall include a description of the State's plan for the annual assessments and reports under section 2108(a) and the evaluation required by section 2108(b).

**(3) AUDITS-** A State child health plan shall include an assurance that the State will afford the Secretary access to any records or information relating to the plan for the purposes of review or audit.

**(c) PROGRAM DEVELOPMENT PROCESS-** A State child health plan shall include a description of the process used to involve the public in the design and implementation of the plan and the method for ensuring ongoing public involvement.

**(d) PROGRAM BUDGET-** A State child health plan shall include a description of the budget for the plan. The description shall be updated periodically as necessary and shall include details on the planned use of funds and the sources of the non-Federal share of plan expenditures, including any requirements for cost-sharing by beneficiaries.

**(e) APPLICATION OF CERTAIN GENERAL PROVISIONS-** The following sections of this Act shall apply to States under this title in the same manner as they apply to a State under title XIX:

**(1) TITLE XIX PROVISIONS-**

**(A)** Section 1902(a)(4)(C) (relating to conflict of interest standards).

**(B)** Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

**(C)** Section 1903(w) (relating to limitations on provider taxes and donations).

**(2) TITLE XI PROVISIONS-**

**(A)** Section 1115 (relating to waiver authority).

**(B)** Section 1116 (relating to administrative and judicial review), but only insofar as consistent with this title.

**(C)** Section 1124 (relating to disclosure of ownership and related information).

**(D)** Section 1126 (relating to disclosure of information about certain convicted individuals).

**(E)** Section 1128A (relating to civil monetary penalties).

**(F)** Section 1128B(d) (relating to criminal penalties for certain additional charges).

**(G)** Section 1132 (relating to periods within which claims must be filed).

**SEC. 2108. ANNUAL REPORTS; EVALUATIONS.**

**(a) ANNUAL REPORT-** The State shall--

**(1)** 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; and

**(2)** report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

**(b) STATE EVALUATIONS-**

**(1) IN GENERAL-** By March 31, 2000, each State that has a State child health plan shall submit to the Secretary an evaluation that includes each of the following:

**(A)** An assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage.

**(B)** A description and analysis of the effectiveness of elements of the State plan, including--

**(i)** the characteristics of the children and families assisted under the State plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the State plan and after eligibility for the State

plan ends,

(ii) the quality of health coverage provided including the types of benefits provided,

(iii) the amount and level (including payment of part or all of any premium) of assistance provided by the State,

(iv) the service area of the State plan,

(v) the time limits for coverage of a child under the State plan,

(vi) the State's choice of health benefits coverage and other methods used for providing child health assistance, and

(vii) the sources of non-Federal funding used in the State plan.

(C) An assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children.

(D) A review and assessment of State activities to coordinate the plan under this title with other public and private programs providing health care and health care financing, including medicaid and maternal and child health services.

(E) An analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children.

(F) A description of any plans the State has for improving the availability of health insurance and health care for children.

(G) Recommendations for improving the program under this title.

(H) Any other matters the State and the Secretary consider appropriate.

(2) REPORT OF THE SECRETARY- The Secretary shall submit to Congress and make available to the public by December 31, 2001, a report based on the evaluations submitted by States under paragraph (1), containing any conclusions and recommendations the Secretary considers appropriate.

## **SEC. 2109. MISCELLANEOUS PROVISIONS.**

(a) RELATION TO OTHER LAWS-

(1) HIPAA- Health benefits coverage provided under section 2101(a)(1) (and coverage provided under a waiver under section 2105(c)(2)(B)) shall be treated as creditable coverage for purposes of part 7 of subtitle B of title II of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and subtitle K of the Internal Revenue Code of 1986.

(2) ERISA- Nothing in this title shall be construed as affecting or modifying section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) with respect to a group health plan (as defined in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg-91(a)(1))).

## **SEC. 2110. DEFINITIONS.**

(a) CHILD HEALTH ASSISTANCE- For purposes of this title, the term 'child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

(1) Inpatient hospital services.

(2) Outpatient hospital services.

(3) Physician services.

(4) Surgical services.

(5) Clinic services (including health center services) and other ambulatory health care services.

(6) Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

(7) Over-the-counter medications.

(8) Laboratory and radiological services.

(9) Prenatal care and pre-pregnancy family planning services and supplies.

(10) Inpatient mental health services, other than services

described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

(11) Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.

(12) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).

(13) Disposable medical supplies.

(14) Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).

(15) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.

(16) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

(17) Dental services.

(18) Inpatient substance abuse treatment services and residential substance abuse treatment services.

(19) Outpatient substance abuse treatment services.

(20) Case management services.

(21) Care coordination services.

(22) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(23) Hospice care.

(24) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is-

(A) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,

(B) performed under the general supervision or at the direction of a physician, or

(C) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

(25) Premiums for private health care insurance coverage.

(26) Medical transportation.

(27) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

(28) Any other health care services or items specified by the Secretary and not excluded under this section.

(b) TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title-

(1) IN GENERAL- Subject to paragraph (2), the term 'targeted low-income child' means a child-

(A) who has been determined eligible by the State for child health assistance under the State plan;

(B)(i) who is a low-income child, or

(ii) is a child- "(1) whose family income (as determined under the State child health plan) exceeds the medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50

percentage points above the medicaid applicable income level;

(II) whose family income (as so determined) does not exceed the medicaid applicable income level (as defined in paragraph (4) but determined as if 'June 1, 1997' were substituted for 'March 31, 1997'); or

“(III) who resides in a State that does not have a medicaid applicable income level (as defined in paragraph (4)); and

“(C) who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).

“(2) CHILDREN EXCLUDED- Such term does not include-

“(A) a child who is an inmate of a public institution or a patient in an institution for mental diseases; or

“(B) a 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.

“(3) SPECIAL RULE- A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.

“(4) MEDICAID APPLICABLE INCOME LEVEL- The term 'medicaid applicable income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)), as of March 31, 1997, for the child to be eligible for medical assistance under section 1902(l)(2) or 1905(n)(2) (as selected by a State) for the age of such child.

“(c) ADDITIONAL DEFINITIONS- For purposes of this title:

“(1) CHILD- The term 'child' means an individual under 19 years of age.

“(2) CREDITABLE HEALTH COVERAGE- The term 'creditable health coverage' has the meaning given the term 'creditable coverage' under section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).

“(3) GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC- The terms 'group health plan', 'group health insurance coverage', and 'health insurance coverage' have the meanings given such terms in section 2791 of the Public Health Service Act.

“(4) LOW-INCOME- The term 'low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.

“(5) POVERTY LINE DEFINED- The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

“(6) PREEXISTING CONDITION EXCLUSION- The term 'preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).

“(7) STATE CHILD HEALTH PLAN; PLAN- Unless the context otherwise requires, the terms 'State child health plan' and 'plan' mean a State child health plan approved under section 2106.

“(8) UNCOVERED CHILD- The term 'uncovered child' means a child that does not have creditable health coverage.

(b) CONFORMING AMENDMENTS-

(1) DEFINITION OF STATE- Section 1101(a)(1) is amended-

(A) by striking 'and XIX' and inserting 'XIX, and XXI', and

(B) by striking 'title XIX' and inserting 'titles XIX and XXI'.

(2) TREATMENT AS STATE HEALTH CARE PROGRAM- Section 1128(h)

(42 U.S.C. 1320a-7(h)) is amended by-

(A) in paragraph (2), by striking 'or' at the end;

(B) in paragraph (3), by striking the period and inserting ', or'; and

(C) by adding at the end the following:

“(4) a State child health plan approved under title XXI.”

## **CHAPTER 2-EXPANDED COVERAGE OF CHILDREN UNDER MEDICAID**

### **SEC. 4911. OPTIONAL USE OF STATE CHILD HEALTH ASSISTANCE FUNDS FOR ENHANCED MEDICAID MATCH FOR EXPANDED MEDICAID ELIGIBILITY.**

(a) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR EXPANDED COVERAGE OF TARGETED LOW-INCOME CHILDREN- Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by section 4702(a)(2), is amended-

(1) in subsection (b), by adding at the end the following new sentence: 'Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures described in subsection (u)(2)(A) or subsection (u)(3) for the State for a fiscal year, and that do not exceed the amount of the State's allotment under section 2104 (not taking into account reductions under section 2104(d)(2)) for the fiscal year reduced by the amount of any payments made under section 2105 to the State from such allotment for such fiscal year, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b).'; and

(2) by adding at the end the following new subsection:

“(u)(1) The conditions described in this paragraph for a State plan are as follows:

“(A) The State is complying with the requirement of section 2105(d)(1).

“(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out the fourth sentence of subsection (b) and section 2104(d).

“(2)(A) For purposes of subsection (b), the expenditures described in this subparagraph are expenditures for medical assistance for optional targeted low-income children described in subparagraph (B).

“(B) For purposes of this paragraph, the term 'optional targeted low-income child' means a targeted low-income child as defined in section 2110(b)(1) (determined without regard to that portion of subparagraph (C) of such section concerning eligibility for medical assistance under this title) who would not qualify for medical assistance under the State plan under this title as in effect on March 31, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1902(l)(1)(D)).

“(3) For purposes of subsection (b), the expenditures described in this paragraph are expenditures for medical assistance for children who are born before October 1, 1983, and who would be described in section 1902(l)(1)(D) if they had been born on or after such date, and who are not eligible for such assistance under the State plan under this title based on such State plan as in effect as of March 31, 1997.”

(4) The limitations on payment under subsections (f) and (g) of

section 1108 shall not apply to Federal payments made under section 1903(a)(1) based on an enhanced FMAP described in section 2105(b).

(b) ESTABLISHMENT OF OPTIONAL ELIGIBILITY CATEGORY- Section 1902(a)(10)(A)(ii) (42 U.S.C.

1396a(a)(10)(A)(ii)), as amended by section 4733, is amended--

- (1) in subclause (XII), by striking 'or' at the end;
- (2) in subclause (XIII), by adding 'or' at the end; and
- (3) by adding at the end the following:

'(XIV) who are optional targeted low-income children described in section 1905(u)(2)(C);'.

(c) EFFECTIVE DATE- The amendments made by this section shall apply to medical assistance for items and services furnished on or after October 1, 1997.

## **SEC. 4912. MEDICAID PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME CHILDREN.**

(a) IN GENERAL- Title XIX of the Social Security Act is amended by inserting after section 1920 the following new section:

### **'PRESUMPTIVE ELIGIBILITY FOR CHILDREN**

'SEC. 1920A. (a) A State plan approved under section 1902 may provide for making medical assistance with respect to health care items and services covered under the State plan available to a child during a presumptive eligibility period.

'(b) For purposes of this section:

'(1) The term 'child' means an individual under 19 years of age.

'(2) The term 'presumptive eligibility period' means, with respect to a child, the period that--

'(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the family income of the child does not exceed the applicable income level of eligibility under the State plan, and

'(B) ends with (and includes) the earlier of--

'(i) the day on which a determination is made with respect to the eligibility of the child for medical assistance under the State plan, or

'(ii) in the case of a child on whose behalf an application is not filed by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

'(3)(A) Subject to subparagraph (B), the term 'qualified entity' means any entity that--

'(i)(I) is eligible for payments under a State plan approved under this title and provides items and services described in subsection (a) or (II) is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act (42 U.S.C. 9821 et seq.), eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.), eligibility of an infant or child to receive assistance under the special supplemental nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786); and

'(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

'(B) The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

'(C) Nothing in this section shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed

under subparagraph (B).

'(c)(1) The State agency shall provide qualified entities with--

'(A) such forms as are necessary for an application to be made on behalf of a child for medical assistance under the State plan, and

'(B) information on how to assist parents, guardians, and other persons in completing and filing such forms.

'(2) A qualified entity that determines under subsection (b)(1)(A) that a child is presumptively eligible for medical assistance under a State plan shall--

'(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

'(B) inform the parent or custodian of the child at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

'(3) In the case of a child who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the parent, guardian, or other person shall make application on behalf of the child for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1902(1)(1).

'(d) Notwithstanding any other provision of this title, medical assistance for items and services described in subsection (a) that--

'(1) are furnished to a child--

'(A) during a presumptive eligibility period,

'(B) by a entity that is eligible for payments under the State plan; and

'(2) are included in the care and services covered by a State plan; shall be treated as medical assistance provided by such plan for purposes of section 1903.'

### **(b) CONFORMING AMENDMENTS-**

(1) Section 1902(a)(47) (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: 'and provide for making medical assistance for items and services described in subsection (a) of section 1920A available to children during a presumptive eligibility period in accordance with such section'.

(2) Section 1903(u)(1)(D)(v) (42 U.S.C. 1396b(u)(1)(D)(v)) is amended by inserting before the period at the end the following: 'or for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section'.

(c) EFFECTIVE DATE- The amendments made by this section shall take effect on the date of the enactment of this Act.

## **SEC. 4913. CONTINUATION OF MEDICAID ELIGIBILITY FOR DISABLED**

### **CHILDREN WHO LOSE SSI BENEFITS.**

(a) IN GENERAL- Section 1902(a)(10)(A)(i)(II) (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended by inserting '(or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193)) and would continue to be paid but for the enactment of that section' after 'title XVI'.

(b) EFFECTIVE DATE- The amendment made by subsection (a) applies to medical assistance furnished on or after July 1, 1997.

Q#AS 1-5

# **THE ADMINISTRATION'S RESPONSES TO QUESTIONS ABOUT THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

**September 11, 1997**

## **INTRODUCTION:**

**Below are a series of answers that respond to some of the questions about the State Children's Health Insurance Program that have been raised by states, providers, consumers, and others. The list is not all-encompassing and there are many other questions critical to the successful implementation of this program that we also intend to answer. The Administration remains committed to providing timely responses to important issues and will issue additional guidance as it becomes available.**

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# **STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

**September 11, 1997**

## **COVERAGE**

**Question 1. How does the state choose its benchmark benefit package? What requirements must be met if a state uses the benchmark-equivalent coverage package?**

**Answer.** States have several options in choosing their benefit package under this Title:

First, under section 2103(a)(1), a state may opt for a benefit package equivalent to one of the three benchmark benefit packages described in the law -- the standard Blue Cross/Blue Shield Preferred Provider option offered under the Federal Employees Health Benefits Program (FEHBP); a health benefits plan that is offered and is generally available to State employees; and the HMO coverage plan with the largest commercial non-Medicaid enrollment in the state.

Second, under section 2103(a)(2), a state may opt for a benefit package whose aggregate actuarial value is at least equal to one of the benchmark plans enumerated in section 2103(a)(1). The benchmark equivalent coverage must also meet the following requirements:

- The package must include coverage for inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services, and well-baby and well-child care (including immunizations);
- If the benchmark plan selected by the state for the purpose of establishing the actuarial value of benchmark-equivalent coverage includes any of the following services -- prescription drugs, mental health services, vision services, or hearing services -- the actuarial value of each of these categories of service in the benchmark equivalent coverage package must be at least 75 percent of the value of such a category of service in the benchmark plan selected by the state. If the benchmark plan does not cover one of these categories of service, then the equivalent plan may, but is not required to, provide coverage for that category of service.

The Secretary of Health and Human Services (HHS) must assure that these requirements are met prior to approving the plan.

Third, three states' existing child health programs -- New York, Florida, and Pennsylvania -- were deemed to meet the benefit requirements of the law for use in these states only. The cost-sharing protections in the new law, however, would also apply in these three states.

The statute also allows a state to apply for approval by the Secretary of HHS of other benefit packages that would provide appropriate coverage for the population of targeted low-income children. The Department has not yet developed criteria for approving such packages.

Finally, states may choose to receive an enhanced federal matching rate to expand Medicaid for optional targeted low-income children. A state choosing the Medicaid option must provide the Medicaid benefit package offered in their state.

**Question 2a) If the state selects a benchmark plan for coverage, and that plan has cost-sharing requirements, which cost-sharing rules apply -- those set out in Title XXI or those of the benchmark original plan?**

**Answer.** The Title XXI limits serve as ceilings on cost-sharing regardless of the benchmark chosen. The state child health plan must include a description of the amount of premiums, deductibles, coinsurance or other cost-sharing charged, and any cost-sharing -- if any -- must be described in a schedule made available to the public. Cost-sharing may not be charged for preventive benefits and states may not favor children from families with higher incomes over families with lower incomes.

**Question 2b). For purposes of determining a benchmark equivalent value, are the differences between the cost-sharing requirements of the benchmark plan and the limitations imposed by Title XXI recognized when computing the actuarial value of the benchmark plan?**

**Answer.** Yes, cost-sharing limitations are taken into account in the calculation of the actuarial value of a benefit package. A state may design its own benefits package, however, it should adjust for the increase in actuarial value due to the limitation on cost-sharing.

**Question 3. What if a child is already covered through private insurance but has extremely minimal benefits and has high premiums; is he or she eligible for Title XXI coverage?**

**Answer.** No. In order for a child to be eligible for child health assistance (eligible for direct services) under Title XXI, the statute requires that the child not be covered under a group health plan or other health insurance, as defined in the Health Insurance Portability and Accountability Act (HIPAA) (definitions attached). Since the HIPAA definitions of group health plans and health insurance coverage define coverage broadly, most children with existing health coverage will not qualify as uninsured for purposes of Title XXI.

There are a few cases in which a child with health insurance could be defined as uninsured. For example, if a child only has coverage for a specific service (e.g. dental care or vision services), this would not be considered health insurance coverage. If a child is deemed uninsured under HIPAA and meets all other state eligibility criteria, that child could be covered under the Title XXI benefits package.

**Question 4. If a state provides coverage to an uninsured child through a specific group plan which is not associated with the state (such as a plan offered by an employer), does that group coverage have to meet the standards in section 2103?**

**Answer.** States may only use funds in this Title for family group coverage if they receive a waiver described under section 2105(c)(3). Group coverage must meet one of the requirements described in Section 2103(a), (i.e., benchmark coverage, benchmark equivalent coverage, existing comprehensive state-based coverage, or Secretary-approved coverage).

#### **STATE PLAN ISSUES**

**Question 5. Will the Administration have guidance for states to carry out the required coordination of their plans with others in the public and private sector?**

**Answer.** Yes. The Department of HHS is committed to providing States with general guidance to develop all aspects of the child health plan, including the issue regarding "crowd-out" of current coverage and how best to coordinate among other coverage options in the private and public sectors. We are reviewing State strategies currently in place that have been successful in minimizing crowd-out and we will use this and other available information to help provide guidance.

Section 2102(c)(2) requires the State Child Health Plan to include a description of the coordination of the plan with other public and private health insurance programs. In terms of evaluating this section of the plan, the Department of HHS will focus on whether the plan is likely to produce the desired goals of Title XXI, such as creating a comprehensive, cohesive system of health insurance that minimizes "crowd-out" of current coverage. In addition, the Department of HHS will evaluate how Medicaid-eligible children identified through Title XXI outreach efforts will be enrolled in Medicaid.

**Question 6. If a state chooses to expand coverage through its Medicaid program, must the benefit package meet all Medicaid requirements? What about the Medicaid rules which do not allow cost-sharing for kids?**

**Answer.** Medicaid rules will apply to any expanded coverage provided under the Title XIX state Medicaid plan (section 2101(a)(2)).

**Question 7. If a state decides to do a combination of Medicaid and the new Child Health Insurance Program, what approval process does the state need to go through? If a state takes the Medicaid approach, must they meet any of the Title XXI requirements? If a state initially chooses one option, can the state change to a different option later?**

**Answer.** The Department of HHS is currently developing guidelines regarding information needed for the approval process. States choosing to expand coverage through Medicaid will be required to complete a Medicaid state plan amendment and an abbreviated plan for Title XXI. For a state selecting a joint Medicaid/Child Health Program, the state would need to submit a Title XXI plan, as well as a Medicaid state plan amendment to be consistent with the Title XXI changes.

States may expand through one option and switch to a different option at any time, if a plan amendment describing this change is approved by the Secretary.

## **FINANCING**

**Question 8. Is cost-sharing by beneficiaries considered part of the state match? (§2107(d))**

**Answer.** No. Amounts of state beneficiary cost sharing receipts would not be considered part of the state match for expenditures under Title XXI as described in section 2105(c)(5). Beneficiary cost-sharing revenues must be applied to offset, that is reduce, federally matchable Title XXI expenditures. Thus, such revenues effectively reduce both the state and federal shares of allowable Title XXI expenditures. This will have the effect that both state and federal governments would be credited with their respective portion of cost-sharing funds.

For example, if the total expenditure for a beneficiary is \$1,000 and the state collects \$100 in beneficiary cost-sharing, the net expenditure claimable for Title XXI against the state's allotment is \$900. If the enhanced federal matching rate for that state is 65 percent, the federal government would provide \$585 and the state would provide \$315. As a result, the amount from the beneficiary cost-sharing is distributed proportionately between the state and federal government.

**Question 9. What is the date by which a state must apply to receive its allotment under Title XXI?**

**Answer.** For states with approved plans, the allotment under Title XXI is available for up to three years. Thus, state allotments for states with approved plans in Federal Fiscal Year (FY) 1998 remain available for expenditure on activities in FY 1998, 1999, and 2000. At the end of FY 2000, all remaining funds from states that have not fully expended their 1998 allotments will be redistributed to states that have exhausted their 1998 allotments. This process will be repeated each year of the program.

Under the law, a state must have an approved state plan for a fiscal year in order to receive an allotment that year. In order for the Department to determine allotments for FY 98, state plan applications should be submitted as soon as possible. The length of time from submission to approval will vary depending upon the quality of the plan and the extent to which requirements under the law are met. We cannot guarantee that we will be able to approve plans submitted after July 1 before the close of the fiscal year. Therefore, the sooner a state submits its plan, the more quickly HCFA will be able to approve it, and the sooner states will have access to their allotments.

