

109. Letter



Office of the Administrator
Washington, D.C. 20201

AUG 6 1998

Dear State Health Official:

The Balanced Budget Act of 1997 established the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. This new Title enables States to expand health insurance coverage for uninsured children. The Department of Health and Human Services (DHHS) has issued numerous letters regarding the implementation of CHIP. This letter is intended to provide detailed guidance for States seeking a waiver or variance of the 10 percent cap (under Section 2105(c)(2)(B)) in implementing their Title XXI plan.

Under Title XXI, a State is eligible for Federal matching funds on certain expenditures only to the extent that those expenditures do not exceed 10 percent of the State's total computable expenditures on health benefits through CHIP. As specified in Section 2105(a)(2), these capped expenditures include those related to:

- other child health assistance;
- health services initiatives;
- outreach as defined in 2102(c)(1); and
- other reasonable costs necessary to administer the Title XXI plan.

(For further clarification regarding the 10 percent cap, please see the letter from Health Care Financing Administration (HCFA) regarding financial issues dated December 8, 1997.)

Subject to certain criteria, States may obtain a variance of the 10 percent cap as specified under the Title XXI law. This variance was designed to create flexibility for States to include community-based delivery systems among their CHIP provider networks. Congress did not intend that the variance be used simply to allow for more administrative spending or outreach services under Section 2105(a)(2), and the statute does not provide this flexibility. Nevertheless, DHHS recognizes that many States will face substantial start-up costs in the early years. As a result, we are committed to working with States and Congress on legislative proposals that will meet States' needs in this regard.

The first attachment provides guidance related to section 2105(c)(2)(B) including the types of expenditures limited by the 10 percent cap on administrative costs, the criteria a State must meet in order to receive a variance of the 10 percent cap, and the structure of State spending on expenditures that previously were subject to the 10 percent cap. The second attachment summarizes guidance that was previously issued to States regarding the 10 percent cap on administrative costs. These preliminary policies will be incorporated into proposed regulations and subject to public comment.

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If there are any questions regarding the variance of the 10 percent cap on expenditures related to other child health assistance, health services initiatives, outreach as defined in Section 2102(c)(1), and other reasonable costs necessary to administer the plan, please contact your HCFA regional office staff.

Sincerely yours,



Claude Earl Fox, M.D., M.P.H.
Administrator
Health Resources and Services Administration



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

Attachment One

Variance of the 10 percent Cap on 2105(a)(2) Expenditures

TYPES OF EXPENDITURES LIMITED BY THE 10 PERCENT CAP

DHHS has defined the four categories of expenditures that are limited by the 10 percent cap as follows:

1. Other child health assistance for targeted low income children Section 2105(a)(2)(A)

Other child health assistance for targeted low income children refers to health benefits coverage provided to targeted low income children that is in addition to the benefit package that the State has designated and meets the requirements of Section 2103. Examples of these benefits include specialty and sub-specialty care that are not part of the benefit package designated by the State as part of the benefit package under Section 2103. These benefits can be provided to targeted low income children.

2. Health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children Section 2105(a)(2)(B)

For the purposes of Title XXI, health services initiatives (either new or ongoing) include activities designed to: protect the public health, protect the health of individuals, improve or promote a State's capacity to deliver public health services, and/or strengthen the human and material resources necessary to accomplish public health goals. These activities must be for the purposes of improving the health of children (including targeted low income children and other low income children.)

3. Outreach activities Section 2105(a)(2)(C)

Section 2105 (a)(2)(C) of Title XXI authorizes funding for outreach activities conducted by the State to identify and enroll eligible children in the State plan or other public or private health coverage. For further guidance on outreach activities, please see the DHHS letter on outreach dated January 23, 1998.

4. Other reasonable costs incurred by the State to administer the plan Section 2105(a)(2)(D)

These expenditures were previously discussed in the HCFA letter regarding financial issues dated December 8, 1997. This excludes the costs associated with, and already included in, the health benefits coverage to low-income children. This category does include activities such as data collection, assessment of the State plan, quality assurance activities, eligibility determination, performance measurement, outreach and coordination, and public involvement.

Attachment Two

Summary of Policies Regarding Claims for Match Under the 10 Percent Cap

HCFA has previously issued guidance to States regarding the flexibility States have to claim match for expenditures on the 10 percent cap. This guidance is summarized below.