It is important to note that section 2104(e) specifies that the redistributed funds will only be available to be drawn down during the year in which they are redistributed. For example, any unused 1998 funds that are redistributed to a state in 2001 must be drawn down by the end of 2001. However, the 1998 redistributed funds can be used to match: 1) previously unmatched expenditures that occurred during the previous three years, and 2) any expenditures made during the fiscal year in which the funds are redistributed. Therefore, despite only being able to draw the redistributed funds during one year, the funds can be used to match expenditures over a four year period of time.

**Question 10. Who determines the amount of the enhanced Medicaid FMAP and how is it determined? (§2104(d)(2))?**

**Answer.** The formula used to calculate the enhanced FMAP is clearly specified in statute. For a given year, the enhanced FMAP is equal to the sum of:

- 70 percent of a state's current FMAP percentage in that year, plus
- 30 percentage points.

No enhanced FMAP rate can exceed 85%.

So, if a state's current FMAP is 50%, the enhanced FMAP rate will be 65%.

The Health Care Financing Administration published the official 1998 enhanced FMAP rates in the September 10, 1997 edition of the Federal Register. In the future, the Assistant Secretary for Planning and Evaluation within the Department of Health and Human Services will publish the enhanced FMAP rate and the regular FMAP rate together in a Federal Register notice.

**Question 11. What "counts" as the Title XXI state share? When must states have their matching funds available (e.g. at the time they apply, at the time they draw down the dollars, by the end of the year)?**

**Answer.** Title XXI includes three specific limitations on what can be used as state share:

- Section 2105(c)(4) indicates that "amounts provided by the federal government, or services assisted or subsidized to any significant extent by the federal government, may not be included in determining the amount of non-federal contributions..."
- Section 2105(c)(5) establishes that a state must offset the amount of expenditures it can claim against its allotment by any premiums or other cost-sharing receipts that it collects. Cost-sharing revenue cannot be counted for the state share.
- Section 2107(e)(1)(C) imposes the same limitations on the use of provider taxes and donations as state share as are imposed under Section 1903(w) of Title XIX.

Additionally, Section 2107(d) requires the state child health plan to include details on the sources of the non-federal share of plan expenditures.

All Government-wide and Departmental requirements for drawing down federal funds will be applicable to Title XXI. The state matching funds must be available at the time the state draws down the federal funds.

We will provide further guidance, including regulations regarding the state share, as soon as they are available.

**Question 12. With respect to the maintenance of effort for 'comprehensive state-only programs,' does this only apply to Florida, New York, and Pennsylvania? In these three states, must the recent levels of funding be maintained? Can this funding then be used to draw down the enhanced match? If not, can the new funding be used only for covering "new children"?**

**Answer.** We believe that the statutory requirement for maintenance of effort for state-only health programs applies only to three states -- Florida, Pennsylvania, and New York. If these three states obtain an approved State Child Health Plan under Title XXI, then the State funds that

are used to fund their existing programs can be used to draw an enhanced federal match for expenditures under their new plans. These states must continue to spend --at least-- the same level of state funding for child health insurance as was spent in 1996, but they can draw an enhanced match on this spending under an approved state plan.

The limited maintenance of effort requirements on spending should not be confused with the more extensive requirements on maintaining Medicaid eligibility levels. In order to receive federal matching funds for a previously state-only child health program under Title XXI, states must continue to maintain their Medicaid eligibility standards and the methodologies that were effective as of June 1, 1997. If a state wants to expand Medicaid and draw down Title XXI funds at the enhanced matching rate, it must maintain the Medicaid eligibility requirements that were effective as of April 15, 1997.

One of the Administration's main objectives is to make sure that federal dollars are used to cover children who have no insurance coverage and are not covered by Medicaid. We are concerned that singling out only three states for the maintenance of effort on current state programs is inconsistent with this intent. We will work with Congress to clarify whether this provision should apply to all states.

**Question 13. Can states use any state-only health program spending to draw down match?**

**Answer.** Yes, subject to the maintenance of effort requirements specified under law and discussed in Question 12 above. A state may convert money that was previously used under a state-only child health program into a Title XXI child health program provided the state meets all of the requirements of Title XXI and has an approved child health plan. State funds previously used to finance the state-only program would be eligible for an enhanced match under an approved Title XXI plan.

However, if the state share of Title XXI spending is reduced below the level of its FY 1996 state-only health spending, its allotment will be reduced proportionately. It is important to note that the statute applies this provision only to Florida, New York and Pennsylvania. (See Question 12 above.)

**Question 14(a) If a state has expanded its Medicaid coverage, would the expenditures for "low-income targeted children" covered under the expansion qualify for the enhanced matching rate? What are some examples of different groups of children who would and would not qualify for the enhanced match?**

**Answer.** If a state uses its Title XXI allotment to expand coverage through a separate child health program, then the state must maintain the eligibility criteria and standards for Title XIX (Medicaid) that are no more restrictive than those in effect on June 1, 1997. As a result, expenditures for children who meet these criteria would not be matchable under Title XXI. This

is true regardless of whether the child is eligible under mandatory Medicaid levels, OBRA-93, an 1115 waiver demonstration, or a 1902(r)(2) expansion. Simply put, any child who meets the eligibility requirements of a state's Medicaid program in effect on June 1, 1997 is not eligible for an enhanced match under a new child health program.

If a state uses its allotment to expand coverage through Medicaid, then there is a different eligibility cut-off date. If a state chooses to expand Medicaid under Title XXI, then any child in that state who meets the eligibility requirements for Title XIX that are no more restrictive than those in effect on April 15, 1997 is not eligible for an enhanced match under Title XXI. The statute does not differentiate between children eligible under mandatory Medicaid levels, OBRA-93, an 1115 waiver demonstration, or a 1902(r)(2) expansion.

### **Examples**

1. If a state expanded Medicaid eligibility through an 1115 waiver during May, 1997 then the children who are newly eligible in May would qualify for an enhanced match only if the state uses its Title XXI allotment to expand coverage through Medicaid, using Medicaid rules. If this same state used its allotment to expand coverage through a new child health program, then the children who become eligible for Medicaid in May would not qualify for the enhanced match.
2. If a State expanded Medicaid eligibility to all children up to 250% of poverty in 1995, none of the children under 250% of poverty would be eligible for an enhanced match under Title XXI. However, if the state now wants to expand coverage to children from 250% to 300% under Title XXI, the children in this higher-income range would be eligible for an enhanced match. These rules apply to both Medicaid and non-Medicaid child health expansions.
3. If a State expanded eligibility to all children up to 250% of poverty in August 1997, the expansion children would be eligible for an enhanced match. These rules apply to both Medicaid and child health expansions.
4. Some states may choose both to expand coverage through Medicaid and through a child health program. The cut-off date for children covered by the Medicaid program would be April 15. Children covered by the children's health program would have a cut-off date of June 1.

For instance, a state which had expanded eligibility to all children below 200% of poverty in May, 1997 from a prior level of 185%, may decide to cover all children up to 225% of poverty through Medicaid and children from 225 to 250%, through the child health program. In this case, the state would receive an enhanced Medicaid match for all children whose income level was between 185% and 225%.

For all these examples, please note that a state needs to have an approved plan under Title XXI to receive an enhanced match, and the enhanced match would be limited to the amount of the allotment.

**Question 14(b). May a state apply for a §1115 waiver of the Title XXI requirements?**

**Answer.** Title XXI was written to provide a broad range of options to allow states maximum flexibility in designing the program that best meets the needs of their children. While the law provides that Section 1115 under the Social Security Act, pertaining to waivers, applies to Title XXI, we believe it would be reasonable for states to have experience in operating their new Title XXI programs before designing and submitting demonstration proposals. Without experience in implementing Title XXI, it would be very difficult for HCFA to review and evaluate the merits of any waiver proposal.

**Question 15(a). What are permissible uses for the 10 percent limit on expenditures not used for Medicaid or health insurance assistance?**

**Answer.** States may use up to 10 percent of their allotment for the following activities:

- 1) Direct purchase of services to provide child health assistance (as defined in Section 2110 (a)) for targeted low-income children.
- 2) Health services initiatives, including public health as well as other health services, for improving the health of targeted low-income children and other low-income children. Any such services must not cover other low-income children unless they include targeted low-income children.
- 3) Outreach activities to enroll children in Title XXI programs or other public or private health coverage programs, and
- 4) Reasonable costs incurred by the state to administer the plan.

**Question 15(b). How is the 10 percent limit on expenditures not used for Medicaid or health insurance assistance calculated?**

**Answer.** Under the statute, the 10 percent limit is calculated as 10 percent of total federal payments under Title XXI or for targeted low income children under Medicaid. For example, if a states' total expenditure in a fiscal year quarter is \$100,000 and the State has an enhanced federal matching rate of 65 percent, the Federal government would pay \$65,000 and the State would provide \$35,000. The 10 percent limit would apply to the Federal payments of \$65,000 and the resulting limit on State expenditures not used for child health insurance would be \$6,500.

**Question 16(a). Can a state implement a child health plan before the plan is approved? Can a state receive matching funds on expenditures made under an implemented plan that has not yet been approved?**

**Answer.** Only states with approved plans will receive allotments for federal matching funds for Title XXI expenditures. After the plan is approved, states can submit an estimate of their expenses for the first quarter of operation and receive these funds prospectively from HCFA.

States may implement a child health assistance plan prior to approval of that plan. However, any state that implements an unapproved child health plan risks the possibility that the plan will not be approved as implemented. In the event that the plan is not approved as it was implemented, the federal government would not match the state's prior expenditures. If a state does implement a plan prior to approval, provided that plan is approved, the state could receive federal matching funds on a retroactive basis (but not for expenses incurred earlier than October 1, 1997 or the beginning of the fiscal year in which the state plan was approved).

**Question 16(b) May a state expand Medicaid eligibility now, and be reimbursed retroactively for the Medicaid services at the enhanced rate?**

**Answer.** A state must submit a Title XXI plan and a Medicaid state plan amendment to be eligible for the enhanced FMAP for a Medicaid expansion. A Title XXI plan may be approved retroactive to its submission date but no earlier than October 1, 1997 or the beginning of the FY in which the state plan was approved. When the Title XXI plan is approved, a state which has expanded Medicaid is eligible to receive federal funds for the difference between its regular FMAP and the enhanced rate for the services provided for the expanded eligibility group retroactive to the beginning of the fiscal year. Federal funds are available until the state's allotment is exhausted, then the Medicaid expenditures are matched at the regular State matching rate.

**Question 17: Why do the HHS state allotments differ from the state allotments published by General Accounting Office?**

**Answer.** The law explicitly provides a formula to calculate state allotments which are based, in part on the last three March supplements to the Current Population Survey as reported and defined by the U.S. Census Bureau. In fiscal years 1998 - 2000, each state with an approved Child Health Plan will receive an allotment based on the state's proportion of the total number of low-income (less than 200 percent of poverty) uninsured children multiplied by a geographic cost factor. From FY 2001 - 2007, states will receive an allotment based on a proportion of a blended number of low-income uninsured and insured children again multiplied by a geographic cost factor.

The are four primary reasons why the HHS draft reserved allotments differ from the GAO's published allotments/formula:

1. As prescribed by law, HHS used the U.S. Census Bureau information to determine the allotments. The GAO did not. The GAO did not use the standard methodology employed by the U.S. Census Bureau in calculating the number of children below 200 percent of poverty. OMB sets government-wide standards for calculating the number of children in poverty. Census, using these standards, has a very specific set of criteria for calculating the number of children at or below 200 percent of poverty and the number of *uninsured* children at or below 200 percent of poverty. As a result, the official U.S. Census Bureau count of the number of children was lower than the GAO's by approximately 500,000 children in the count of low-income uninsured children and 1.8 million in terms of low-income children.
2. GAO did not follow the final formula specified in law for calculating the reserved allotments. In the statute, Congress included specific instructions on how to calculate the allotments. However, the final formula in the statute was not provided to the GAO for their calculations. As a result, GAO used a different calculation methodology and this difference resulted in different final allotments.
3. Even though the statute calls for the formula to be based on the number of children "at or below" 200 percent of poverty; GAO staff only calculated the number of children "below" 200 percent of poverty. Typically, most grant programs specify eligibility as being below a certain poverty level. In absence of a final draft of the bill to review, GAO assumed that this was true of the child health program. However, the child health bill clearly specifies that the formula is based on a count of those "at or below" 200 percent of poverty.
4. The base allotments used by the GAO differ from what is specified in law. Section 4921 specifies the \$60 million for diabetes programs is to be transferred from the total amount of money available for the state allotments (\$30 million from 1998-2002 to the Indian Health Services, and \$30 million to the Public Health Service for research on diabetes). The GAO staff did not remove this \$60 million from their calculations. As a result, the state allotments provided GAO are inflated by a total of \$60 million.

## **ELIGIBILITY ISSUES**

**Question 18.** If a state's Medicaid eligibility varies depending on the age of the child, can a state choose to go up to 200 percent of poverty for one age category and 50 percent above the current level for another age category?

**Answer.** Yes, but with limitations. For purposes of Title XXI, there are two limitations on financial eligibility standards:

- Eligibility is generally limited to "targeted low-income children." A "targeted low-income child" is generally defined in section 2110(b)(1) as a child whose family income exceeds the Medicaid applicable income level, but not by more than 50 percent; or 200 percent of the poverty line, whichever is higher.
- Under section 2102(b)(1)(B), eligibility standards may not, within any defined group of covered targeted low-income children, "cover such children with higher income without covering children with a lower family income."

Under the Medicaid approach, normal eligibility requirements apply. It appears that a state may define eligibility groups and apply different income standards to those groups, as long as those income standards are below the maximum income levels in the definition of "targeted low-income children" and do not favor children with higher incomes over others. As a result, a state may cover children in certain age groups with incomes above 200 percent of poverty if its current eligibility standards for such children is above 150% of poverty.

**Question 19(a).** Is the Children's Health Insurance Program a "federal means-tested public benefit", meaning that certain legal immigrant children cannot be covered?

**Answer.** The Children's Health Insurance Program must be considered a "means-tested benefit" according to the interpretation of the term as published in the Federal Register on August 26, 1997. The Children's Health Insurance Program meets the essential elements included in this definition:

- It is a mandatory spending program as defined in section 2101(c) of Title XXI.
- The program meets the Department of HHS' definition of "means-tested" -- eligibility is based on an individual's family income and resources.
- While the statute does not explicitly require verification of income, the purpose of the program is to enable states to provide coverage to "uninsured, low-income children". The eligibility standards define a "low-income child" as one whose family income is at or below 200 percent of the Federal Poverty Level.

Therefore, many legal immigrant children who arrived in the United States after August 22, 1996 (the date of enactment of the welfare reform legislation) will not be eligible for any state health insurance program funded through Title XXI for the first 5 years of residency. However, qualified legal immigrant children in one of the excepted groups will be eligible for the program, including refugees, children of veterans or active duty service members, etc.

It is important to note that legal immigrant children who were in the United States on August 22, 1996 may be eligible for the Children's Health Insurance Program, at state option.

Undocumented immigrant children are not eligible for coverage regardless of their date of entry into the United States.

A sixty day period is available for comments on the August 22, 1997 Federal Register notice regarding the definition of "means-tested" benefit.

**Question 19(b). What about emergency services for undocumented children? Can children's health insurance funds (including the 10 percent for non-insurance related items) be used to pay for undocumented children?**

**Answer.** The only federal funds that are available for these undocumented immigrants to cover the cost of emergency services (services related to a medical condition which would place the patient's health in serious jeopardy, or would result in serious impairment of bodily functions), regardless of age, are funds provided through Medicaid. These services are available to all undocumented immigrants, provided they would otherwise meet the Medicaid eligibility requirements.

We have not yet determined whether the 10 percent non-insurance related allotment can be used to provide such emergency services to legal immigrants, for example, with incomes at a higher percentage of poverty than Medicaid allows. We will provide guidance on this issue as soon as it is available.

**Question 20. What children are excluded from participation in Title XXI?**

**Answer.** Several groups of children are explicitly excluded from participation:

- A child who is found to be eligible for Medicaid;
- A child who has health insurance coverage;
- A child who is covered under a group health plan;

- A child who is an inmate of a public institution or a patient in an institution for mental diseases; or
- A 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.

## **ADMINISTRATION**

**Question 21. What part of the Department of Health and Human Services will administer the program? Will there be a designated part of an agency or a specific person in charge? Who should states call with questions?**

**Answer.** The Center for Medicaid and State Operations (CMSO) within the Health Care Financing Administration (HCFA) will have primary responsibility for administering the federal aspects of Title XXI. In addition, there will be a team from other offices within the Department of Health and Human Services working together to provide support for this program.

Within HCFA, the implementation effort will be led by Debbie I. Chang, Director of the Office of Legislation. Debbie is working in cooperation with the Health Resources and Services Administration (HRSA) and other parts of the Department. Her phone number is 202-690-5960. Within HRSA, Earl Fox, MD, Administrator, is the lead on this effort. His number is 301-443-2216. Rick Fenton, Deputy Director of the Family and Children's Health Programs Group, will be the Center for Medicaid and State Operations' coordinator for policy and implementation activities. His phone number is 410-786-5920.

**Question 22. What will be the role of Governors, providers and children's advocacy and other interested groups in implementing the program?**

**Answer.** We plan to work with a range of interested parties to get input on the process and to make sure that implementation occurs as smoothly as possible. In particular, we will work closely with the states through the National Governors Association.

any agency or instrumentality of such Government.

**Genetic information** means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

**Governmental plan** means a governmental plan within the meaning of section 3(32) of ERISA.

**Group health insurance coverage** means health insurance coverage offered in connection with a group health plan.

**Group health plan** means an employee welfare benefit plan (as defined in section 3(1) of ERISA) to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the PHS Act and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

**Group market** means the market for health insurance coverage offered in connection with a group health plan. (However, unless otherwise provided under State law, certain very small plans may be treated as being in the individual market, rather than the group market; see the definition of "individual market" in this section.)

**Health insurance coverage** means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

**Health insurance issuer or issuer** means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). This term does not include a group health plan.

**Health maintenance organization or HMO** means—

(1) A Federally qualified health maintenance organization (as defined in section 1301(a) of the PHS Act);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same

manner to the same extent as such a health maintenance organization.

**Health status-related factor** means health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability.

**Individual health insurance coverage** means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. Individual health insurance coverage can include dependent coverage.

**Individual market** means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHS Act, such term also includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

**Internal Revenue Code (Code)** means the Internal Revenue Code of 1986, as amended (Title 26, United States Code).

**Issuer** means a health insurance issuer.

**Large employer** means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year, unless otherwise provided under State law.

**Large group market** means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer, unless otherwise provided under State law.

**Late enrollment definitions (late enrollee and late enrollment)** are set forth in 45 CFR 146.111 (a)(2)(iii) and (a)(2)(iv).

**Medical care or condition** means amounts paid for any of the following:

(1) The diagnosis, cure, mitigation, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body.

(2) Transportation primarily for and essential to medical care referred to in paragraph (1) of this definition.

(3) Insurance covering medical care referred to in paragraphs (1) and (2) of this definition.

**Medical condition** means any condition, whether physical or mental,

including, but not limited to, any condition resulting from ill injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

**NAAC** stands for the National Association of Insurance Commissioners.

**Network plan** means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

**Non-Federal governmental plan** means a governmental plan that is not a Federal governmental plan.

**Participant** has the meaning given the term under section 3(7) of ERISA, which states, "any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit."

**PHS Act** stands for the Public Health Service Act.

**Placement, or being placed, for adoption** means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with the person terminates upon the termination of the legal obligation.

**Plan sponsor** has the meaning given the term under section 3(16)(B) of ERISA, which states "(i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan."

**Plan year** means the year that is designated as the plan year in the document of a group health plan. If that if the plan document does not designate a plan year or if there is no plan document, the plan year is:

(1) The deductible/limit year under the plan.

"(iv) substitutes for the reference to '30-day period' in sections 2701(b)(2) and 2701(d)(1) a reference to a greater period;

"(v) prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701(d) or expands the exceptions described in such section;

"(vi) requires special enrollment periods in addition to those required under section 2701(f); or

"(vii) reduces the maximum period permitted in an affiliation period under section 2701(g)(1)(B).

"(c) **RULES OF CONSTRUCTION.**—Nothing in this part shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

"(d) **DEFINITIONS.**—For purposes of this section—

"(1) **STATE LAW.**—The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

"(2) **STATE.**—The term 'State' includes a State (including the Northern Mariana Islands), any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

#### "PART C—DEFINITIONS; MISCELLANEOUS PROVISIONS

##### "SEC. 2701. DEFINITIONS.

"(a) **GROUP HEALTH PLAN.**—

"(1) **DEFINITION.**—The term 'group health plan' means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"(2) **MEDICAL CARE.**—The term 'medical care' means amounts paid for—

"(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

"(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

"(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

"(3) **TREATMENT OF CERTAIN PLANS AS GROUP HEALTH PLAN FOR NOTICE PROVISION.**—A program under which creditable coverage described in subparagraph (C), (D), (E), or (F) of section 2701(c)(1) is provided shall be treated as a group health plan for purposes of applying section 2701(e).

"(b) **DEFINITIONS RELATING TO HEALTH INSURANCE.**—

"(1) **HEALTH INSURANCE COVERAGE.**—The term 'health insurance coverage' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical

care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

"(2) **HEALTH INSURANCE ISSUER.**—The term 'health insurance issuer' means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974). Such term does not include a group health plan.

"(3) **HEALTH MAINTENANCE ORGANIZATION.**—The term 'health maintenance organization' means—

"(A) a Federally qualified health maintenance organization (as defined in section 1301(a)),

"(B) an organization recognized under State law as a health maintenance organization, or

"(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

"(4) **GROUP HEALTH INSURANCE COVERAGE.**—The term 'group health insurance coverage' means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

"(5) **INDIVIDUAL HEALTH INSURANCE COVERAGE.**—The term 'individual health insurance coverage' means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

"(c) **EXCEPTED BENEFITS.**—For purposes of this title, the term 'excepted benefits' means benefits under one or more (or any combination thereof) of the following:

"(1) **BENEFITS NOT SUBJECT TO REQUIREMENTS.**—

"(A) Coverage only for accident, or disability income insurance, or any combination thereof.

"(P) Coverage issued as a supplement to liability insurance.

"(C) Liability insurance, including general liability insurance and automobile liability insurance.

"(D) Workers' compensation or similar insurance.

"(E) Automobile medical payment insurance.

"(F) Credit-only insurance.

"(G) Coverage for on-site medical clinics.

"(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

"(2) **BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.**—

"(A) Limited scope dental or vision benefits.

"(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

"(C) Such other similar, limited benefits as are specified in regulations.

"(3) **BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.**—

"(A) Coverage only for a specified disease or illness.

**THE ADMINISTRATION'S RESPONSES TO QUESTIONS ABOUT THE  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM  
October 3, 1997**

**INTRODUCTION:**

This document responds to some of the questions about the State Children's Health Insurance Program that have been raised by States, providers, consumers and others. This is the second in an on-going series of questions and answers released by the Administration. The first set was released on September 11, 1997 and is available on the Internet ([www.hcfa.gov](http://www.hcfa.gov)) or by calling (410)786-0673. The list is not all-encompassing and there are many other questions critical to the successful implementation of this program that we also intend to answer. The Administration remains committed to providing timely responses to important issues and will issue additional guidance as it becomes available.

**STATE PLAN DEVELOPMENT**

Question 23(a). Section 2103(c)(4) requires an actuarial analysis of the actuarial value of benchmark benefit packages that the State is offering in its child health plan. Will this be done on a national level or must each State hire an actuarial firm to do the calculation individually? Can a number of States work together jointly to do an analysis for all of them? . . . . . 3

Question 23(b). What is the process for assessing States' actuarially-equivalent benefit packages? . . . . . 3

Question 23(c). Since the FEHBP Blue Cross Blue Shield PPO is a national plan, can't the Federal government determine its actuarial value for all States and save them the expense of hiring actuaries? . . . . . 4

Question 24. Do the requirements for basic and additional services apply only when a State decides to provide benchmark-equivalent coverage? Does this requirement also apply to the other three options, the benchmark package, the existing State program and the Secretary-approved coverage, (Sections 2103(a)(1), (a)(3) and (a)(4) respectively)? . . . . . 4

Question 25(a). How will the benchmark coverage that is based on coverage through an HMO be determined? . . . . . 4

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Question 31. With respect to the maintenance of effort provision for Medicaid, do the June 1, 1997 and April 15, 1997 dates refer to the State plans "in effect," meaning in operation? Would plans submitted or approved, but not "in effect" qualify? . . . . . 7

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## **STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

**October 3, 1997**

### **STATE PLAN DEVELOPMENT**

**Question 23(a). Section 2103(c)(4) requires an actuarial analysis of the actuarial value of benchmark benefit packages that the State is offering in its child health plan. Will this be done on a national level or must each State hire an actuarial firm to do the calculation individually? Can a number of States work together jointly to do an analysis for all of them?**

When the State submits its State child health plan, it must provide an actuarial report that compares the benchmark package to the State-designed benchmark-equivalent package and that also demonstrates that the requirements under Title XXI are met. States must assure that the assumptions used to estimate the State-designed benchmark-equivalent package are the same as those used in the actuarial analysis of the benchmark package. Also, assumptions must be used consistently throughout the actuarial analysis. The actuarial report must be prepared in accordance with the principles and standards of the Actuarial Standards Board of the American Academy of Actuaries.

States are free to pool their resources to obtain actuarial services. The actuarial value of the benchmark plans and the State-designed plans, however, will vary from State to State, so the determination of actuarial value would have to be tailored to the individual State.

**Question 23(b). What is the process for assessing States' actuarially-equivalent benefit packages?**

States should submit to the Health Care Financing Administration (HCFA) all information necessary for HCFA's actuaries to review a State's calculations and determine the accuracy of their calculations for benchmark-equivalent benefit packages. The HCFA actuaries will review the plans of all States that elect to adopt an actuarially equivalent benchmark benefit plan. HCFA will review the actuarial report as part of the overall plan approval process. The law provides that: (1) a State plan or amendment is considered approved unless the Secretary notifies the State in writing, within 90 days after receipt of the plan or amendment, that the plan or amendment is disapproved (and the reasons for disapproval); or (2) additional information is needed. Thus, if the actuarial report is not complete or raises questions, HCFA will contact the State, request clarification and the 90-day clock stops. If, even after complete information is received, HCFA determines that the benefits do not meet the requirements in law, it may disapprove the State's child health plan.

**Question 23(c). Since the FEHBP Blue Cross Blue Shield PPO is a national plan, can't the Federal government determine its actuarial value for all States and save them the expense of hiring actuaries?**

No. If a State offers benchmark-equivalent coverage (not the actual benefits in this plan), it must obtain an opinion from a member of the American Academy of Actuaries to determine the value of the FEHBP Blue Cross Blue Shield preferred provider option benefit plan because the actuarial value of this plan will vary from State to State (e.g., due to regional cost variation and differences in the target population).

**Question 24. Do the requirements for basic and additional services apply only when a State decides to provide benchmark-equivalent coverage? Does this requirement also apply to the other three options, the benchmark package, the existing State program and the Secretary-approved coverage, (Sections 2103(a)(1), (a)(3) and (a)(4) respectively)?**

Requirements related to the actuarial value of basic and additional services (specified in Section 2103(c)(1-2)) only apply to benchmark-equivalent coverage and not to the other three options. The law specifies the manner in which the benchmark-equivalent coverage must compare to the benchmark model that is selected by the State.

**Question 25(a). How will the benchmark coverage that is based on coverage through an HMO be determined?**

One benchmark benefit package specified in the statute is:

“[t]he health insurance coverage plan that is offered by a health maintenance organization . . . and, that has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved. (Section 2103(b)(3)) (Emphasis added).

The benchmark coverage being identified is the particular insurance product (i.e., benefit package) with the largest number of enrolled commercial, non-Medicaid covered lives offered by an HMO, rather than simply the HMO with the largest total commercial enrollment within all benefit packages offered by the HMO. States wishing to use this option should describe in their State plan their methodology for identifying the HMO product with the largest enrollment.

**Question 25(b). Can the "HMO with the largest insured commercial, non-Medicaid enrollment" participate in the FEHBP? Are Federal employees considered commercial enrollees?**

Yes. The HMO benefit coverage that has the largest insured commercial, non-Medicaid enrollment of covered lives may be a plan in the FEHBP. The benchmark plan specified by section 2103(b)(3) can only be a single benefit package that is identified as being delivered by an HMO in the State to the most commercial, non-Medicaid covered lives in the State. For these purposes, Federal employees are considered to be commercial enrollees.

**Question 26. Can States enrich the coverage offered by a benchmark benefit package?**

Yes. The State is free to offer more benefits than are included in the benchmark package.

**Question 27. Can the State give money to community health centers to expand and cover children for certain services? Can a community health center be designated as the delivery system?**

A State may pay a community health center to obtain the minimum child health assistance benefits coverage for eligible children. In that instance, a community health center would, if qualified, furnish such coverage independently. Or a community health center could provide some of the health benefits and develop arrangements with other providers to furnish the remaining scope of such coverage. A community health center also could provide some part of the minimum coverage under arrangement or contract with an entity that is responsible for furnishing the overall coverage.

Section 2105(c)(2)(A) also permits payment for other child health assistance for low-income children, which could be provided through community health centers through contracts with the State. In addition, Section 2105(c)(2)(B) allows the State to request a waiver from the Secretary to permit the State to exceed the 10 percent limitation on the use of funds (as specified in section 2105(a)). This waiver would apply for services that meet the coverage requirements of section 2103, as long as these services: (1) do not cost more (on an average per child basis) than coverage provided under section 2103; and (2) are provided through a community-based health delivery system or with hospitals such as those that receive disproportionate share payments.

## **STATE PAYMENT PROCESS**

### **Question 28. What premiums may the State charge for children in eligibility categories under title XXI? What about copayments?**

A State may not charge a premium that exceeds the maximum monthly charge permitted under section 1916(b)(1) of the Social Security Act for a targeted low-income child whose family income is at or below 150% of the poverty line. The premiums are based on an income-related sliding scale. The maximum monthly premium (per family) allowed are \$19 for a family of 1 or 2 persons, \$16 for a family of 3 or 4, and \$15 for a family of 5 or more. A State may not charge a deductible, cost sharing or a similar charge that exceeds an amount that is nominal under section 1916(a)(3) and, as specified in section 2103(e)(3), "with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable" for a targeted low-income child whose family income is at or below 150 percent of the poverty line. The maximum copayment that a recipient currently can be charged is \$3 for any service more than \$50.

For children above 150% of poverty, premiums may be imposed on a sliding scale related to family income. The total annual aggregate cost-sharing (including premiums, copayments, etc.) for all targeted low-income children in a family, however, may not exceed 5% of total family income for the year. (Section 2103(e)(3)(B), subject to paragraphs (1)(B) and (2) of section 2103(e))

For optional targeted low-income children who are covered under Title XIX, the cost-sharing provisions contained in the Medicaid program continue to apply. Thus, no cost-sharing could be imposed on these children. (Section 1916(b)(2))

### **Question 29. Are intergovernmental transfers included in the State share for matching purposes?**

Yes, so long as the State share complies with the limits outlined in statute and the State spending maintenance of effort (see question 11 from 9/11/97 document). HCFA will provide more guidance on the State match at a later time.

### **Question 30. The law includes appropriations for this program until FY 2007; what happens after 2007?**

If Congress does not continue the mandatory appropriation, additional funds will be needed to continue the program after FY 2007. Funds already appropriated will remain available through the year 2010 (procedures are outlined in section 2104(e); (see question #9 from our 9/11/97 document). After settlement of all expenditures through the year 2010, Title XXI appropriation authority will expire.

## MEDICAID ISSUES

**Question 31. With respect to the maintenance of effort provision for Medicaid, do the June 1, 1997 and April 15, 1997 dates refer to the State plans "in effect," meaning in operation? Would plans submitted or approved, but not "in effect" qualify?**

"In effect" means that the policy was being applied by the State on the specified date. The State must be paying for coverage under their State plan amendment as of the maintenance of effort date. A submitted and pending State plan amendment adding the policy, but with a later effective date, would not be "in effect" on that date, regardless of when it was submitted.

**Question 32(a). When do expenditures under the presumptive eligibility provision of Medicaid qualify for the enhanced match and when do such costs count against the Title XXI allotment?**

Newly enacted Section 1920A of the Social Security Act permits States to cover medical assistance to a child during a presumptive eligibility period. During the presumptive eligibility period, expenditures are matched at the regular Federal medical assistance percentage (FMAP) rate under Section 1905(b).

However, if a child is ultimately determined to have been eligible for Medicaid (under any Medicaid eligibility category) during a retroactive period, including some or all of the period of presumptive eligibility, then claims may instead be submitted under that eligibility category during that period. For children eligible under traditional Medicaid categories, Federal payments would be made at the regular FMAP and would not count against the Title XXI allotment. For children eligible under the newly enacted Medicaid optional targeted low-income children category, Federal payments would be at the enhanced FMAP and would count against the Title XXI allotment. For children determined ineligible for Medicaid or if an application is not filed, then the Federal payments will be counted against the Title XXI allotment.

**Question 32(b) How are the costs of presumptive eligibility determined that are counted against individual State allotments (2104(d)(1))?**

The costs associated with presumptive eligibility are equal to the amount of Federal payments provided to the State under Medicaid as matching funds for services provided to children who are only presumptively eligible. It should be noted, however, that although a child may be initially determined as presumptively eligible, once the State has determined eligibility under current Medicaid, that eligibility would be effective from the month of application and those costs would not be deducted from the Title XXI allotment. Generally, the only Federal funds related to presumptive eligibility that will be deducted from the Title XXI allotment are for services provided to children who are determined presumptively eligible but who: (1) do not file an application for Medicaid; or (2) file an application, but are determined to be ineligible for Medicaid.



OCT 10 1997

Dear State Medicaid Director:

The purpose of this letter is to provide initial policy and State plan guidance on implementing the new health coverage provisions for children in the Balanced Budget Act of 1997 (P.L. 105-33, BBA '97) that apply under Medicaid.

The new law creates a new Children's Health Insurance Program (CHIP) in title XXI of the Social Security Act and permits the expansion of Medicaid eligibility for children. These changes allow a State to expand coverage for uninsured, low-income children through the Medicaid program, through a new or expanded separate child health insurance program, or through a combination of the Medicaid program and a separate child health insurance program. To allow States to cover these children under Medicaid, section 4911 of the BBA '97 establishes a new optional group of targeted low income children.

The new law also added three other options for States to expand coverage of children under Medicaid. Section 4912 amends title XIX to add an option for States to provide presumptive Medicaid eligibility to children for a limited period of time. Section 4731 amends title XIX to give States the option to provide continuous eligibility to children for up to a year. This section also gives States the option to accelerate the phase-in Medicaid coverage of children under the eligibility group for children under age 19 in families with income up to 100% of the Federal poverty level.

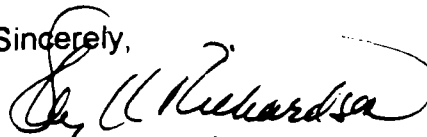
In order to expand coverage for children through the Medicaid program under these options, you must amend your Medicaid State plan. Attached are draft preprint pages for amending a Medicaid State plan to adopt any of the Medicaid options mentioned above. These draft pages, or other preprint pages which reflect the requirements of the law, can be used pending publication by HCFA of final State plan preprint pages for these options. These should be treated as standard State plan amendments, which you should submit to your HCFA regional office in accordance with the usual procedures for submitting State plan amendments. State plan amendments can be effective no earlier than the first day of the quarter in which they are submitted to the regional office.

States choosing to implement the Children's Health Insurance Program through Medicaid may receive an enhanced federal match for expenditures on optional targeted low-income and accelerated poverty level children. To receive an enhanced match for targeted low-income children, States must submit and have approved a State child health plan under title XXI. (An abbreviated title XXI child health plan can be submitted in such cases.) To facilitate the review and approval process, we encourage you to submit both the Medicaid State plan amendment and the title XXI State child health plan to the regional office at the same time. Your regional office is prepared to provide any assistance that you may need in preparing your State child health plan or Medicaid State plan amendments to implement the Medicaid options discussed in this letter.

We are working closely with the joint Federal/State Eligibility Technical Advisory Group to resolve policy issues identified during the implementation process. That process is continuing and will culminate in the publication of new State Medicaid Manual guidelines in the near future. In the meantime, we have attached initial guidance on some of the issues related to these provisions. The guidance includes the funding source for each option, the availability of an enhanced match rate, and an explanation of when title XIX payments will reduce the title XXI allotment. The attached guidance will be included in a broader series of questions and answers addressing issues related to implementation of CHIP in general. The broader series is available on the Internet at "www.hcfa.gov." (If you wish, your HCFA regional office will also provide you with a copy of all questions and answers as they are placed on the Internet.)

We will keep you informed as new policy guidance becomes available. In the meantime, if there are any questions, please contact your HCFA regional office staff.

Sincerely,



Sally K. Richardson

Director

Center for Medicaid and State Operations

**Attachments**

cc: All HRSA/HCFA Regional Administrators

**STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)**  
**MEDICAID RELATED PROVISIONS**

October 9, 1997

**INTRODUCTION:**

This document builds on the series of questions about the State Children's Health Insurance Program that have been raised by States, providers, consumers and others. This is the third installation of questions and answers released by the Administration, and will be available on the Internet ([www.hcfa.gov](http://www.hcfa.gov)) or by calling (410) 786-0673. This list deals specifically with questions that relate specifically to the relationship between the new Children's Health Insurance Program and the Medicaid program. We will continue to answer critical questions and the Administration remains committed to providing timely responses to important issues. We will issue additional guidance as it becomes available.

**OPTIONAL TARGETED LOW-INCOME CHILDREN (§4911)**

**Question 33.** The CHIP Medicaid option (section 1905(u)(2)(C)) requires that an optional targeted low-income child be ineligible for medical assistance under the title XIX State plan. If a State chooses the CHIP Medicaid option, can a child who is eligible or potentially eligible for Medicaid as medically needy be covered as an optional targeted low-income child?

If a child is medically needy, without a spenddown, the child is otherwise Medicaid eligible and cannot be an optional targeted low-income child. Section 1905(u)(2)(C) of the Social Security Act refers to the definition of "targeted low-income child" under section 2110(b)(1) of the Act. This section provides that a targeted low-income child cannot be eligible for medical assistance under title XIX regardless of how they are eligible. Moreover, section 1905(u)(2)(C) contains maintenance of effort language which precludes States from covering as a targeted low-income child a child who would qualify for medical assistance under a State plan in effect on April 15, 1997. Thus, if the child would have qualified for Medicaid as medically needy without a spenddown under the State's April 15 State plan rules, even if not eligible under current rules, the child could not be covered as a targeted low-income child.

It should be noted that, if a State determines that the child is not yet medically needy because he/she has not yet met the spenddown, then the child is not otherwise Medicaid eligible. Accordingly, these children could be covered as targeted low-income children.

**Question 34. Do the exclusions in the Title XXI definition of a targeted low-income child apply under the Medicaid optional targeted low income children group? (The exclusion includes children who are inmates of public institutions, patients in institutions for mental diseases, or children who are members of families that are eligible for health benefits coverage under a State health benefits plan).**

No. These exclusions only apply for purposes of establishing a separate child health option under title XXI. However, the existing Medicaid restrictions on Federal financial participation (FFP) for services provided to inmates of a public institution and patients in institutions for mental diseases would apply to optional targeted low income children under Medicaid. (Note that FFP is available under Medicaid for inpatient psychiatric services for children under age 21.)

**Question 35. Are States that go the traditional Medicaid route required to provide the full Medicaid benefit package, including EPSDT, to children covered under the Medicaid option?**

Yes. The State must provide the Medicaid benefits package, including EPSDT, to all children covered under Medicaid, including optional targeted low-income children.

**Question 36. Do the immigration restrictions adopted under welfare reform (as amended by the Balanced Budget Act) apply to optional targeted low income children under Medicaid?**

Yes. The Children's Health Insurance Program is considered a "means-tested benefit" according to the interpretation published in the Federal Register on August 26, 1997.

**Question 37. Can a State limit the children covered under the Medicaid optional targeted low-income children group to certain children or must they cover all children who meet the definition of targeted low-income child?**

A State may choose to cover any reasonable group or groups of children as optional targeted low-income children. However, other applicable requirements of the Medicaid law must be met. For example, States must make groups eligible on a Statewide basis and must furnish equivalent coverage to all children within each eligible group.

**Question 38. If a State has expanded coverage of children under its Medicaid State plan prior to October 1, 1997, can the State claim enhanced match for the expansion children as optional targeted low income children?**

Children covered under a Medicaid State plan expansion as qualified or poverty-level children cannot be included as optional targeted low-income children under the statute. This is because the statute provides that a child who is in a mandatory eligibility group, such as the qualified or the poverty level children, cannot be included as an optional group such as the optional targeted

low-income children. (See section 1902(a)(10)(A)(ii).) However, if a State expanded the eligibility of children under Medicaid *after* April 15, 1997, the State has the option to amend its State plan to include the expansion group as an optional group of targeted low-income children, for which there is an enhanced match.

**Question 39. Must a State submit a title XXI plan if it decides to use title XXI funds to expand Medicaid?**

Yes, but only certain sections of the title XXI plan have to be submitted. Information on specific sections and the recently released draft template and instructions are available through your regional office.

**Question 40. In a state which chooses the Medicaid route, what happens when the title XXI allotment has all been spent?**

Unless the State plan is amended to drop the optional targeted low-income children, it is obligated to continue providing services to eligible children. The State can claim regular Medicaid matching funds for such children. This is similar to discontinuing coverage for any other Medicaid group, a State must submit and have approved a State plan amendment in order to do so.

**Question 41. What is the source of funding for this Medicaid group of optional targeted low-income children?**

Federal payments for expenditures for children covered under a Medicaid CHIP option should come out of the title XIX appropriation and are applied against the State's title XXI allotment until that allotment is exhausted. After the title XXI allotment has been spent, expenditures for children covered under a Medicaid CHIP option are matched at the regular Medicaid rate, except that, for any children included in the group who were born before 10/1/83 (described in section 1905(u)(3) -- with family incomes less than 100% of the FPL), the FMAP remains at the enhanced rate even after the title XXI allotment is exhausted.

**MEDICAID PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME CHILDREN (§4912)**

**Question 42. Is a State which elects the State plan option to provide presumptive eligibility for children required to provide all Medicaid services to presumptively eligible children?**

Yes. A State is required to provide all services covered under the State plan to presumptively eligible children, including all EPSDT services as provided for under current law.