FLEXIBILITY TO CLAIM ADMINISTRATIVE AND OUTREACH EXPENDITURES UNDER MEDICAID OR CHIP

States that choose to expand Medicaid as a result of the CHIP legislation have a choice of programs under which to claim Federal Financial Payments (FFP) for the related administrative and outreach expenditures.

These States can elect to claim FFP under the Title XXI at the Title XXI enhanced matching rate for all Title XIX administrative and outreach activities related to providing health insurance coverage for targeted low-income children under Sections 1905(u)(2) and 1905 (u)(3) of the Social Security Act and provision of medical assistance to a child under Title XIX during a presumptive eligibility period under Section 1920A of the Act. States pursuing this option must continue to claim all such expenditures under Title XXI until the 10 percent limit is reached or until the available CHIP allotment funds for that fiscal year are expended. These States may then begin to claim the CHIP related Title XIX administrative and outreach expenditures that are above the 10% limit under the Medicaid program and receive reimbursement at the applicable Medicaid matching rate.

Alternatively, these States may elect to claim such administrative expenditures for XXI expansions under the Medicaid program. Administrative and outreach expenditures claimed in this fashion will not reduce a State's Title XXI allotment or count against the 10 percent limit and will be reimbursed at the applicable Medicaid matching rate.

DELAYED CLAIMING OF ADMINISTRATIVE EXPENDITURES

All States have the option of delaying the submission of claims for administrative expenditures to HCFA for payment for up to two years from the date of the expenditure for the service. Claims for administrative expenditures which were incurred in one particular fiscal year, and which if submitted in the fiscal year would exceed the 10% limit for that fiscal year may be submitted in a subsequent fiscal year. States delaying the submission of such claims until a subsequent fiscal year will be able to receive reimbursement at the enhanced matching rate, as long as the administrative costs being claimed during the subsequent fiscal year do not exceed the 10 percent limit for that fiscal year. This will allow States with low benefit expenditures in the early years of their program to eventually receive reimbursement for administrative expenditures at the enhanced Federal matching rate.

ISSUES RELATED TO RECEIVING A VARIANCE

In order to receive a variance, States must meet the following requirements.

- Coverage to some portion of CHIP enrollees must be provided through a community-based delivery system;
- The coverage provided to CHIP enrollees served by the community-based delivery system must meet the requirements of Section 2103 of the Social Security Act.
- Coverage provided to CHIP enrollees by this system must be cost-effective (meaning that this coverage must not cost more, on an average per child basis, than it would have if the coverage were otherwise provided under Section 2103.)

States do not need to serve all of their CHIP enrollees through a cost-effective community-based delivery system in order to receive a variance of the 10 percent cap. They can receive a variance for each system or a network delivering care in a particular geographic area in order to pursue and benefit from cost-effective health coverage alternatives. Variances will be granted for two years. States will have the ability to reapply for approval of the variance.

What is a community-based delivery system?

A community-based delivery system is a network of providers that must have a contract with the State to provide care under Title XXI. A State must ensure that its community-based delivery system (either through direct provision or referral) can provide all appropriate services to targeted low-income children under Section 2103. In addition, all participating community-based providers must comply with all other Title XXI provisions. Statutory examples of providers that may constitute a community-based delivery system include Federally Qualified Health Centers (FQHCs) and disproportionate share hospitals. This is not an exhaustive list of providers that may qualify for inclusion. We look forward to working with States as they design their community-based delivery systems.

How does a State demonstrate and HCFA evaluate the cost effectiveness of its community-based delivery system?

The amount paid to the community-based delivery system on a Federal fiscal year, per child basis must not be greater than the amount that would otherwise have been paid for that child to receive coverage under Title XXI. Therefore, in order to demonstrate its cost effectiveness, States must compare the cost of providing benefits to CHIP enrollees through a community-based system to the cost of insuring a child for a benefit package that is otherwise available to that child under the State's Title XXI plan.