**Question 43. Is a child limited to one period of presumptive eligibility?**

No. However, we do not believe that it is reasonable to allow an unlimited number of periods of presumptive eligibility within a short time frame, as this could result in almost continuous eligibility for an individual who is actually ineligible. We will work with the Eligibility Technical Advisory Group (E-TAG) to develop additional guidance on this issue.

**Question 44. Must a State use a single income test?**

No. Unlike presumptive eligibility for pregnant women, States are not required to have a single income standard for an eligibility group for all children. States must use the highest income standard under which a child is potentially eligible. For example, the standards for presumptive eligibility might be 133 percent of the FPL for children under 6 and 100 percent for children under age 19, if these were the highest standards applicable to children of the specified age under a State's Medicaid plan.

**Question 45. Can entities other than those listed in the law make determinations of presumptive eligibility (e.g., welfare workers, home visitors, advocacy groups, volunteers)?**

No. Only "qualified" entities listed in the law under presumptive eligibility (§1920A.(b)(2)) may make determinations of presumptive eligibility. These are entities that provide health care items and services covered under the State plan and are eligible for payments under the State plans, and entities authorized to determine eligibility for the Head Start program, child care funded under the Child Care and Development Block Grant, or WIC. Therefore, States could certify a cash assistance worker as a qualified entity only if that worker were also authorized by the State to determine eligibility for Head Start or child care as outlined above.

**Question 46. The law requires that the qualified entity making the determination of presumptive eligibility inform the parent or custodian of the child that an application for Medicaid must be filed by the end of the following month. Can this person be any interested adult who has the child in his/her care at the moment or must it be the parent or legal guardian?**

The State may allow the qualified entity to inform the adult who is caring for the child at the time that the determination of presumptive eligibility is made. We will defer to States on the determination of whether this adult is considered 'custodian' of the child for these purposes.

**Question 47. If a State chooses to provide presumptive eligibility, must it be made available Statewide?**

Yes. Presumptive eligibility is part of the State plan and §1902(a)(1) requires that the plan must be in effect in all political subdivisions of the State.

**Question 48. What is the source of funding for presumptive eligibility for children provided under Medicaid? What about a State that does not have a title XXI plan, but wants to use this option?**

Payments made on behalf of a child who is ONLY presumptively eligible (not subsequently determined to be eligible for Medicaid or title XXI), come out of the title XIX appropriation and are applied against the title XXI allotment, if any (a State only has an allotment if it has an approved title XXI plan). The FMAP is at the regular Medicaid rate.

Payments made on behalf of a child who is subsequently determined Medicaid eligible for the period in question should be made under the applicable policy for the Medicaid group under which they have been determined to be eligible rather than under presumptive eligibility. (The FMAP would be at the regular or enhanced rate, as appropriate for the child's age and eligibility group.) Medicaid eligibility (other than presumptive eligibility) is effective the month of application and potentially for up to three months prior to application. Therefore, the only payments which should be made under presumptive eligibility are those made on behalf of children who fail to file an application for regular Medicaid or who are determined to be ineligible for Medicaid for some or all of the presumptive eligibility period.

**Question 49. Can presumptive eligibility be made available only to certain subgroups of children?**

No

### **CONTINUOUS ELIGIBILITY FOR CHILDREN (\$4731)**

**Question 50. Can a State choose to provide continuous eligibility only to certain groups of children?**

A State may place an age limit on the children eligible for continuous eligibility. However, the State must cover all children within the chosen age limit who the State determines are eligible under the State plan.

**Question 51. What is the source of funding for continuous eligibility?**

Payment for continuous Medicaid eligibility under title XIX comes out of the title XIX appropriation, and is made at the appropriate FMAP rate based on the child's eligibility status (the enhanced rate may be available for optional targeted low-income children, for example). Payments would not be applied against the title XXI allotment, except when those payments are made at the enhanced FMAP rate.

Citation

Groups Covered

B. Optional Coverage Other Than the Medically Needy  
(Continued)

1902(a)(10)(A)  
(ii)(XIV) of the Act

19. Optional Targeted Low Income Children who:

- a. are not eligible for Medicaid under any other optional or mandatory eligibility group or eligible as medically needy (without spenddown liability);
- b. would not be eligible for Medicaid under the policies in the State's Medicaid plan as in effect on April 15, 1997 (other than because of the age expansion provided for in §1902(l)(2)(D));
- c. are not covered under a group health plan or other group health insurance (as such terms are defined in §2791 of the Public Health Service Act coverage) other than under a health insurance program in operation before July 1, 1997 offered by a State which receives no Federal funds for the program;
- d. have family income at or below:  
  
200 percent of the Federal poverty level for the size family involved, as revised annually in the Federal Register; or  
  
A percentage of the Federal poverty level, which is in excess of the "Medicaid applicable income level" (as defined in §2110(b)(4) of the Act) but by no more than 50 percentage points.

The State covers:

— All children described above who are under age \_\_\_\_\_ (18, 19) with family income at or below \_\_\_\_\_ percent of the Federal poverty level.

— The following reasonable classifications of children described above who are under age \_\_\_\_\_ with family income at or below the percent of the Federal poverty level specified for the classification:

(ADD NARRATIVE DESCRIPTION(S) OF THE REASONABLE CLASSIFICATION(S) AND THE PERCENT OF THE FEDERAL POVERTY LEVEL USED TO ESTABLISH ELIGIBILITY FOR EACH CLASSIFICATION.)

1902(e)(12) of the Act — 20.

A child under age \_\_\_\_\_ (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of \_\_\_\_\_ months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.

1920A of the Act — 21.

Children under age 19 who are determined by a "qualified entity" (as defined in §1920A(b)(3)(A)) based on preliminary information, to set the highest applicable income criteria specified in this plan.

The presumptive period begins on the day that the determination is made. If an application for Medicaid is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the State agency makes a determination of eligibility based on that application. If an application is not filed on the child's behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on that last day.

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February

(MB)

ATTACHMENT 2.2-A  
Page 4a

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

1902(a)(10)(A)  
(I)(IV) and  
1902(1)(1)(A)  
and (B) of the  
Act

8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(I)(IV) and 1902(1)(1)(A) and (B) of the Act. The income level for this group is specified in Supplement 1 to ATTACHMENT 2.6-A.

The State uses a percentage greater than 133 but not more than 105 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.

9. Children:

1902(a)(10)(A)  
(I)(VI)  
1902(1)(1)(C)  
of the Act

- a. who have attained 1 year of age but have and not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.

1902(a)(10)(A)(I)  
(VII) and 1902(1)  
(1)(D) of the Act

- b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Children born after

(specify optional earlier date)  
who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Income levels for these groups are specified in  
Supplement 1 to ATTACHMENT 2.6A.

TN No. \_\_\_\_\_  
Supersedes

Approval Date \_\_\_\_\_ Effective Date \_\_\_\_\_

**THE ADMINISTRATION'S RESPONSES TO QUESTIONS ABOUT THE  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

**November 26, 1997**

**INTRODUCTION:**

This document responds to some of the questions about the State Children's Health Insurance Program (CHIP) that have been raised by States, providers, consumers and others. This is the fourth in an on-going series of questions and answers released by the Administration. Previously released sets are available on the Internet ([www.hcfa.gov](http://www.hcfa.gov)) or by calling (410) 786-0673. The policies outlined in this document are subject to change based on further review. The list is not all-encompassing and there are many other questions critical to the successful implementation of this program that we also intend to answer. In early 1998, responses to these questions, adjusted due to feedback on them, will be included in interim final regulations, for which there will be a formal public comment process. The Administration remains committed to providing timely responses to important issues and will issue additional guidance as it becomes available.

**STATE PLAN ISSUES**

**52. Question: Will HHS post Children's Health Insurance Program (CHIP) State plans on the website for review by other States and other interested parties?**

We plan to provide access to State CHIP plans by listing an appropriate contact person for the States on our website (at <http://www.hcfa.gov/init/children.htm>.) and by setting up a link from our website to State websites for those States that make their CHIP plan available on the Internet. Requests for copies of the submitted or approved plans should initially be made to the State. However, HCFA will make copies of the submitted or approved plans available upon request.

**53. Question: The Current Population Survey (CPS) census data is the best information we have on the uninsured population. Where else can the State look for data?**

**Answer:** There is no other nationwide source of information on the number of uninsured children in each State in the CPS. In some States, State-specific survey information is available from surveys conducted by the State, certain State agencies, or through foundation-funded initiatives. In addition, Title XXI requires States to submit annual reports describing progress in reducing the number of uninsured low-income children (Section 2108(a)). The table at Section 10 of the draft application template displays the type of uniform information that would enable the federal government and States to compare any given State's progress to another State's and would enable the Secretary to make a meaningful report to Congress on the national impact of the program. It is meant to be illustrative. We intend to work with the States on this in the coming months on the best way to collect such information.

**COVERAGE**

**54. Question: If a child is enrolled in CHIP because no health insurance was available at the time of application but insurance becomes available later, is the State obligated to cancel coverage? What kind of redetermination process does the State have to have, if any?**

**Answer:** No. The State would not be obligated to cancel coverage if insurance became available to a child enrolled in CHIP. The definition of "targeted low-income child" at Section 2110(b) specifies that children who are not covered under a group health plan or other health insurance coverage are eligible to participate in CHIP if they meet the income and state-specific standards. Therefore, the mere availability of health insurance does not necessarily preclude a child from participation in CHIP. However, there is an exception in the law concerning children who are eligible for a State health benefit plan on the basis of a family member's employment with a public agency. The availability of a State health benefit plan does, in general, preclude these children's participation in a CHIP State program if the State subsidizes dependent coverage for any of the plans.

Section 2102(b)(3) requires the State to describe in its Title XXI plan how it will assure that coverage under CHIP does not substitute for other coverage, including procedures for follow-up screening. The State may wish to conduct periodic redetermination of a child's continued eligibility for CHIP utilizing the same methods and criteria as in the initial determination, or it may propose some alternate method of conducting follow-up screening, such as requiring families to notify the program when they become covered under another insurance plan. If a child were found to no longer meet the definition of "targeted low-income child" as a result of follow-up screening, the State would be obligated to cancel coverage under CHIP.

**55. Question: Is the actuarial value of a benchmark plan based on the family coverage option or the individual option?**

**Answer:** The statute does not specify whether States that decide to use a benchmark-equivalent plan must use the family coverage option or the individual option when calculating actuarial equivalence. Therefore, States may choose either the family coverage option or the individual option.

It should be noted that premiums are not taken into account when determining the actuarial value of a health insurance plan -- only benefits and cost-sharing (e.g., copayments, coinsurance, and deductibles) are taken into account. In addition, the benefit packages under family and individual options rarely differ. The benefits are usually the same and employees are simply given a choice of whether to cover themselves only or additional family members. Therefore, the actuarial value of family coverage and individual coverage should be essentially the same.

**56. Question: What is meant by the term "creditable health coverage"? How does this relate to creditable coverage under the Health Insurance Portability and Accountability Act (HIPAA)?**

**Answer:** The term "creditable health coverage" (Section 2110(c)(2)) is defined to have the same

meaning as "creditable coverage" for purposes of HIPAA. The law expressly provides that coverage furnished under CHIP must be treated as creditable coverage for purposes of HIPAA.

**57. Question: If an individual dropped existing insurance and enrolled in CHIP, would it be considered crowd-out? Is changing coverage to improve benefits crowd-out?**

**Answer:** Yes to both questions. Dropping coverage and changing coverage to increase benefits both contribute to concerns about "crowd-out" of existing coverage. Crowd-out occurs when individuals substitute public benefits for private sector benefits. Preventing crowd-out is critical to accomplishing the goal of Title XXI to expand the total number of children who have health insurance.

In order for a child to be eligible for child health assistance under Title XXI, the statute requires that the child not be covered under a group health plan or other health insurance, as defined in HIPAA. Therefore, most children enrolled in existing health coverage plans will not qualify for Title XXI eligibility. In addition, Title XXI requires that States develop procedures to ensure that "insurance provided under the State child health plan does not substitute for coverage under group health plans" (Section 2102(b)(3)(c)).

## **FINANCING**

**58. Question: Section 2110(b)(3), by special rule, allows low-income children who have insurance coverage under a State program operating since before 7/1/97 without federal funds to be considered targeted low-income children. Does that mean that children covered by private "Caring Programs" are eligible for CHIP?**

**Answer:** As of May 1997, there were more than 20 Blue Cross/Blue Shield (BC/BS) Caring Programs for Children. These programs are generally funded by contributions from the community that are matched by BC/BS. No Federal funds have been used to support these programs and each program covers anywhere from 2,000 to 14,000 children.

The answer to whether these children can be covered under CHIP depends on whether the caring program is State-operated or not. According to Section 2110(b)(3), children covered by programs "offered by a State which receives no Federal funds for the program's operation" are eligible for CHIP. To the extent that a Caring Program is State-operated, i.e., administered by the State in some respect, it is clear that these children would not be precluded from being considered as targeted low-income children. The children would also have to meet the other eligibility requirements, and each program would need to be analyzed individually to determine whether or not it was State-operated.

**59. Question: Do in-kind services provided by the public or private sector (e.g., hospital personnel developing a data collection system for the State's program) qualify as State match?**

**Answer:** We intend to apply to CHIP the regulations at 45 CFR Part 74 that deal with uniform

administrative requirements for awards and subawards including grants and agreements with States under Medicaid.” Under these regulations, in-kind contributions provided by either the public or private sector qualify as State match if they meet the criteria set forth in 45 CFR 74.23 (see attached). At the same time, Section 2107(e)(1)(C) of the Act indicates that the provisions of Section 1903(w) of the Act relating to limitations on provider taxes and donations also apply with respect to CHIP. Therefore, in-kind services may qualify for State match if they do not violate applicable Medicaid laws or Federal regulations.

**60. Question: Although the 10% cap limits the amount of Federal matching funds available for certain administrative/outreach expenditures and direct services, may a State spend its own funds (not including State matching funds) for such expenditures that are in excess of the 10% cap?**

**Answer:** Yes. The 10% cap does not limit a State’s ability to spend its own money (with the exception of the State match) on whatever projects it finds appropriate. A State can spend as much state-only money as it sees fit on administrative activities, direct services, public health initiatives, and outreach. However, under CHIP, Federal matching funds are only available for the amount of such expenditures up to the 10% cap and the States matching for administrative costs is also limited once the 10% cap is reached. Expenditures exceeding the 10% cap would have to be funded totally by the State and State match could not be used. An upcoming letter to State Medicaid Directors will clarify the formula to be used for making the 10% reimbursement calculation.

**61. Question: If a State receives approval of a limited plan or its approved plan begins late in a fiscal year so that it will not use its full allotment in that fiscal year, does the approval of the plan still protect the full allotment for use in future fiscal years?**

**Answer:** Yes. The approval of a State plan for a fiscal year secures the full allotment for the State for the entire period of availability of the allotment -- three fiscal years -- even if the State does not use the entire allotment in a fiscal year. For example, a State with an approved plan that either begins in the fourth quarter of 1998 or with a limited program may not use its full allotment in 1998. The balance of the full allotment, however, will be available for use in 1999 and 2000 for allowable expenditures.

**62. Question: If a State is using a State employee benchmark plan and the coverage includes co-pays, would the co-pays under the benchmark plan have to be limited to the Medicaid limits as under Title XIX, or could they be the same as under the public employees plan?**

**Answer:** Section 2103(e) sets the cost-sharing limits that apply to all non-Medicaid coverage plans under CHIP, regardless of which benchmark plan is used for its cost-sharing. For children in families with income at or below 150 percent of poverty, cost-sharing charges cannot exceed the limits for the medically needy under Medicaid. (For more detail, see Question 28 from the October 3, 1997, set of questions and answers.) For children in families with income above 150 percent of the poverty line, cost-sharing may be imposed on a sliding scale related to income, but the total annual aggregate

cost-sharing for all targeted low-income children in the family cannot exceed 5 percent of the family's annual income. For States choosing the Medicaid option under CHIP, Medicaid cost sharing applies.

**63. Question: If a State modifies a benchmark plan by changing cost-sharing requirements to comply with CHIP, does the State now have to complete the requirements for a benchmark equivalent plan?**

**Answer:** Not Necessarily. If the State makes adjustments to the benchmark plan's cost sharing requirements to make them more generous in order to meet the requirements of Title XXI, it does not have to submit any further documentation regarding actuarial equivalence.

## **ELIGIBILITY**

**64. Question: Does the continuous eligibility option under Medicaid apply to children who are medically needy? If so, how is this done if a spenddown is involved?**

**Answer:** No. States cannot extend continuous eligibility to children who are medically needy. The BBA provision establishing the State option for continuous eligibility for children does not cross-reference Section 1902(a)(10)(c), which describes the medically needy eligibility group.

**65. Question: Are American Indian/Alaska Native children eligible for the Children's Health Insurance Program?**

**Answer:** Yes, American Indian/Alaska Native children are eligible for CHIP on the same basis as other children in their State. Children, both Indian and non-Indian, may be eligible for CHIP if they meet State eligibility standards based on the definition of "targeted low-income child" in Section 2110(b) of the law. The eligibility of Indian children for CHIP is not affected by the fact that they may also be eligible for or are recipients of health care services funded by the Indian Health Service (IHS). Section 2105(c)(6)(B) of the law specifically exempts programs operated or financed by IHS from the requirement to prevent duplication between CHIP and other federally operated or financed health programs. Finally, Section 2102(b)(3)(D) of the law requires each State to describe, in its CHIP State plan, the procedures to be used to ensure the provision of child health assistance to targeted low-income children in the State who are American Indians or Alaska Natives.

## **MEDICAID**

**66. Question: Under regular Medicaid, a person can have private insurance as well as Medicaid coverage. CHIP excludes children with private coverage. Are children with private coverage eligible if a State chooses a CHIP Medicaid expansion?**

**Answer:** No. The regular Medicaid eligibility criteria for the targeted low-income children expansion group, at Section 1905(u)(2)(C), incorporates the CHIP definition found at Section 2110(b)(1)(C).

Under that rule, a child with private coverage could not qualify as a "targeted low-income child." Because the regular Medicaid eligibility criteria expressly include this rule, it would apply even if a State elected the CHIP Medicaid expansion option. As a result, a child with private health coverage cannot be included in a CHIP Medicaid expansion group for targeted low-income children.

**67. Question: Do all regular Medicaid requirements apply to children covered through a CHIP Medicaid expansion?**

**Answer:** Yes, except the eligibility difference described in Question 66, which states that the legislation requires children in the CHIP Medicaid expansion to be targeted low-income children. The definition of a targeted low-income child specifies that the child cannot be covered under a group health plan or under health insurance coverage. Once a State decides to expand coverage to targeted low-income children eligible for the program, through a CHIP Medicaid program, all regular Medicaid requirements apply.

**68. Question: What income and resource methodologies are used to determine that a child is eligible as an optional targeted low-income children for a CHIP Medicaid expansion?**

**Answer:** The regular Medicaid financial methods that govern eligibility of children must be used to determine if a child is eligible as an optional targeted low-income child for a CHIP Medicaid expansion. These are the income and resource methodologies under the State's AFDC plan in effect on July 16, 1996. However, a state can adopt less restrictive methodologies under the authority of Section 1902(r)(2) or 1931(d).

# **THE ADMINISTRATION'S RESPONSES TO QUESTIONS ABOUT THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

July 29, 1998 -- Fifth Set

## **INTRODUCTION:**

This document responds to some of the questions about the State Children's Health Insurance Program (CHIP) that have been raised by States, providers, consumers and others. This is the fifth in an on-going series of questions and answers released by the Administration. Previously released sets are available on the Internet ([www.hcfa.gov](http://www.hcfa.gov)) or by calling (202) 690-6257. The policies outlined in this document are subject to change based on further review. This list is not all-encompassing and there are many other questions critical to the successful implementation of this program that we also intend to answer. In 1998, responses to these questions, adjusted to take into account feedback on them, will be included in interim final regulations, for which there will be a formal public comment process. The Administration remains committed to providing responses to important issues and will issue additional guidance as necessary.

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## COVERAGE

### **69. Question: What immunization, well-baby and well-child care benefits should Title XXI plans include?**

Answer: With respect to immunizations, State CHIP plans must include coverage of all immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) in accordance with the periodicity schedule prescribed by that body. These immunization requirements are identical to the requirements that apply in both Medicaid and the Vaccines for Children (VFC) program.

With respect to well-baby and well-child care, we strongly encourage States, in designing their well-baby and well-child care coverage under CHIP, to adopt the benefits and periodicity schedules that are recommended in the American Academy of Pediatrics (AAP) *Recommendations for Preventive Pediatric Health Care* (*Pediatrics*, August 1995, vol 96:2, pp 373-374) and the American Academy of Pediatric Dentistry (AAPD) *Reference Manual* (*Pediatric Dentistry*, Special Issue, 1997-8, vol 19:7, pp 71-72), and further described in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (Green M., (Ed.). 1994). These guides are models of coverage and care that are appropriate to the specific needs of children, reflect consensus in the professional community about appropriate clinical practice, and enjoy the strong support of advocates for children's health.

### **70. Question: How will HHS define well-baby and well-child care services for purposes of the prohibition on cost-sharing outlined in Section 2103(e)(2) of Title XXI?**

Answer: As consistent with Medicaid regulations, all cost-sharing on services provided to children is prohibited in standard Medicaid CHIP expansions. For purposes of the cost-sharing prohibition that applies in non-Medicaid CHIP programs, HHS has adopted the definition of well-baby and well-child care that is used by the American Academy of Pediatrics (AAP) and incorporated in the FEHBP Blue Cross and Blue Shield (BCBS) benchmark plan, and the definition of routine dental services that is used by the American Academy of Pediatric Dentistry (AAPD).

Accordingly, in non-Medicaid CHIP programs, all the well-baby and well-child services below are subject to the prohibition against cost-sharing under Section 2103(e)(2):

- All healthy newborn inpatient physician visits, including routine screening (inpatient or outpatient);
- Routine physical examinations, laboratory tests, immunizations, and related office visits as recommended in the AAP's "*Guidelines for Health Supervision III*" (June 1997), and described in "*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*" (Green M., (ed.). 1994); and

- Routine preventive and diagnostic dental services (i.e., oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) as described by the AAPD's *Reference Manual (Pediatric Dentistry, Special Issue, 1997-8, vol 19:7, page 71-2)*.

Note that this cost-sharing prohibition applies equally to fee-for-service and managed care delivery systems.

**71. Question: Does the Mental Health Parity Act of 1996 apply to Title XXI?**

Answer: Yes. States choosing to offer non-Medicaid CHIP programs that include coverage of mental health services must comply with the Mental Health Parity Act (MHPA) regulations. States choosing to offer Medicaid CHIP programs must comply with the parity regulations for Medicaid managed care plans. These requirements are discussed below. Parity regulations are not an issue in fee-for-service Medicaid programs because there are no limits on mental health benefits. (For further information, see the State Medicaid letter dated January 20, 1998, seventh in a series of letters that provides guidance on the implementation of the Balanced Budget Act of 1997. This letter is available on the Internet at [www.hcfa.gov](http://www.hcfa.gov).)

Section 4704(a) of the BBA creates a new section in the Social Security Act (1932(b)(8)) that requires each Medicaid managed care organization to comply with certain requirements added to the Public Health Service Act by the MHPA, Public Law 104-204. MHPA provides for parity in the application of certain dollar limits on mental health benefits when limits are placed on medical and surgical benefits.

MHPA was enacted on September 26, 1996, and provides that a group health plan, or health insurance coverage offered in connection with a group health plan (as those terms are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA)), providing both medical and surgical benefits and mental health benefits may not impose an aggregate lifetime dollar limit or annual dollar limit on mental health benefits unless it also imposes such a dollar limit on substantially all of the medical and surgical benefits. If the plan does impose an aggregate lifetime limit or annual limit on substantially all medical and surgical benefits, the plan can only impose a comparable limit on mental health benefits that is less than or equal to that applied to the medical and surgical benefits. If a group health plan offers two or more benefit package options under the plan, the requirements of MHPA apply separately to each option. MHPA makes clear that the requirements of the law apply to group health plans and health insurance issuers offering coverage under such plans, regardless of whether the mental health benefits are separately administered under the plan.

Group health plans and health insurance coverage offered in connection with group health plans are not required by MHPA to provide mental health benefits. In addition, the law does not affect the terms and conditions (including cost-sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of

mental health benefits under a plan or coverage, except as specifically provided in regard to parity of aggregate lifetime limits and annual limits. Finally, MHPA requirements do not apply to benefits for substance abuse or chemical dependency.

The Department of Health and Human Services, the Department of Labor, and the Department of the Treasury developed interim rules to implement MHPA. These interim rules were published in the Federal Register on December 22, 1997 at 62 FR 66932. Please see these rules for a detailed discussion of the parity provisions. Information is also available on the Internet at: [www.hcfa.gov/hipaa/hipaahm.htm](http://www.hcfa.gov/hipaa/hipaahm.htm).

**72. Question: Can a State offer a different benefit package for children who have special needs/physical disabilities?**

Answer: If the State has chosen the CHIP Medicaid expansion option, all children must receive the same benefit package because of the Medicaid comparability requirement.

In non-Medicaid CHIP programs, States may offer different benefit packages for children with special needs. The State can define the benefit package under Section 2103 to include supplemental services for children with special needs/physical disabilities based upon medical necessity. Alternatively, the State may have more than one benefit package that meets all the requirements of Section 2103, including one designed for children with special needs/physical disabilities, as long as the eligibility criteria for that coverage complies with the Americans with Disabilities Act (ADA) requirements for non-discrimination.

If the State offers a limited package of services to address special needs (e.g., a package of long-term care support services) that is not part of comprehensive insurance coverage required under Section 2103, spending for these services would be subject to the 10 percent limitation on funds for other child health assistance.

**73. Question: Since Title XXI does not include a definition of “Institutions for Mental Diseases (IMDs),” does the Title XIX definition apply?**

Answer: Yes, the Title XIX definition applies. Section 2110(b)(2) excludes from the definition of targeted low-income children a child who is an inmate of a public institution or who is a patient in an IMD. The definition of IMDs in Title XIX regulations at 42 CFR 435.1009 states, in part, that an IMD:

“means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.”

**74. Question: Section 2110(b)(2)(A) of Title XXI excludes from eligibility children who reside in Institutions for Mental Diseases (IMDs). However, Section 2110(a)(10) allows for coverage of inpatient mental health services in CHIP. Would you address this apparent contradiction in the law?**

Answer: It is important to distinguish between eligibility under a State program and coverage of services provided under that program.

Under a non-Medicaid CHIP program, the law excludes any child who is a patient in an institution for mental diseases (IMD) from the definition of a targeted low-income child. We view this eligibility exclusion as applying when an eligibility determination is made, either at the time of application or during any periodic review of eligibility (e.g., at the end of an enrollment period). Therefore, a child who is an inpatient in an IMD at the time of application for CHIP, or during any eligibility determination, would be ineligible for insurance coverage under the program.

If a child is enrolled in a non-Medicaid CHIP plan and subsequently requires inpatient services in an IMD, the benefits for IMD services included under the plan would be covered, subject to any limits specified in the plan's benefit package. If the child needs to reside in an IMD, however, eligibility and payment would end at the time of redetermination.

For individuals enrolled under a CHIP Medicaid expansion, the rules governing eligibility and payment for inpatients in IMDs are identical to those governing the State's approved Medicaid plan. Therefore, all otherwise qualified individuals residing in an IMD qualify for eligibility, but IMD services can only be reimbursed if the State has elected to cover such services for the under 21 population in the State's approved Medicaid plan.

## **STATE PAYMENT PROCESS**

**75. Question: How are IHS services treated under a non-Medicaid CHIP plan option?**

Answer: Under Section 2102(b)(3), CHIP plans must "include a description of procedures to be used to ensure . . . the provision of child health assistance to targeted low-income children in the State who are Indians." In a non-Medicaid CHIP program, States would receive Federal matching payments for expenditures on targeted low-income children, including Native American children, at the State's CHIP enhanced matching rate. Such payment would count against the State's CHIP allotment. Native American children may be eligible as targeted low-income children, even though they are eligible for IHS services. Section 2105(c)(6)(B) specifically provides that payment may be made under CHIP for covered services provided through programs operated or financed by IHS to children enrolled in CHIP as described in question 76 below.

**76. Question: Targeted low-income Indian children can be eligible for both CHIP and IHS-funded services. Which program pays for their care?**

Answer: Title XXI does not change IHS authority. Therefore, CHIP-expanded Medicaid and/or non-Medicaid CHIP-purchased health insurance would pay for services that are covered by the CHIP plan and are provided by IHS/Tribal programs participating in the CHIP plan. IHS and IHS-funded Tribal health programs would continue to serve as the "payor of last resort." IHS programs essentially "wrap around" any third party coverage that the individual may have (including CHIP expanded Medicaid and purchased insurance). IHS only pays for items and services not covered by CHIP or other third-party coverage.

The Indian Health Care Improvement Act grants IHS and IHS-funded Tribal programs authority to bill Medicaid and all other third party insurance for services the IHS/Tribal program provides directly to the Indian person. The IHS/Tribal program also may require that health care providers with whom they contract for other services for Indian beneficiaries to bill Medicaid and other health insurance before billing the IHS/Tribal program.

**77. Question: Who is eligible for enhanced match under Section 1902(u)(2)?**

Answer: Section 1905(b) provides that enhanced Federal matching is available for services provided to children described in Section 1902(u)(2) -- optional targeted low income children. These are children under the age of 19 who meet the Title XXI financial and other eligibility requirements established by the State, do not have creditable health insurance coverage or group health plan coverage, and would not be eligible under the Medicaid State plan in effect on March 31, 1997. Thus, enhanced matching is available for any children in the new optional targeted low-income children's group and also may be available for some children in other Medicaid eligibility groups. For example, if a State expanded a mandatory poverty-level-related eligibility group by adopting less restrictive financial requirements than were in effect on March 31, 1997, enhanced Federal matching would be available for that subset of children made eligible by the expansion who meet all the criteria in the definition at Section 1902(u)(2). To receive the enhanced matching, the State would need to identify those children in the poverty-level-related group who: (1) meet the Title XXI financial and eligibility requirements established by the State; and (2) are eligible only as a result of the expansion; and (3) who do not have creditable health insurance coverage as described under HIPAA.

Enhanced matching is not available for services provided to children who become eligible for Medicaid as a result of a change in the cost-of-living amount, such as in the SSI program, or a change in the Federal poverty levels. A cost-of-living change does not affect the methods and standards under the State plan; therefore, the children would actually be eligible under the policies of the plan in effect on March 31, 1997.

Example: On March 31, 1997, a State covered all children under age 19 whose family income did not exceed 100 percent of the Federal Poverty Level (FPL) and whose family resources were

below \$1000. In 1998, the State decides to drop the resource test for the group of poverty-level-related children under age 19 and also to cover the group of optional targeted low-income children with family income between 100 and 200 percent of the FPL. Enhanced Federal matching would be available for services provided to all the children in the group of optional targeted low income children who would not otherwise be Medicaid-eligible in a poverty-level-related or other mandatory eligibility group. Children with health insurance cannot be included in this group. Enhanced matching would also be available for services provided to children in the poverty-level-related group who do not have creditable health insurance or group health plan coverage and whose resources exceed \$1000. FFP would be at the regular Medicaid matching rate for children in this group who have insurance or whose resources are below \$1000.

**78. Question: Who is eligible for enhanced Federal match under Section 1902(u)(3)?**

Answer: Section 1905(b) provides that enhanced Federal matching is available for services provided to children described in Section 1902(u)(3) -- children under age 19, born before October 1, 1983, who are eligible under the poverty-level related group of children under age 19 and who would not be eligible for Medicaid under the Medicaid State plan in effect on March 31, 1997. Unlike the children described in Section 1902(u)(2), the children described in Section 1902(u)(3) does include those children with health insurance. Thus, enhanced matching is available for services provided to children under age 19, born before October 1, 1983, whether or not they have health insurance, if they only are eligible under the poverty-level-related group and would not be eligible for Medicaid under the policies in the State plan in effect on March 31, 1997. However, enhanced match for these children phases out as this group becomes Medicaid eligible under current law.

Example: On March 31, 1997, a State did not cover children born before October 1, 1983 under the poverty-level-related group of children under age 19 (nor under an expanded group of qualified children). On March 31, 1997, the State did cover all children under age 19 under the optional group of children whose income and resources met the AFDC requirements. In 1998, the State decides to accelerate the age of the poverty-level-related group and cover all children under age 19 to 100 percent of the poverty level. Enhanced Federal matching is available for services provided to all children in the poverty-level-related group who were born before October 1, 1983, whose income and resources exceed the AFDC levels, whether or not they have insurance but only until the children become eligible for regular Medicaid under current law.

**79. Question: Does enhanced Federal matching for a Medicaid expansion under Section 1905(b) terminate if the child is subsequently determined eligible for Medicaid under the requirements of the State plan that was in effect on March 31, 1997?**

Answer: Yes. If the State determines during the eligibility redetermination period that a child is eligible for Medicaid based on the State plan in effect on March 31, 1997, then the enhanced Federal matching terminates for services provided to that child. For example, eligibility based on the State plan in effect on March 31, 1997 would apply if the family's income dropped below the

effective Medicaid income level for the poverty level group on March 31, 1997. In that event, Federal matching would revert to the regular FMAP rate.

Please note that under Medicaid regulations, the State must have procedures designed to ensure that recipients make timely and accurate reports of any changes in circumstances that may affect their eligibility. When the State receives information about changes in circumstances, it must promptly redetermine the child's eligibility. If the State has elected the option to guarantee eligibility of the child without regard to changes in circumstances under Section 1902 (e)(12), then eligibility must be redetermined at the end of the guaranteed period.

**80. Question: Can a State include the costs of the children enrolled in non-Medicaid CHIP programs when calculating the uncompensated care costs of a hospital for computing the Omnibus Budget Reconciliation Act (OBRA) 1993 hospital-specific Disproportionate Share Hospital (DSH) payment limits?**

Answer: Those children insured under a non-Medicaid State CHIP program cannot be counted as uninsured in the calculation of the hospital-specific DSH limit. Also, the shortfall (costs less any CHIP payment) for these children cannot be counted as uncompensated care.

However, if a State is doing a Medicaid expansion that is also referenced in an approved State child health plan, these children must be counted in the calculation of the hospital specific DSH limit. DSH payments made for services (either as lump-sum or service specific) rendered to children in the Medicaid expansion group must be claimed at the enhanced FMAP and are counted against the State's Title XXI allotment. If DSH payments are made unrelated to specific services (for example in a lump sum), the State must work with the HCFA Regional Office to develop an appropriate allocation methodology to allocate a portion of the DSH payments to the Medicaid expansion group so that they are appropriately claimed at the enhanced FMAP and are counted against the State's Title XXI allotment. Federal payments for such DSH expenditures (based on either the enhanced or regular FMAP) would be counted against the State's Medicaid DSH allotment.

**81. Question: When the Medicaid administrative Federal Financial Participation (FFP) rate is greater than 50 percent, how should States claim FFP for Title XIX administrative expenditures related to CHIP Medicaid expansions?**

Answer: The Health Care Financing Administration's December 8, 1997 financial letter offered States two options for claiming Federal financial participation (FFP) for administrative expenditures related to the Medicaid expansions. As discussed below, we believe States should have the flexibility to apply either of the two administrative claiming options for administrative expenditures with FFP rates greater than 50 percent. Thus, the State could elect Option 1 for claiming administrative expenditures for which the regular Medicaid FFP rate is 50 percent, and Option 2 for claiming administrative expenditures for which the Medicaid FFP rates are 75 and 90 percent (as discussed below).

Under the Medicaid program, the FFP rate for general administrative expenditures necessary for the proper and efficient administration of the Medicaid program is 50 percent (Section 1903(a)(7) of the Social Security Act). However, there are other FFP rates for Medicaid administration specified in Section 1903(a) of the Act and referenced in Federal regulations at 42 CFR 433.15 which range from 75 to 100 percent.

In the December 8 all-State letter, States were offered two options for claiming FFP for (CHIP-related) Title XIX program expansion administration expenditures:

**Option 1.** Under this option, States could elect to claim FFP for CHIP-related Medicaid administrative expenditures at the Title XXI enhanced FMAP rate. As indicated in the December 8 letter, States choosing this option “must continue to claim all such expenditures on the Title XXI expenditure forms until the 10 percent limit and/or the Title XXI allotment is reached.” Afterward, expenditures are matched at the regular FFP rate.

**Option 2.** Under this option, States could elect to claim FFP for CHIP-related Medicaid administrative expenditures under the Title XIX Medicaid program. As indicated in the December 8 letter, States choosing this option for such expenditures “will be reimbursed at the applicable Medicaid administrative matching rate.”

Although not explicit, the “applicable Medicaid administrative matching rate,” referenced in the December 8 letter refers to the 75 to 100 percent FFP rates as well as to the regular rate of 50 percent. As a result, States should consider their situation in deciding how to seek the administrative match.

Once a State chooses an option, it must consistently apply that option for the entire fiscal year. The State may then change its option at the beginning of the next fiscal year. This is because the CHIP allotment, the 10 percent limit, and the enhanced FMAP rates are all established on a fiscal year basis.

States should indicate their choice(s) for claiming FFP for CHIP related Medicaid administrative expenditures under Option 1 or 2 in their August submissions of the budget reports, either Form HCFA-37 (for the Medicaid program) or Form HCFA-21B (for the CHIP).

**82. Question: What are the procurement and prior approval requirements States must follow under CHIP with respect to contracts, including contracts with managed care organizations (MCOs)? Must the State obtain prior approval from the Federal government for sole source procurements?**

Answer: Procurement requirements found at 45 CFR Part 92 contain the overall administrative requirements for grants to State and local governments that are applicable to programs administered by the Department of Health and Human Services. Although these requirements are generally applicable to many types of procurements, other regulatory provisions apply to

procurements of automatic data processing (ADP) equipment and services. (The requirements related to ADP sole-source procurements are discussed in Question 83.)

Regulations at 45 CFR 92.36(c) require procurement transactions to be "conducted in a manner providing full and open competition." However, these regulations also recognize that competitive procurements may not always be appropriate. Specifically, 45 CFR 92.36(d)(4) allows for procurement on a noncompetitive basis when the item is only available from one source, when a competitive process would cause a delay in a situation where a "public exigency or emergency" exists, when the awarding agency authorizes noncompetitive proposals, and "after solicitation of a number of sources, competition is deemed inadequate." Generally, States utilizing a sole source procurement process for MCO contracts do so on the basis of inadequate competition. Please contact your Regional Office for more details.

With respect to prior approval, the general procurement regulations permit HHS component agencies broad latitude to impose prior approval requirements. We are not requiring prior approval of any contracts with MCOs under Title XXI.

For both procurement and prior approval, HCFA is willing to work with any State that would like to discuss these issues. We encourage States to work with us. It should be noted that HCFA has the right to subsequently review all procurement transactions under HHS grants to ensure that they comply with Federal requirements.

The State could be at risk if the Federal government determines that the State has not met such requirements. Therefore, we believe it would be beneficial for States to work cooperatively with the Federal government prior to the award of any contracts on a noncompetitive basis.

To avoid disallowances, HCFA will seek to advise States during the State plan approval process when it becomes aware of a contracting arrangement which does not comply with Federal requirements, and (if true) will not knowingly approve a plan which relies on such an arrangement.

**83. Question: What is the process for using the Medicaid Management Information System (MMIS) under CHIP?**

Answer: States have the option of expanding their existing Medicaid program under CHIP or of developing non-Medicaid CHIP programs. Although States must use their MMIS systems if they choose to expand their existing Medicaid program under CHIP, Title XIX enhanced funding is available for system changes to their MMIS. (See requirements under Part 11 of the State Medicaid Manual.) Please note that system changes directly related to eligibility determinations are not part of the MMIS and receive only a 50 percent Federal Financial Participation (FFP), as noted in Part 11.

( At their option, States may use their MMIS platform to accommodate their non-Medicaid CHIP needs. States are encouraged to consider using their MMIS systems in developing their CHIP-only programs because it may be more efficient to build upon already existing platforms. However, modifications to the MMIS must be discussed before implementation with HCFA Regional Office staff because of the potential impact upon the MMIS' overall system architecture. Even though such changes are funded only with Title XXI funds, and not with Title XIX, prior approval may still be required due to changes in the scope of the MMIS. The extent to which the MMIS may be altered under such circumstances varies widely. Consequently, States that are contemplating this approach must first discuss the changes they have in mind with our Regional Offices.

**84. Question: Must States submit cost allocation plans as required for other programs administered by Health and Human Services for Title XXI administrative costs?**

Answer: Yes. Under 45 CFR Part 94, Subpart E, States must submit cost allocation plans which describe the procedures States use in identifying, measuring, and allocating all State agency costs incurred in support of all Federal programs administered or supervised by the State agencies. Therefore, States must include information in their cost allocation plans on both Medicaid expansions and non-Medicaid CHIP programs under Title XXI.

**84a. Question: Title XXI seems to contain a very broad definition of outreach. For purposes of cost allocation, what principles should be applied to outreach expenditures?**

Answer: Under the provisions of OMB Circular A-87 and the associated regulations, costs that are common to more than one program are generally allocated to the related programs in accordance with the relative benefits received by each program. In general, this principle would apply to administrative costs for the Title XXI program. However, Title XXI provides for an exception to the general cost allocation principle, allowing States some flexibility in claiming FFP for "outreach" activities. Section 2102(c)(1) of the Social Security Act describes "outreach" as:

"Outreach to families and children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in, such a program."

As contained in this description, "outreach" under Title XXI of the Act may include activities for informing about, and assisting in, enrollment in a State's Title XXI program and other public and private health coverage programs. Therefore, we believe States have flexibility in allocating and claiming for the outreach activities specifically described in Section 2102(c)(1) of the Act under two options:

Option 1. Claim the entire costs of such outreach activities under the State's Title XXI program, without having to cost allocate to the other benefitting programs, or

Option 2. Claim the costs of such outreach activities in accordance with the provisions of Circular A-87 and related regulations. This option would require the State to allocate such costs.

Under either option, States must submit a cost allocation plan describing how they allocate administrative costs among the programs. This plan will be evaluated for approval by the Department's Division of Cost Allocation within the Program Support Center. Since cost allocation encompasses several types of programs, this issue is evaluated separately from the CHIP plan approval process. Due to the existence of a separate cost allocation plan review process, there is no need for States also to comment on cost allocation within the Title XXI plan.

**85. Question: Can a State do presumptive eligibility (PE) under its State Title XXI program?**

Answer: Yes, although there is no express provision for PE under Title XXI, a State may craft an equivalent procedure in a non-Medicaid CHIP program as a health initiative. As such, expenditures provided during the PE period are subject to the 10 percent limit for administration, outreach, health services initiatives and other child health assistance and are initially counted against the State's Title XXI allotment as described in question. A State, however, has the following options for claiming such expenditures:

**a. Identify and Claim PE on Ongoing Basis -No Adjustments.** The State can identify and claim FFP for all PE expenditures on an ongoing basis (as such expenditures are incurred and claimed to the State) with no subsequent adjustments after the actual eligibility determination. In this case, the amount of the PE expenditures would be applied against the allotment, would be claimed at the enhanced FMAP, and would be applied against the State's 10 percent limit. This approach may be the easiest for States to administer and may be best for those States with sufficient room under their 10 percent cap.

**b. Report After Actual Eligibility Determination.** The State can wait and report potential PE expenditures after the actual determination of eligibility; in that case expenditures would be classified in accordance with the actual eligibility determination:

- Expenditures for children determined to be eligible for Medicaid are funded at the appropriate Medicaid FMAP (enhanced or regular) and are not subject to the 10 percent limit.
- Expenditures for children determined to be eligible under a State's CHIP are funded at the enhanced FMAP, are counted against the allotment, and are not subject to the 10 percent limit.

- Expenditures for children determined not to be eligible for either program are funded at the enhanced FMAP, are applied against the allotment, and are subject to the 10 percent limit; that is, such expenditures are treated and reported as PE expenditures.

**c. Identify and Claim PE on Ongoing Basis -Adjust After Actual Eligibility Determination.**

The State can identify and claim FFP for all PE expenditures on an ongoing basis, as such expenditures are paid by the State (as would be done in a. above). However, after the actual determination of eligibility is made, adjustments would be made to reflect the actual eligibility category determination. In this case, the amounts of the PE expenditures would be reported on an ongoing basis, applied against the allotment, would be claimed at the enhanced FMAP, and applied against the 10 percent limit. As actual eligibility determinations are made, the State would make adjustments to the previously reported expenditures as in b. above.

**86. Question: Can States collect drug rebates under a non-Medicaid CHIP program?**

Answer: The Medicaid drug rebate program operates under the authority of Section 1927 of the Social Security Act and requires rebates for individuals eligible under Title XIX. There are no similar requirements for children made eligible only under Title XXI.

A State cannot collect Medicaid drug rebates for individuals eligible under a non-Medicaid CHIP. A State can, however, collect Medicaid drug rebates on behalf of those Medicaid expansion groups described in Section 1905(u)(2) and 1905(u)(3) of the Act and those Medicaid presumptive eligibles under 1920A.

**87. Question: In a non-Medicaid State CHIP plan, may States impose premiums on a quarterly or yearly basis? What is the interaction between premiums and enrollment fees?**

Answer: Under Section 2103(e)(3)(A), for children in families with income at or below 150 percent of the Federal Poverty Level (FPL), the State child health plan may not impose: "...an enrollment fee, premium or similar charge that exceeds the maximum monthly charge permitted consistent with standards established to carry out Section 1916(b)(1) (with respect to individuals described in such section)..." Section 1916(b)(1) sets out the requirements for cost-sharing under Medicaid for individuals who are not described within the categorically needy eligibility categories or as qualified Medicare beneficiaries. Under the regulations implementing those requirements (42 CFR 447.52), the maximum charges per month are set forth in a scale (from \$1 to \$19) based on monthly family income.

These regulations, however, do not describe payment methodologies and do not require a monthly collection process. Therefore, States will be permitted to collect quarterly or yearly charges in CHIP plans, allowing States to reduce the administrative burden of collecting fees. An enrollment fee, in addition to any premium that is imposed, is permissible to the extent that the total cost-sharing amount, allocated on a monthly basis, does not exceed the Medicaid cost-

( sharing limits specified at 42 CFR 447.52. To assure that these fees do not act as a barrier to enrollment, States wishing to collect premiums on an annual, semi-annual, or quarterly basis are required to provide beneficiaries with the option of paying their premiums on a monthly basis in payments that do not exceed the monthly maximums as described in 42 CFR 447.52.

For example, for a family of three with a gross monthly income of \$500, \$6 is the maximum monthly charge under 42 CFR 447.52. States would be permitted to bill families for charges that exceed the maximum monthly charge (e.g., quarterly or yearly), as long as the total amount does not exceed the allowable monthly amount multiplied by the periodicity, if the State plan includes an option that would allow the enrollee to pay on a monthly basis. The family in this example could be billed \$18 for a 3-month period if the family has agreed to this billing structure, or the family could opt to pay \$6 per month over the same quarter. States should refund a pro-rated share should the individual disenroll in the middle of a quarter.

For children in families with income above 150 percent of FPL, cost-sharing (including enrollment fees) must not exceed 5 percent of the family's income for the year. In a CHIP Medicaid expansion, no enrollment fee, premium or similar charge is permitted.

**88. Question: For those States that use CHIP funds to subsidize employer-sponsored insurance, can employer contributions for its employees count toward the State match?**

Answer: Payments made by employers to health insurance companies cannot be counted as the State matching payment. The State cannot receive a match for payments it does not make (Section 1903(w) of the Act).

**89. Question: Can donations from health insurers be used in computing the State match?**

Answer: Donations made to a State from health insurers are considered "provider-related" donations. Any provider-related donation made to a State, regardless of whether or not the State uses the contribution for Federal matching purposes, is subject to the statutory provisions of Section 1903(w) of the Act. In order for a provider-related donation to be considered bona fide, and therefore eligible for Federal match, the donation cannot have an indirect or direct relationship to Medicaid payments. It should be noted that the indirect relationships to Medicaid payments include linkages between provider-related donations and non-Medicaid payments from the State, including CHIP. For further information, please see 42 CFR 433.54(c) of Federal regulations.

**90. Question: How does a State assure HCFA that it is using State match that is allowable under CHIP?**

Answer: Section 9.10 of the Title XXI State plan application template dated September 12, 1997, requires that the State provide HCFA with details on the sources of the non-Federal share of plan expenditures. HCFA's approval of a State's Title XXI plan is contingent on the State's

use of permissible funding sources for the non-Federal share of plan expenditures. Furthermore, HCFA reserves the right to disallow funds, to the extent it finds the State is using impermissible funding for the non-Federal share of plan expenditures under a previously approved plan. For further information, please see 42 CFR 433.54(e).

## **STATE PLAN DEVELOPMENT**

**91. Question: When a State chooses the non-Medicaid program option, but offers the same benefit package as in their Medicaid State plan, must the State conduct an actuarial test to determine benchmark equivalence?**

Answer: No. A State will not be required to demonstrate actuarial equivalence of its CHIP benefit package to a benchmark plan if it offers the same coverage as it provides under the State's Medicaid State Plan. The Medicaid package will be considered Secretary-approved coverage under Section 2103(a)(4).

A State that has altered or reduced its Medicaid benefit package for children through a Statewide Section 1115 demonstration also will not need to demonstrate actuarial equivalence as long as the benefit package is comprehensive and provided both to the traditional Medicaid and to the expansion population of children in the State or includes full EPSDT services. Benefit packages in approved, existing Section 1115 demonstrations that meet these requirements will be considered as Secretary-approved coverage under Section 2103(a)(4).

**92. Question: In July 1997, HCFA requested that State Medicaid Directors consult with Indian Tribes in their State on Section 1115 waivers. Did HCFA request that State Medicaid Directors consult with Tribes on CHIP?**

Answer: Yes. Section 2102(b)(3)(D) of the CHIP law requires States to describe in their CHIP plan procedures used to ensure the provision of child health assistance to targeted low-income children in the State who are Indians. Therefore, States are encouraged to consult with Tribes and Indian organizations throughout the process of developing and implementing their CHIP plans, outreach strategies, and other policies and procedures. These are matters of great interest to Tribes and others in the Indian health community and on which they have significant expertise and insight. Experience with Section 1115 demonstrations and other Medicaid issues demonstrates the benefit of early consultation to identify issues when they can be resolved more successfully. For these reasons, we issued a letter to States on February 24, 1998, on the subject of Indian consultation on CHIP. Informational copies of the letter have been sent to Tribal leaders and Indian organization officials. The letters include a list of Federal agency contact persons for Indian issues, who can assist States, Tribes, and Indian organizations with their consultations upon request.

**93. Question: Must States have enabling legislation in place to implement their Title XXI plans before submitting an application?**

Answer: When the passage of State enabling legislation is required to implement a Title XXI plan, a State can submit its plan application prior to the passage of the legislation. States are asked to indicate in their application if such legislation is necessary and when it will be in place. States, as part of their application, are asked to include a statement agreeing not to draw down Title XXI funding until the enabling legislation has been enacted in a manner consistent with HCFA's State Plan approval. Additionally, States would be asked to concur that plan changes required as a result of the State legislation would be submitted as a plan amendment prior to program implementation and drawing down Federal funds. States providing this assurance could have their State plan reviewed and approved prior to the enactment of legislation. States that do not agree to these provisions would not have their plans approved.

**94. Question: Can the effective date of a CHIP State plan be retroactive to a fiscal year prior to the one in which the State's plan is submitted and approved? For example, if a State submitted and HCFA approved its CHIP plan during FY 1999, could the State receive a FY 1998 effective date?**

Answer: Yes, a State's CHIP plan can be effective prior to the fiscal year in which its State plan is submitted and approved and its allotment established, but no earlier than October 1, 1997. Matching payments may be made retroactively only if the plan eventually approved by HCFA is exactly the same as the plan in effect as of the retroactive date. (See question 16(a) released on September 11, 1997 on the risks States' may be taking in this instance.) Note, however, that there are certain special provisions applicable for CHIP State plans approved during FY 1999 and relating to the establishment of allotments for FY 1998 and FY 1999.

Under Public Law 105-74, recently enacted on May 1, 1998, if a State submits a State child health plan during FY 1999, and the plan is approved by HCFA by the end of FY 1999, that is by September 30, 1999, CHIP allotments may be established for the State for both FY 1998 and FY 1999. The effective date for the State plan would be as requested by the State, but no earlier than the beginning of FY 1998, that is October 1, 1997.

For CHIP State plans approved by HCFA after September 30, 1999, (that is during FY 2000 or later), the State's CHIP plan must be approved by HCFA by the end of that fiscal year in order to receive a State CHIP allotment for a fiscal year. For example, if HCFA approves a State's initial CHIP State plan during FY 2000, the State could only receive a State allotment for FY 2000; the State could not receive an allotment for FY 1998 or for FY 1999. Since the State did not have a child health plan approved by HCFA in FY 1998 or by the end of FY 1999, it would not receive a State allotment for FY 1998 or FY 1999.

Under Section 2106(a)(2)(B) of the Act, States may specify an effective date in their State plans, but no earlier than October 1, 1997. In the example of a State child health plan that is first

approved during FY 2000, a FY 2000 allotment would be established, but there would be no allotments for FY 1998 or FY 1999. However, the FY 2000 allotment is potentially available for providing Federal Financial Participation (FFP) for the State's allowable FY 1998 and 1999 expenditures, assuming the State has requested an effective date for its State plan in those fiscal years. Thus, a State may potentially have an effective date for its CHIP plan in a fiscal year for which it does not have a CHIP State allotment.

Note, in order for the State to receive FFP for expenditures related to a retroactive period, the CHIP State plan must comply with all applicable statutory requirements during the retroactive period and meet the requirements and specifications made by HCFA during the approval process for the State plan that was eventually approved. For example, Section 2103(e)(3) requires that cost-sharing for children in families below 150 percent of the FPL be consistent with Medicaid regulations. Therefore, a State that had higher cost-sharing than permitted under Section 2103(e)(3) for children under 150 percent of FPL would result in no retroactive financing.

**95. Question: What must States do to meet the Title XXI requirement to involve the public in the design and implementation of their child health insurance programs and to develop a mechanism that will ensure ongoing public involvement once the plan has been implemented?**

Answer: States are required under Section 2107(c) of Title XXI to ensure public involvement in the design and implementation of the plan and to ensure a method for ongoing public involvement. Beneficiaries, providers, and interested groups and organizations can provide valuable input in developing a plan and insight into the successes and challenges that arise during implementation and throughout the operation of the program. States can assure such involvement through a wide variety of approaches. Specific examples have been provided in a letter from HCFA, dated February 23, 1998. The plan reviewers will consider the viability of the approaches the State is taking and their appropriateness to each phase of the plan's development and ongoing program operation. States are strongly encouraged to utilize those methods that encourage the greatest participation.

**96. Question: What is the relationship between Title V Maternal and Child Health programs and State CHIP programs?**

Answer: Title V agencies have a statutory responsibility to assure mothers and children access to quality health care services and to provide and promote family-centered, community-based, coordinated care. These agencies complement CHIP because Title V provides States with a health care delivery infrastructure and coordinated services focusing on the needs of children and establishing standards of care for children with special health care needs and reporting systems that could enhance Title XXI evaluation.

Title V agencies and States are encouraged to work together during the design and implementation of Title XXI programs in order to augment the activities that Title V agencies are

already conducting in the area of child health as well as to share their expertise in this area with the State agency responsible for the Title XXI program.

**97. Question: What is the appeals process for a State whose Title XXI plan is disapproved?**

Answer: Upon disapproval, a State has 60 days to petition for reconsideration. This is done by submitting a written request for reconsideration to HCFA, as specified in the State's amendment disapproval letter. Until there are final regulations for the CHIP program, the appeals process for CHIP will follow the same process that applies to Medicaid State plans.

## **ELIGIBILITY**

**98. Question: How are children of public agency employees defined for purposes of CHIP eligibility?**

Answer: For purposes of Title XXI, "children of public agency employees" are children who have a family member who works for a public agency within the State and who are eligible to participate in a State health benefits plan. A public agency may be an agency of the State, county, city or other type of municipal agency. A State health benefits plan is one offered or organized by the State government. Please note that children of public agency employees who work for an agency that does not offer a State employee health insurance plan may be eligible for CHIP. For example, if a local government, such as a county or a city, has its own insurance plan that is separate from the State employee plan, the children of that entity's employees could be eligible for CHIP, as long as they are uninsured and meet all other CHIP eligibility criteria. (For more detail, see Question 54 from the November 26, 1997 set of questions and answers.)

**99. Question: Are there any circumstances under which the children of State employees can be covered by CHIP?**

Answer: Yes. Although Section 2110(b)(2)(B) excludes children who are 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, there are two methods by which low-income children of public agency workers can be covered under CHIP.

**State Program Option** -- This option applies to States that choose to expand coverage through a non-Medicaid CHIP State program. States may cover the children of public agency employees when there is no employer premium subsidy for any State health insurance coverage option in a particular public agency, assuming the children meet all other CHIP eligibility criteria. HCFA intends to provide further guidance through a regulation specifying a maintenance-of-effort date for States that do subsidize the coverage of dependent children and wish to change their program in order to exercise this

option. This is to ensure that States do not change their contributions to make children eligible for CHIP. (Note: There only are a few States that can exercise this option and that the State should consult with their Regional Offices.)

**Medicaid Option** -- States are permitted to cover the children of State workers at the enhanced matching rate if the State chooses to expand coverage through a CHIP Medicaid expansion, if these children meet all other CHIP eligibility criteria. States may exercise this option because the statute's public agency exclusion applies only to State CHIP programs, not to CHIP Medicaid expansions.

To the extent that a State provides coverage through a private insurer, under Section 2105(c)(6)(A), no CHIP payment is available for child health assistance to a child who would have been served by that insurer but for a provision of its insurance contract excluding children based on eligibility for CHIP assistance. This prevents a State from carving out CHIP children from its State health benefits plan.

**100. Question: What types of workers are included in the term "public agency" according to Section 2110(b)(2)(B)?**

Answer: Public agency employees include those of a State, county, city or other type of municipal agency including workers for whom the State contracts out. This definition includes, for example, public school districts, transportation districts, irrigation districts, and any other type of public entity.

**101. Question: What constitutes a "State health benefits plan," according to Section 2110(b)(2)(B)?**

Answer: The definition of a "State health benefits plan" is one that is offered or organized by the State government on behalf of State employees or other public agency employees within the State. It does not include separately run county plans, city plans or other public agency plans.

**102. Question: What if some public agencies with access to the State health benefits plan offer a premium subsidy for dependent coverage, while other public agencies with access to the State health benefits plan do not offer a premium subsidy for dependent coverage? Can the children who do not receive subsidized coverage be eligible for CHIP?**

Answer: Yes. Children of public agency employees whose families are offered no subsidy for the cost of dependent coverage are not truly receiving a benefit, and thus are not subject to the exclusion pertaining to children who are 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 some children of public agency employees with access to State health benefits may be eligible for non-Medicaid State CHIP programs, while others may not be eligible for non-Medicaid CHIP programs, depending on whether or not the parent's public agency employer

offers any subsidy for the cost of their coverage.

As noted in Question 99, the children of all public agency employees are always eligible for CHIP Medicaid expansions, assuming they meet other CHIP eligibility criteria.

**103. Question: If a teenager is enrolled in a non-Medicaid CHIP program because she is not eligible for Medicaid as a child and subsequently becomes pregnant and, therefore, eligible for Medicaid under the poverty-level-related group of pregnant women, must the State disenroll the teen from the non-Medicaid CHIP program? Which program would be responsible for paying for prenatal care provided prior to Medicaid enrollment?**

Answer: If the teen is enrolled in a non-Medicaid CHIP program, then becomes pregnant and thus is eligible as a poverty-level-related pregnant woman under Medicaid, the teen's non-Medicaid CHIP eligibility may end: (1) at the next scheduled redetermination of CHIP; (2) when it comes to the State's attention that the teen is pregnant and eligible under Medicaid such as when a family applies for Medicaid and the child is found eligible; or (3) when a qualified provider determines that teen is presumptively eligible for Medicaid as a pregnant woman (if the State has elected this option). (Of course, if a determination is made that a presumptively eligible pregnant teen is not eligible for Medicaid, she may be eligible for CHIP again.)

A CHIP beneficiary has a right to apply for, and receive, if eligible, Medicaid regardless of the State's practice for determining and reevaluating CHIP eligibility. This is not an option, but a requirement. When the State determines that the individual is Medicaid eligible, she can no longer be considered as CHIP eligible. If, however, the individual does not independently act to change her status, HCFA will not require the State to do so until the State redetermines CHIP eligibility.

In many instances, because the Medicaid benefits package includes pregnancy-related services, it may be more beneficial for the child to be enrolled in Medicaid. Therefore, in those cases, States are encouraged to refer and enroll pregnant teens in Medicaid.

**104. Question: Under the Vaccines for Children Program (VFC), how are the costs for vaccines reimbursed for the Medicaid expansion groups (Section 1905(b)) and the Medicaid presumptive eligibles (PEs) (Section 1920(a)), when this Medicaid expansion is also referenced in an approved State child health plan?**

Answer: Children in Medicaid expansion groups described in Section 1905(b) and the presumptively eligible described in Section 1920(a) are eligible under the Federal Vaccines for Children (VFC) program. The cost of vaccines provided under the VFC program to these groups will not be counted against the States' Title XXI allotments. Further guidance on the coverage of immunizations under Title XXI and VFC is contained in a State Health Official letter released May 11, 1998, which can be found on the HCFA website at [www.hcfa.gov](http://www.hcfa.gov).

**105. Question: Is there any income which MUST be excluded under a non-Medicaid State CHIP program?**

Answer: Yes. Certain Federal statutes other than the Social Security Act provide that payments made under that statute must not be considered income or resources in determining eligibility for benefits under any Federal or Federally assisted program or must not be considered income in determining eligibility under any means-tested program under the Social Security Act. Such payments may not be counted as income under a non-Medicaid State CHIP program.

A recent example is Section 421 of Public Law 104-204 which authorized the VA to make payments to children with spina bifida who are born to veterans who served in Vietnam. These benefits may not be considered income under any Federal or Federally assisted program. These payments must be excluded in determining non-Medicaid CHIP eligibility. Other examples include home energy assistance payments or allowances provided under subchapter II of Chapter 94, Title 42 of the U.S. Code, and relocation assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970.

**106. Question: If a State elects a non-Medicaid CHIP program, what legal immigrant children must the State cover?**

Answer: A State must cover those legal immigrant children who meet the Federal definition of qualified alien and who are otherwise eligible. The following qualified alien children who are otherwise eligible must be covered:

- All qualified alien children who were in the United States before August 22, 1996;
- Refugees, asylees, and certain Cuban, Haitian and Amerasian immigrants;
- Unmarried, dependent children of veterans and active duty service members of the Armed Forces; and
- Immigrant children who enter the United States on or after August 22, 1996 as lawful permanent residents and who are in continuous residence for 5 years. (Earliest eligibility for this group will be August 22, 2001.)

Somewhat different requirements apply under Medicaid giving the State the option to deny Medicaid to some of the immigrants who must be covered under a non-Medicaid CHIP program (e.g., qualified aliens who were in the United States before August 22, 1996). Please see Section 3210 of the State Medicaid Manual.

A State choosing a non-Medicaid CHIP program also may cover battered immigrants as determined by INS and as added by Section 501 of Division C of public law 104-208 to the definition of Qualified Alien in Section 431 of Welfare Reform, provided the immigrant is otherwise eligible for the program.

A more complete policy statement is contained in the State Health Official letter of January 14, 1998, which can be found on the HCFA website at [www.hcfa.gov](http://www.hcfa.gov).

Note that this answer clarifies the answer to Question 19(a) on the circumstances when coverage is at State option for qualified aliens who were in the United States before August 22, 1996.

**107. Question: What are States doing about limiting substitution, or crowd-out, of private health insurance coverage for public coverage under CHIP?**

Answer: Keeping the occurrence of crowd-out to a minimum has been a priority for both the Congress in drafting the CHIP legislation, and for the Administration in working with the States to approve their CHIP plans.

Following is a table that summarizes each of the twenty-four approved CHIP plans as they relate to crowd-out. As you will see, the approved plans give a variety of examples for preventing crowd-out of private health insurance coverage.

**Approved CHIP Plans as of 7/16/98\***

| State       | Type of CHIP plan         | Income eligibility threshold | Description of Crowd-out strategy                                                                                                                                                     |
|-------------|---------------------------|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Alabama     | Medicaid                  | 100% of FPL up to age 19     | No separate enrollment from Medicaid. Eligibility system is designed to use data matches and client interviews to ensure that only eligible targeted low-income children are covered. |
| California  | Combination               | 200% of FPL up to age 19     | 3 month waiting period                                                                                                                                                                |
| Colorado    | Non-Medicaid CHIP program | 185% of FPL up to age 17     | Ineligible for CHIP if eligible for Medicaid or has other creditable insurance coverage with at least a 50% employer contribution within past 3 months.                               |
| Connecticut | Combination               | 300% of FPL up to age 18     | 6 month period of uninsurance (may be extended to 12 months)                                                                                                                          |

|                |                           |                                                                                                                                                 |                                                                                                                                                                                                                                 |
|----------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Florida        | Combination               | 185% of FPL<br>up to age 19                                                                                                                     | Study and report within 6 months of implementation; if results show crowd-out, will implement a 3 month waiting period with certain exceptions. Re-evaluation at the end of 3 years.                                            |
| Idaho          | Medicaid                  | 150% of FPL<br>up to age 19                                                                                                                     | No separate enrollment from Medicaid. Children with access to private health insurance ineligible, with certain exceptions.                                                                                                     |
| Illinois       | Medicaid                  | 133% of FPL<br>up to age 19                                                                                                                     | Monitoring                                                                                                                                                                                                                      |
| Indiana        | Medicaid                  | 150% of FPL<br>up to age 19                                                                                                                     | Monitoring                                                                                                                                                                                                                      |
| Massachusetts  | Combination               | 200% of FPL<br>up to age 19                                                                                                                     | Monitoring. If study results show crowd-out, State will implement a 3 month period of uninsurance.                                                                                                                              |
| Michigan       | Non-Medicaid CHIP program | 200% of FPL<br>up to age 19                                                                                                                     | 6 month look-back/waiting period                                                                                                                                                                                                |
| Missouri       | Medicaid                  | 300% of FPL<br>up to age 19                                                                                                                     | 6 month period of uninsurance                                                                                                                                                                                                   |
| New Jersey     | Combination               | 200% of FPL<br>up to age 19                                                                                                                     | 12 months of uninsurance, with certain exceptions                                                                                                                                                                               |
| New York       | Non-Medicaid CHIP program | 185% of FPL<br>up to age 19                                                                                                                     | 9 month study – if results show crowd-out, implement either a waiting period or deny children with access to employer based coverage (at least 50% subsidized) or an alternative as later defined by the Secretary.             |
| North Carolina | Non-Medicaid CHIP program | 200% of FPL<br>up to age 19<br><br>200 to 225% FPL<br>up to age 19; enrollees will be allowed to buy into the program for one year at full cost | Applications will first be processed for Medicaid eligibility. Six month period of uninsurance for eligibility, with certain exceptions. Six months after the program has been implemented, the waiting period will be 60 days. |
| Ohio           | Medicaid                  | 150% of FPL<br>up to age 19                                                                                                                     | Monitoring                                                                                                                                                                                                                      |

|                |                           |                                                       |                                                                                                                                                                                                                        |
|----------------|---------------------------|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Oklahoma       | Medicaid                  | 185% of FPL<br>children born on or after<br>10/1/83   | Survey to determine the<br>extent of dropping existing<br>private coverage due to the<br>availability of CHIP.                                                                                                         |
| Oregon         | Non-Medicaid CHIP program | 170% of FPL<br>up to age 19                           | Six month waiting period                                                                                                                                                                                               |
| Pennsylvania   | Non-Medicaid CHIP program | 185% of the FPL<br>through age 16                     | Annual study of crowd-out.<br>If data results show a rate of<br>substitution greater than<br>12%, State will implement a<br>strategy to prevent further<br>crowd-out. Will seek<br>legislative change if<br>necessary. |
| Puerto Rico    | Medicaid                  | 200% of Commonwealth<br>Poverty Level<br>up to age 19 | Monitoring                                                                                                                                                                                                             |
| Rhode Island   | Medicaid                  | 250% of FPL<br>ages 8 through 18                      | Must not have refused<br>coverage with premiums<br>between \$150 and<br>\$300/month within the past<br>year.                                                                                                           |
| South Carolina | Medicaid                  | 150% of FPL<br>up to age 19                           | No separate enrollment from<br>Medicaid. Application<br>includes a question about<br>other health insurance<br>coverage. State will not<br>charge Title XXI for any<br>child with other coverage.                      |
| Texas          | Medicaid                  | 100% of FPL<br>ages 15 to 18                          | Monitoring                                                                                                                                                                                                             |
| Utah           | Non-Medicaid CHIP program | 200% of FPL<br>up to age 19                           | Every CHIP application will<br>go through the Medicaid<br>eligibility determination<br>process. Must not have<br>voluntarily terminated<br>coverage within three months<br>prior to application for CHIP.              |
| Wisconsin      | Medicaid                  | 100% of FPL<br>up to age 18                           | Monitoring                                                                                                                                                                                                             |

\* Corrected on August 13, 1998

## ADDITIONAL ISSUES

108. Question: In what ways was Title XXI amended by the Washington, D.C.

**appropriations bill (P.L. 105-100)?**

Answer: The following changes were made to the Title XXI program:

**(1) Section 1903(f)(4).**

► **Add “optional targeted low-income child” to exceptions for limits on FFP**

Technical correction: The new Medicaid category of “optional targeted low-income child” under Section 1905(u) is added to the list of exceptions to the limits on Federal matching in Section 1903(f)(4).

Explanation: Section 1903(f) limits Medicaid payments to individuals in families that are below 133 1/3 percent of the AFDC payment level. A number of eligibility groups, however, have received exceptions from these limits. The original law did not add this eligibility category as an exception under Section 1903(f)(4).

**(2) Section 1905(b):**

► **Enhanced match for acceleration of coverage of 15-18 years olds under 100 percent of Poverty**

Technical correction: A State’s payment made on behalf of children under Section 1905(u)(3) who are 15 to 18 year olds and below 100 percent of poverty who are not eligible under the State Medicaid plan using methodologies and criteria in effect as of March 31, 1997 cannot exceed the State’s available allotment.

Explanation: This change limits the amount of enhanced match available for these children to the amount available in the State’s CHIP allotment. The original law did not limit expenditures on behalf of children under 1905(u)(3) to the amount of the State’s available allotment.

**(3) Section 1905(u):**

► **Medicaid maintenance of effort.**

Technical correction: The definition of an “optional targeted low-income child” was amended to include a child who would not qualify for Medicaid under a State plan in effect on March 31, 1997.

Explanation: States cannot claim an enhanced match for children who would have been eligible for Medicaid on March 31, 1997. States that expand coverage through Medicaid can receive an enhanced match for children covered through expansions taking effect on April 1, 1997 or after. The original law used a date of April, 15, 1997.

- ▶ **Reference to acceleration of coverage of 15-18 year olds below 100% of poverty.**

Technical correction: The reference to this category of children is changed to 1902(l)(1)(D).

Explanation: The original law incorrectly used a reference to Section 1902(l)(2)(D), which does not exist.

- ▶ **Exemption from spending limit for Territories.**

Technical correction: The spending limits under Section 1108 for the Territories will not apply to Federal payments made based on the enhanced match under Section 2105(b).

Explanation: Section 1108 sets Medicaid spending limits for the Territories. The original law did not make an exception for Federal payments made under Section 2105(b). This change allows the Territories to use their Title XXI allotments without regard to their Medicaid spending cap.

#### **(4) Section 2104**

- ▶ **Expenditures must be applied against the allotment on a quarterly basis and in the order in which they are claimed**

Technical correction: State Medicaid expenditures will be applied against the applicable fiscal year allotment based upon the quarter in which they are claimed by the State.

Explanation: The original law required that expenditures be applied against the allotment based upon the quarter in which the State paid the expenditures. This change means that States will not have to revise the available allotments each time they receive a claim for a previous quarter.

- ▶ **Federal Allotment Amount.**

Technical correction: The CHIP appropriation for fiscal year 1998 was increased by \$20 million to \$4.95 billion.

Explanation: The original law provided an appropriation of \$4.75 billion.

#### **(5) Section 2105.**

- ▶ **Applicability of Expenditures to Allotments.**

Technical correction: A new section was added providing States with flexibility in when they submit claims.

Explanation: This change clarifies that States may claim expenditures in a quarter, although they

were incurred in a previous quarter. The original bill would have prevented States from claiming a past year's expenditures in a future fiscal year. This is inconsistent with Congressional intent to have a three-year "carry over" of allotments.

► **Reference to paragraph 5.**

Technical correction: The phrase "Subject to paragraph (5)" is deleted.

Explanation: The original law included a reference to a paragraph 5 that does not exist.

**(6) Section 2105(c)(2)(A).**

► **Calculation of the 10 percent limit on a fiscal year basis.**

Technical correction: The 10 percent limit (for outreach, administration, direct services and other child health assistance) was amended to be calculated on a fiscal year basis.

Explanation: The original law required the 10 percent limit to be calculated on a quarterly basis. This change will allow States to exceed the 10 percent limit in a particular quarter, as long as this limit is not exceeded when costs are calculated for the entire fiscal year.

► **Calculation of the 10 percent limit on total computable basis.**

Technical correction: The 10 percent limit (for outreach, administration, direct services and other child health assistance) was amended to be calculated based on total computable expenditures (Federal and State).

Explanation: The original law calculated the 10 percent limit based only on Federal expenditures. This change allows States to calculate the 10 percent limit based on the sum of both Federal and State expenditures, not just Federal expenditures.

**(7) Section 2110(b):**

► **Definition of a "targeted low income child."**

Technical correction: The definition of a "targeted low income child" was amended to include two additional options under Section 2110(b)(1)(B)(ii). First, it added a category for a child whose family income does not exceed the Medicaid applicable income level (determined as if "June 1, 1997" were substituted for "March 31, 1997.") Second, it added a category for a child who resides in a State that does not have a Medicaid applicable income level.

Explanation: The original law included only one category: a child whose family income exceeds the Medicaid applicable income level but does not exceed 50 percentage points above the

Intro letter



AUG 27 1997

Dear State Official:

The Balanced Budget Act of 1997 created a new children's health insurance program under Title XXI of the Social Security Act. This new Title enables States to initiate and expand health insurance coverage for uninsured children. The Department of Health and Human Services is pleased to be a part of this historic initiative and is looking forward to working with States on the implementation and oversight of these programs. These programs will make an unprecedented investment and contribution to the quality of life for millions of vulnerable children.

The President signed the children's health title into law just four weeks ago. The short time frame between the enactment of the bill and the effective date of the legislation requires that States and the Department work together expeditiously so that States can begin implementing new programs as soon as possible. While there are a number of technical questions to be resolved, this letter outlines the basic provisions of the program. A summary of the new legislation is enclosed.

### **OVERVIEW OF PROGRAM**

**Determination of State Allotments.** Funding for the new program is available through an enhanced match of State expenditures beginning on October 1, 1997. To receive Federal matching funds, a State must have an approved State plan. The total Federal payments available to States are specified in statute and will be allocated to States according to the statutory formula that is based on the number of uninsured, low-income children in each State and a geographic cost factor. We plan to publish by mid-September, through the rulemaking process, the preliminary fiscal year 1998 allotments of Federal funds for each State and territory, along with the assumptions and methodologies used to determine these allotments. It is important to note that while funding is available October 1, 1997, for States with approved plans, the new law allows each State to access its fiscal year 1998 allotment for three years for expenditures on children's health insurance coverage under Title XXI. For fiscal year 1998, the total amount allocated for the program is \$4.275 billion.

**Requirement to Submit a State Plan.** In order to be eligible for payment under this new legislation, each State must submit one Title XXI plan for approval by the Secretary that details how the State intends to use the funds. Under the law, a State plan is considered approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. If a State wishes to use Medicaid to expand coverage through Title XXI, it must submit a Medicaid plan amendment for an eligibility expansion. This plan should encompass all of the child health assistance being provided using title XXI funding. It is important to note that, once a Title XXI plan is approved, the State will be obligated to continue providing benefits as described in that plan until the plan is amended. (The same is true for

Medicaid.) Consistent with the law, however, States have the flexibility to modify their plans by submitting state plan amendments. The Department will be working with States to facilitate and expedite the application and approval process.

**Program Options.** The law allows States to expand coverage for children through a separate child health insurance program, through the Medicaid program, or through a combination of these programs. States have the following options under Title XXI:

**Option to Expand Medicaid.** States may elect to expand coverage through Medicaid. This new option for States would be available for children who do not qualify for Medicaid under State rules in effect as of April 15, 1997. Under this option, current Medicaid rules would apply.

**Option to Create or Expand a Separate Program.** States electing to use their available Title XXI funds to establish or expand a separate child health insurance program will be subject to new cost-sharing and benefit rules in the law (see summary). These States must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid. The law requires that any State that lowers its Medicaid eligibility standards for children below the June 1, 1997 levels be denied access to the new child health funds.

**Combination of Options.** The new law allows States to elect to use a combination of the Medicaid program and a separate child health insurance program to increase health coverage for children. For example, a State may cover children up to 133% of poverty through Medicaid and a targeted group of children above that level through a separate program. For the children the State chooses to cover under Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create or Expand a Separate Program" would apply.

**Matching Rate.** For qualifying expenditures, States will receive an "enhanced" federal matching rate that is equal to its the current FMAP increased by 30 percent of the difference between its regular matching rate and 100 percent, except that the enhanced match can not exceed 85 percent. It is important to note, for planning purposes, that a State using the Medicaid expansion may continue to collect a Federal match, at the State's regular matching rate, after exceeding its allotment. A State that elects to put its Title XXI funds into a separate state insurance program cannot receive additional federal funds for the cost of covering more children once the Title XXI funds are exhausted. If a State does not use all of its Title XXI funds in any given year, States may access the remaining unused funds in the two succeeding fiscal years.

**Limitations on Use of Funds.** The new child health program focus on low-income children and, therefore, Title XXI funding is available for "targeted low-income children" as described in the law. In their plan, States must describe the standards used to determine the eligibility of targeted

low-income children under this new program. Under the statute, funding may not be used for children who are: eligible for Medicaid or other health insurance coverage; inmates of a public institution; patients in an institution for mental diseases; or in families who are eligible for coverage under a state health benefits plan because of a family member's employment with a public agency in the State. Although children found to be eligible for other health insurance coverage generally are not eligible for Title XXI assistance, children currently covered by a State children's health program that receives no federal funds and was in operation before July 1, 1997 can be considered targeted low income children. Title XXI does not create an entitlement for any child served under a separate State program. States may claim up to 10 percent of their total expenditures for administration, outreach and the direct purchase of health services listed in the law. The law requires that Federal payment for these types of matchable expenses only may be made based on actual or expected expenditures for a given period under the child health assistance plan (up to the amount of the State's allotment), not based on the State's allotment.

**Additional Medicaid Changes.** In conjunction with the new State child health insurance program, the Balanced Budget Act included three new provisions designed to increase children's health care coverage through the Medicaid program: (1) presumptive eligibility for children; (2) coverage of SSI children; and (3) the option to provide 12 month continuous coverage.

**Presumptive Eligibility:** States now have the option of establishing a presumptive Medicaid eligibility procedure to facilitate the enrollment of children. Certain qualified entities may enroll children in Medicaid on a temporary basis, relying on information supplied by the family on income levels. This can be a particularly useful tool for reaching children who are not receiving welfare and whose parents are employed at low-wage jobs that do not offer health insurance coverage.

**Coverage of SSI Children:** States also are now required to continue Medicaid coverage for all disabled children who were receiving SSI on August 22, 1996 but who lost their Medicaid eligibility as a result of last year's law restricting the SSI child disability standards.

**12 Month Continuous Eligibility:** States now have the option to guarantee 12 months of coverage to children enrolled in Medicaid regardless of whether the child experiences changes in family income or other circumstances that would render him/her ineligible for Medicaid during the 12 month period.

### **Overview of Implementation**

Implementation of the new program will involve a crosscutting effort throughout the Department of Health and Human Services. The new program will be administered by the Center for Medicaid and State Operations (CMSO) within HCFA. We will be working jointly with the Health Resources and Services Administration (HRSA) to implement and monitor the new program as a part of the Department's overall strategy to support coordination with other Federal and State health programs in providing outreach to uninsured children and promoting coordination of care and other public health interventions.

Page 4 - State Official

We are very excited about this historic opportunity to work in partnership with States to implement a program that holds great promise of bringing health care to uninsured, low-income children. We recognize the urgency of this issue and States' desire to move quickly to cover as many uninsured children as possible. To assist States with their plans, we are developing the necessary material and instructions to implement the programs. There are, however, many issues that need to be resolved.

We are preparing information on allotments and developing a template that will provide information on the requirements and options under the new law to assist States in submitting their plans. We plan to have both available to States by mid-September. We also are working on developing a procedure for plan submittal, development of financial reporting forms and claims procedures, coordination with Medicaid expansions for children's health, and the development of procedures for annual reports, evaluations, and studies. HHS staff will gladly offer technical assistance to any State that requests it, and we will be creating avenues such as a web page to help states answer immediate questions about the new legislation and its implementation. We will be soliciting input and feedback from interested consumer and advocacy groups, the National Governor's Association and other State and local government groups, as well as individual states, throughout the entire process.

We are working to get information out to the states as quickly as possible. If you have questions about issues not addressed in this letter, please contact Rick Fenton, Deputy Director of the Family and Children's Health Programs Group at (410) 786-5920.

Sincerely,



Sally K. Richardson

Director

Center for Medicaid and State Operations

Enclosure

cc: Governor's Office

# **BALANCED BUDGET ACT OF 1997**

## **PUBLIC LAW 105-33**

### **SUBTITLE J--STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

#### **Chapter 1--State Children's Health Insurance Program**

##### **Establishment of Program (Section 4901)**

###### **Provision**

- o Amends the Social Security Act to add a new title--Title XXI--State Children's Health Insurance Program. The provisions described below list the section numbers of the new title XXI.

##### **"Section 2101 Purpose; State Child Health Plans"**

###### **Provision**

- o The purpose is to enable States to initiate and expand child health assistance to uninsured, low-income children. Such assistance should be provided primarily through either or both of two methods: (1) a program to obtain health insurance coverage that meets requirements in Section 2103 relating to the amount, duration, and scope of benefits; or (2) expanding eligibility for children under the State's Medicaid program. In order to be eligible for funds, States must submit to, and obtain approval from, the Secretary for a State Child Health Plan. This program is a capped entitlement for States.

###### **Effective Date**

- o No State is eligible for payments for child health assistance provided prior to October 1, 1997.

##### **"Section 2102 General Contents of State Child Health Plan; Eligibility; Outreach"**

###### **Provisions**

- o A State Child Health Plan must include general background on the extent children currently have coverage, current State efforts to obtain coverage, how the plan will be coordinated with other efforts, proposed delivery methods and methods to assure quality and access to covered services.
- o A State Child Health Plan must describe standards and methods used to establish and

continue eligibility and enrollment for targeted low-income children. The standards must cover lower income children within a category of covered children before higher income children and may not deny eligibility based on a preexisting condition. It also must include a description of screening procedures to ensure that: only targeted low-income children receive assistance; Medicaid-eligible children are enrolled in Medicaid; this assistance does not substitute for group coverage; eligible Indian children receive assistance; and that there is coordination with other programs.

- o A State Child Health Plan must describe procedures for outreach to families of children likely to be eligible for assistance under the Plan or under other public or private coverage and to inform them of the availability of, and assist in, enrollment in these programs.
- o The Plan must describe coordination of the State program with other public and private insurance programs.

#### Effective Date

- o No State is eligible for payments for child health assistance provided prior to October 1, 1997.

### **"Section 2103 Coverage Requirements for Children's Health Insurance"**

#### Provisions

- o Child Health Assistance (other than Medicaid), for a targeted low-income child must consist of at least any of the following:
  - (1) Benchmark Coverage--Benefit plans must be equivalent to: the standard Blue Cross/Blue Shield Preferred Provider option offered under the Federal Employees Health Benefits Program (FEHBP); a health benefits plan that is offered and generally is available to State employees; and the HMO plan with the largest commercial enrollment in the State.
  - (2) Benchmark-Equivalent Coverage- The health benefit coverage must have an aggregate actuarial value that is at least equivalent to one of the benchmark packages. The coverage must include benefits in the following categories of basic services: inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and x-ray services; and well-baby and well-child care, including age-appropriate immunizations. The coverage also must be at least 75 percent of the actuarial value of the benchmark package value for each of the following additional services: prescription drugs, mental health, vision, and hearing services.
  - (3) Existing Comprehensive State-Based Coverage-- Health Benefit coverage under an

existing comprehensive State-wide program is defined as a program that: provides a range of benefits; is administered by the State and receives State funds; is offered in New York, Florida or Pennsylvania; was offered on the date of enactment of this title and, if modified, still includes a range of benefits and has an actuarial value equal to, or greater than, either its value on August 5, 1997 or the value of one of the benchmark benefit packages.

(4) Secretary-Approved Coverage--Any other coverage that the Secretary determines provides appropriate coverage for targeted low-income children.

- o A State Child Health Plan must include a description of the amount (if any) of cost-sharing and must be in accordance with a public schedule. For States using Medicaid, Medicaid limits apply. Cost-sharing may be varied only based on income in a manner that does not favor higher-income children over lower-income children. No cost-sharing is permitted for well-baby and well-child care, including age-appropriate immunizations. Cost-sharing for children in families with income at or below 150 percent of poverty must be consistent with Medicaid. Cost-sharing for children with income above 150 percent of poverty must be based on an income-related sliding scale and the annual aggregate for all children in a family cannot exceed 5 percent of the family's income.
- o The State Child Health Plan may not impose pre-existing condition exclusions for covered benefits. States that provide for benefits through a group health plan or group health insurance coverage may permit pre-existing condition exclusions as allowed under the applicable section of the Employee Retirement Income Security Act (ERISA) and the Health Insurance Portability and Accountability Act (HIPAA).

#### Effective Date

- o No State is eligible for payments for child health assistance provided prior to October 1, 1997.

#### "Section 2104 Allotments"

##### Provisions

- o Total allotments are: \$4.275 billion for fiscal years 1998-2001; \$3.15 billion for fiscal years 2002-2004; \$4.05 billion for fiscal years 2005-2006; and \$5 billion for fiscal year 2007. For each fiscal year, .25 percent of the total allotment must be allocated to the territories. In addition, \$60 million of the total allotment is to be used for the special diabetes programs (see Sections 4921 and 4922).
- o In fiscal years 1998-2000, each State with an approved Child Health Plan will receive an allotment based on the State's proportion of the total number of low-income (less than

200 percent of poverty) uninsured children multiplied by a geographic cost factor. For fiscal years 2001-2007, States will receive their allotment based on their proportion of a blended number of low-income uninsured and insured children multiplied by a geographic cost factor.

- o For 2001, the blended number of low-income uninsured and insured children is equal to the sum of two factors: (1) 75 percent of the number of low-income uninsured children in the State; and (2) 25 percent of the number of low-income children in the State. For each succeeding year, the blended number of low-income uninsured and insured children is equal to the sum of two factors: (1) 50 percent of the number of low-income uninsured children in the State; and (2) 50 percent of the number of low-income children in the State. The geographic cost factor is based on annual wages in the health care industry. The number of children is calculated as a 3-year rolling average from the most recent March supplements of the Current Population Survey data sets.
- o Each State will receive a minimum floor of \$2 million. Amounts allotted to a State will be available for 3 years. Any amounts unused after 3 years will be redistributed to States that have fully spent their allotments.
- o The territories will receive .25 percent of the total yearly allotments, to be divided among Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands in the following manner:
  - + Puerto Rico receives 91.6 percent;
  - + Guam receives 3.5 percent;
  - + the Virgin Islands receive 2.6 percent;
  - + American Samoa receives 1.2 percent; and
  - + the Northern Mariana Islands receive 1.1 percent.
- o The amount of a State's allotment will be reduced by the amount of Federal payments based on the State's expenditures for: (1) periods of presumptive Medicaid eligibility for children under section 1920A; (2) Medicaid coverage described in section 1902(u)(2); and (3) Medicaid coverage for children under age 19, born before October 1, 1983, who would not have been eligible under the Medicaid State plan as of April 15, 1997, described in section 1902(u)(3).

#### Effective Date

- o No State is eligible for payments for child health assistance provided prior to October 1, 1997.

## **"Section 2105 Payment to States"**

### **Provisions**

- o The Secretary will make payments to States with approved Child Health Plans for child health assistance for targeted low-income children who meet the coverage requirements in Section 2103, after reducing for expenditures for presumptive eligibility and for targeted low-income children under Medicaid. No more than 10 percent of a State's payments may be used for the total costs of: other child health assistance for targeted low-income children; health services initiatives; outreach; and administrative costs.
- o The enhanced Federal medical assistance percentage (FMAP) for child health assistance provided under this title is equal to the current FMAP increased by 30 percent of the difference between 100 and the current FMAP. The enhanced FMAP may not exceed 85 percent. Federal funds, premiums, other cost-sharing, provider taxes and donations cannot be used for the State matching requirements.
- o The Secretary may waive the 10 percent limitation for coverage meeting the benefits requirements of Section 2103 that she deems is a cost effective alternative and is provided through contracts with health centers receiving funds under section 330 of the Public Health Service Act or through disproportionate share hospitals. The Secretary also may allow payment to a State for the purchase of family coverage under a group health plan if the State establishes to her satisfaction that it is cost-effective and it would not substitute for existing coverage.
- o No payment may be made for expenditures that would have been made under private coverage or under any Federally-operated/financed program other than an IHS-operated or -financed program.
- o In addition, payments may not be used to pay for abortions or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion. Exceptions are provided for abortions that are necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. This would not prevent a State, locality or private person or private funds from purchasing coverage that includes abortions.
- o States will not receive any payments for child health assistance if they adopt income and resource standards and methodologies for determining a child's eligibility for Medicaid that are more restrictive than those in effect on June 1, 1997. A State's allotment will be reduced by the amount by which the total of the State's children's health insurance expenditures in the preceding year is less than such expenditures in 1996. State children's health insurance expenditures are defined as the State share under this title, the State share under Medicaid attributable to an enhanced FMAP, and State expenditures for the

“existing comprehensive State-based coverage.”

#### Effective Date

- o No State is eligible for payments for child health assistance provided prior to October 1, 1997.

### **“Section 2106 Process for Submission, Approval and Amendment of State Child Health Plans”**

#### Provisions

- o In order to receive funds under this title, a State must submit and obtain approval from the Secretary of its Child Health Plan. No funds are available prior to October 1, 1997. A State may submit an amendment to its Child Health Plan at any time. Any amendment that restricts or eliminates eligibility may not take effect unless the State certifies that it has provided prior public notice of the change and will not be effective for longer than 60 days unless it has been transmitted to the Secretary during the 60 day period. Other types of amendments will not remain in effect after the fiscal year (or, if later, the end of a 90 day period) unless the amendment has been transmitted to the Secretary.
- o A State Child Health Plan or plan amendment is deemed approved unless the Secretary notifies the State in writing within 90 days after receiving the plan or amendment, that it is disapproved or that additional information is needed. The Secretary must provide a reasonable period for correction in the case of a disapproval.
- o States must conduct the program in accordance with the approved plan and plan amendments. The Secretary must establish a process for enforcing the requirements under this title, including withholding funds in the case of substantial noncompliance. The Secretary must provide a reasonable period of correction before taking financial sanctions.

#### Effective Date

- o No State is eligible for payments for child health assistance provided prior to October 1, 1997.

### **“Section 2107 Strategic Objectives and Performance Goals; Plan Administration”**

#### Provisions

- o A State Child Health Plan must include a description of strategic objectives, performance goals and performance measures for providing child health assistance to targeted low-

income children and for maximizing health benefits coverage for other low-income children and children generally in the State. The Plan must describe how performance measures will be assessed through objective, independently verifiable means and compared against performance goals.

- o A State Child Health Plan must include an assurance that the State will collect data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. It also must describe the State's plan for annual assessments, reports, and evaluations and assure the Secretary access to records for audit purposes.
- o A State Child Health Plan must include a description of its process for involving the public in the design and implementation of the plan, as well as for ongoing public involvement. There must also be a description of the budget for the Plan.
- o Medicaid provisions relating to conflict of interest, limitations on payment, and limits on provider taxes and donations apply to this title. In addition, a number of fraud and abuse provisions of title XI of the Social Security Act apply to this title.

#### Effective Date

- o No State is eligible for payments for child health assistance provided prior to October 1, 1997.

#### **"Section 2108 Annual Reports; Evaluations"**

##### Provisions

- o The State must assess the operation of the State plan, including progress made in reducing the number of uncovered low-income children and report annually to the Secretary by January 1.
- o By March 31, 2000, each State with an approved State Child Health Plan must submit to the Secretary an evaluation addressing: the State's effectiveness in increasing the number of children with creditable coverage; the effectiveness of other elements of the State's Plan, including characteristics of children served, quality, amount and level of assistance, service area, time limits, coverage and other sources of non-Federal funding; the effectiveness of other public and private programs in increasing the availability of affordable quality health coverage; the State's coordination between other public and private programs for children; an analysis of the changes and trends that affect affordable, accessible coverage for children; the State's plans for improving the availability of children's coverage; recommendations for improving the State's program; and other matters the State and Secretary deem appropriate.

- o The Secretary must submit a report based on the State evaluations to Congress by December 31, 2001.

#### Effective Date

- o No State is eligible for payments for child health assistance provided prior to October 1, 1997.

#### **"Section 2109 Miscellaneous Provisions"**

##### Provision

- o Coverage other than Medicaid will be considered creditable coverage for purposes of HIPAA. ERISA will not be affected by this title.

#### **"Section 2110 Definitions"**

##### Provisions

- o The following terms are defined: child health assistance; targeted low-income child; child; creditable health coverage; group health plan; health insurance coverage; low-income; poverty line; preexisting condition exclusion; State Child Health Plan; and uncovered child.
- o The term "targeted low-income child" means a child who: meets the eligibility standards set by the State; resides in a family with income below the greater of the following: 200 percent of poverty or 50 percentage points above the Medicaid eligibility limit; and is not eligible for Medicaid or other health insurance coverage. An exception is that the term may include children covered under a health insurance coverage program in operation since before July 1, 1997 that is offered by the State and receives no Federal funds. Children excluded are those who: are inmates of public institutions; patients in an institution for mental diseases (IMDs); and children whose families are eligible for the State employee benefits plan.

#### Effective Date

- o No State is eligible for payments for child health assistance provided prior to October 1, 1997.

## **SUBTITLE J—STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

### **Chapter 2—Expanded Coverage of Children Under Medicaid**

#### **Optional Use of State Child Health Assistance Funds for Enhanced Medicaid Match for Expanded Medicaid Eligibility (Section 4911)**

##### **Provisions**

- o States may elect to use child health assistance funds to expand Medicaid eligibility. In order to receive funds to expand Medicaid eligibility, States must meet two conditions: (1) they must maintain their Medicaid eligibility at levels that are not more restrictive than those applied as of June 1, 1997; and (2) they must provide for reporting of information about expenditures relating to presumptive eligibility and to child health assistance provided to "optional targeted low-income children" under the expanded Medicaid program.
- o States that elect to use the child health assistance funds to expand Medicaid eligibility and meet the two conditions described above will be eligible to receive an enhanced Medicaid match for "optional targeted low-income children." The enhanced Medicaid match is the State's current FMAP increased by 30 percent of the difference between 100 and the current FMAP.
- o The enhanced Medicaid match will apply to expenditures for "optional targeted low-income children." They are defined as targeted low-income children who would not qualify for Medicaid based on the plan that was in effect on April 15, 1997. It would not apply to expenditures for children below the poverty level who were born after September 30, 1983 as they age onto Medicaid under current law. If these expenditures exceed a State's allotment for the year (reduced by any expenditures for child health assistance paid to the State under the grant program), the State would receive only the regular FMAP, rather than an enhanced FMAP for the excess expenditures.
- o The enhanced Medicaid match also will apply to expenditures for children born before September 30, 1983 who are under age 19 and who are not eligible under the State Medicaid plan as of April 15, 1997.

##### **Effective Date**

- o For items and services furnished after October 1, 1997.

#### **Medicaid Presumptive Eligibility for Low-Income Children (Section 4912)**

##### **Provisions**

- o States are permitted under their Medicaid program to make medical assistance available to children under 19 during a presumptive eligibility period. The period begins with a date that a qualified entity determines, using preliminary information, that the family income does not exceed the income eligibility level; and the period ends with the earlier of an eligibility determination or, if an application for eligibility has not been filed, on the last day of the month following the month the entity makes the preliminary determination.
- o The term a "qualified entity" means an eligible provider under Medicaid or any entity authorized to determine eligibility for the Head Start program, the Child Care and Development Block Grant Act, or WIC. The Secretary may issue regulations further limiting qualified entities.
- o A qualified entity must notify the State agency of the determination within 5 working days and inform the parent or custodian of the child and that an application is required to be filed by the end of the following month.

**Effective Date**

- o Upon enactment.

**Continuation of Medicaid Eligibility for Disabled Children Who Lose SSI Benefits (Section 4913)**

**Provision**

- o States must continue Medicaid eligibility for disabled children who would have lost SSI benefits because of the change in the definition of childhood disability under the Personal Responsibility and Work Opportunity Act of 1996.

**Effective Date**

- o July 1, 1997.

## **SUBTITLE J—STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

### **Chapter 3—Diabetes Grant Programs**

#### **Special Diabetes Programs for Type I Diabetes (Section 4921)**

##### **Provision**

- o The Secretary must provide—directly or through grants—for research into the prevention and cure of Type I diabetes. Grants will be made available to children's hospitals, grantees under section 330 of the Public Health Service Act, and other Federally qualified health centers (FQHCs), State and local health departments and other public or non-profit private entities. For each of fiscal years 1998-2002, \$30 million is transferred from title XXI for grants under this section.

#### **Special Diabetes Programs for Indians (Section 4922)**

##### **Provision**

- o The Secretary must make grants for the prevention and treatment of diabetes (for individuals of all ages) for services provided through the Indian Health Service (IHS), through an Indian health program operated by a tribe or tribal organization funded by IHS, or through an urban Indian health program funded by IHS. For each of fiscal years 1998-2002, \$30 million must be transferred from title XXI for grants under this section.

#### **Report on Diabetes Grant Programs (Section 4923)**

##### **Provision**

- o The Secretary must conduct an evaluation of the diabetes grant programs in sections 4921 and 4922 and submit an interim report to Congress by January 1, 2000 and a final report by January 1, 2002.

Template

**DRAFT - 9/12/97**

**DRAFT MODEL APPLICATION TEMPLATE FOR  
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

**Preamble**

This draft model application template outlines the types of information that are likely to be included in the state child health plan required under Title XXI. It has been designed to reflect many of the requirements that will be necessary for state plans under Title XXI. It is not intended to be comprehensive or final. We provide it for preliminary guidance as well as to solicit additional information from states and other interested parties on the appropriate content.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like benefits definitions, maintenance of effort provisions, collection of baseline data, and methods for preventing substitution of new Federal funds for existing state and private funds. As such guidance becomes available, the model application template will be revised and finalized. We will work to distribute it in a timely fashion to provide assistance as states submit their state plans.

**DRAFT - 9/12/97**

**MODEL APPLICATION TEMPLATE FOR  
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

**(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))**

State/Territory: \_\_\_\_\_  
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

\_\_\_\_\_  
(Signature of Governor of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuances of the Department.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Proposed Effective Date \_\_\_\_\_

**Section 1. General Description and Purpose of the State Child Health Plans (Section 2101)**

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1. ☐ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**
- 1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**
- 1.3. ☐ A combination of both of the above.

**Section 2. General Background and Description of State Approach to Child Health Coverage**  
(Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

- 2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).
- 2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2)
  - 2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

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  - 2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

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- 2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered:  
(Section 2102)(a)(3)

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**Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4))**

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4)

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3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

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**DRAFT - 9/12/97**

**Section 4. Eligibility Standards and Methodology. (Section 2102(b))**

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A))

- 4.1.1. ☐ Geographic area served by the Plan: \_\_\_\_\_
- 4.1.2. ☐ Age: \_\_\_\_\_
- 4.1.3. ☐ Income: \_\_\_\_\_
- 4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources): \_\_\_\_\_
- 4.1.5. ☐ Residency: \_\_\_\_\_
- 4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility): \_\_\_\_\_
- 4.1.7. ☐ Access to or coverage under other health coverage: \_\_\_\_\_
- 4.1.8. ☐ Duration of eligibility \_\_\_\_\_
- 4.1.9. ☐ Other standards (identify and describe): \_\_\_\_\_  
\_\_\_\_\_

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B))

- 4.2.1. ☐ These standards do not discriminate on the basis of diagnosis.
- 4.2.2. ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3. ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

**DRAFT - 9/12/97**

- 4.3. Describe the methods of establishing eligibility and continuing enrollment.  
(Section 2102)(b)(2))
- 

- 4.4. Describe the procedures that assure:

4.4.1. Through intake and followup screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))

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4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))

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4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))

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4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D))

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4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))

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**Section 5. Outreach and Coordination (Section 2102(c))**

Describe the procedures used by the state to accomplish:

- 5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))
- 

- 5.2. Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))
-

**Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)**

☐

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.**

- 6.1. The state elects to provide the following forms of coverage to children:  
(Check all that apply.)

- 6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1))

- 6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1))  
(If checked, attach copy of the plan.)

- 6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

- 6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

- 6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). **See instructions.**

- 6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage."

- 6.1.4. ☐ Secretary-Approved Coverage. (Section 2103(a)(4))

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- 6.2. The state elects to provide the following forms of coverage to children:  
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a))

- 6.2.1. ☐ Inpatient services (Section 2110(a)(1))
- 6.2.2. ☐ Outpatient services (Section 2110(a)(2))
- 6.2.3. ☐ Physician services (Section 2110(a)(3))
- 6.2.4. ☐ Surgical services (Section 2110(a)(4))
- 6.2.5. ☐ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6. ☐ Prescription drugs (Section 2110(a)(6))
- 6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. ☐ Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. ☐ Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10. ☐ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11. ☐ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12. ☐ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13. ☐ Disposable medical supplies (Section 2110(a)(13))
- 6.2.14. ☐ Home and community-based health care services (See instructions) (Section 2110(a)(14))
- 6.2.15. ☐ Nursing care services (See instructions) (Section 2110(a)(15))
- 6.2.16. ☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17. ☐ Dental services (Section 2110(a)(17))
- 6.2.18. ☐ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

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- 6.2.19. ☐ Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. ☐ Case management services (Section 2110(a)(20))
- 6.2.21. ☐ Care coordination services (Section 2110(a)(21))
- 6.2.22. ☐ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23. ☐ Hospice care (Section 2110(a)(23))
- 6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. ☐ Medical transportation (Section 2110(a)(26))
- 6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

- 6.3. **Waivers - Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: (Section 2105(c)(2) and(3))

- 6.3.1. ☐ **Cost Effective Alternatives.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

- 6.3.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28.** (Section 2105(c)(2)(B)(i))

- 6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and **Describe the cost of such coverage on an average per child basis.** (Section 2105(c)(2)(B)(ii))

- 6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** (Section 2105(c)(2)(B)(iii))

6.3.2. ☐ **Purchase of Family Coverage.** Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3))

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** (Section 2105(c)(3)(A))

6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B))

**Section 7. Quality and Appropriateness of Care**

☐

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.**

- 7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A))
- 

Will the state utilize any of the following tools to assure quality?  
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1. ☐ Quality standards  
7.1.2. ☐ Performance measurement  
7.1.3. ☐ Information strategies  
7.1.4. ☐ Quality improvement strategies

- 7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))
-

**Section 8. Cost Sharing and Payment** (Section 2103(e))

- ☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. ☐ YES

8.1.2. ☐ NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income:  
(Section 2103(e)(1)(A))

8.2.1. Premiums: \_\_\_\_\_

8.2.2. Deductibles: \_\_\_\_\_

8.2.3. Coinsurance: \_\_\_\_\_

8.2.4. Other: \_\_\_\_\_

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income: \_\_\_\_\_

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: (Section 2103(e))

8.4.1. ☐ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))

8.4.2. ☐ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))

8.4.3. ☐ No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

8.4.4. ☐ No Federal funds will be used toward state matching requirements.  
(Section 2105(c)(4))

8.4.5. ☐ No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))

8.4.6. ☐ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.

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(Section 2105(c)(6)(A))

8.4.7. ☐ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1))

8.4.8. ☐ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.  
(Section 2105)(c)(7)(B))

8.4.9. ☐ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A))

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved: (Section 2103(e)(3)(B)) \_\_\_\_\_

8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:

8.6.1. ☐ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); **OR**

8.6.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe:  
\_\_\_\_\_

**Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)**

- 9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2))  
\_\_\_\_\_
- 9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3))  
\_\_\_\_\_
- 9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops: (Section 2107(a)(4)(A),(B))  
\_\_\_\_\_

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

- 9.3.1. ☐ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. ☐ The reduction in the percentage of uninsured children.
- 9.3.3. ☐ The increase in the percentage of children with a usual source of care.
- 9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.
- 9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. ☐ Immunizations
- 9.3.7.2. ☐ Well child care
- 9.3.7.3. ☐ Adolescent well visits
- 9.3.7.4. ☐ Satisfaction with care
- 9.3.7.5. ☐ Mental health
- 9.3.7.6. ☐ Dental care

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- 9.3.7.7. ☐ Other, please list: \_\_\_\_\_
- 9.3.8. ☐ Performance measures for special targeted populations.
- 9.4. ☐ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1))
- 9.5. ☐ The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))  
\_\_\_\_\_
- 9.6. ☐ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3))
- 9.7. ☐ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

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- 9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX:

(Section 2107(e))

- 9.8.1. ☐ Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. ☐ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. ☐ Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. ☐ Section 1115 (relating to waiver authority)
- 9.8.5. ☐ Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
- 9.8.6. ☐ Section 1124 (relating to disclosure of ownership and related information)
- 9.8.7. ☐ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 9.8.8. ☐ Section 1128A (relating to civil monetary penalties)
- 9.8.9. ☐ Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10. ☐ Section 1132 (relating to periods within which claims must be filed)

- 9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c))
- 

- 9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

A financial form for the budget is being developed, with input from all interested parties, for states to utilize.