CALCULATION OF STATE SPENDING ABOVE THE 10 PERCENT CAP

Once a State meets the above criteria and receives a variance, it is no longer subject to the 10 percent cap limitation; however, the State must meet the limits described below. With the variance, the State then has the opportunity to receive a limited amount of match for funds spent above the 10 percent cap on administrative programs, outreach, direct services, and health initiatives (such as, immunization campaigns, injury prevention programs, lead poisoning prevention programs, and services provided by poison control centers.) The funds receiving match that are spent in excess of the previous 10 percent cap do not necessarily have to be spent through a community-based delivery system. As we discuss below, however, limits must be placed on State spending above the 10 percent cap to preserve cost-effectiveness as prescribed under the law.

The statute provides for a variance only "to the extent" that certain conditions, including cost-effectiveness, are met. The amount of additional spending allowed under the variance cannot result in the elimination of cost-effectiveness. In order to determine the level of spending above the 10 percent cap that can still receive match, the following methodology will be used. States are allowed to spend, on a per child basis, the difference between the cost of services provided through the community-based system and the cost of coverage that would have been paid otherwise to provide insurance for the child under Title XXI. In order for States to receive substantial additional funds under this option, the community-based health delivery system must be able to provide substantial savings while providing comparable services. In other words, application of cost effectiveness means that the savings accrued from the coverage side are added to the total amount of the 10% spending limit. While this methodology is relatively easy to implement under a managed care system, a fee-for-service system may make this type of analysis more complicated. HCFA will work closely with States that seek a 10 percent variance under a fee-for-service delivery system, as well as under a managed care system.

CALCULATION OF STATE SPENDING ABOVE THE 10 PERCENT CAP -- AN ILLUSTRATION

The following is meant to help illustrate the concept of cost effectiveness outlined above.

In a given State, assume that a child has three coverage options under Title XXI from which to choose. Two options are Title XXI managed care plans that have annual capitated rates of \$1000 and \$1020 respectively. The third option is that the child could receive the standard CHIP benefit package as described in Section 2103 of the Act from a community-based delivery system at a cost of \$900 annually. Further assume that 4,000 children choose to enroll in coverage provided through the community-based delivery system and that a constant number of children remain enrolled in the program over the course of the fiscal year.

In order to calculate the level of spending that the State can receive for match above the 10 percent cap, the State would take \$1000 (the lower price of the two available non-community

based provider plans) less \$900 dollars (the cost of the community-based provider plan.) This means that, by enrolling a child in a community based provider plan, the State has saved \$100. Since there are 4,000 children enrolled in the community-based provider system, this means that the State has saved a total of \$400,000. As a result, the State could exceed the 10 percent cap by, and receive match for, an additional \$400,000 before the overall cost of this approach is no longer cost-effective. If the 10 percent cap level in this State was estimated to be \$1,000,000 with the community-based delivery system implemented, then the variance under this scenario would increase the estimated cap level to \$1,400,000.

SSN letter



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

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

SEP 10 1998

Dear State Health Official:

This letter is a follow-up to a letter issued by the Department of Health and Human Services on January 23, 1998 regarding opportunities for outreach to uninsured children. First, it highlights the flexibility States have to simplify the application and enrollment processes. Second, it provides clarification of two eligibility-related issues that have come to our attention as a result of the January letter: the provision of Social Security numbers (SSNs) for applicants and non-applicant family members; and establishment of immigration status for non-citizens.

I. Application and Enrollment Simplification

As we indicated in our letter dated January 23, 1998, a major key to successfully enrolling children in CHIP and Medicaid is a simple application and enrollment process. While it is important to maintain program integrity, a burdensome application and enrollment process can be a significant barrier to successful enrollment.

Many States have already begun to simplify their application and enrollment processes. Listed below are actions that States already have taken, as well as some other recommendations that States could adopt to change their current processes and to reduce the stigma and complexity of seeking assistance:

- ◆ Shorten application forms and/or use mail-in applications;
- ◆ Create joint CHIP/Medicaid applications;
- ◆ Use joint Medicaid and CHIP applications;
- ◆ Eliminate assets test;
- ◆ Allow self-reporting of income by the family with follow-up verification by the State;
- ◆ Reduce verification/documentation requirements that go beyond Federal regulation;
- ◆ Allow redeterminations to be done by mail;
- ◆ Speed up processing;
- ◆ Develop a follow-up process for families not completing the application process;
- ◆ Establish an effective referral system between the State's CHIP eligibility agency, the Medicaid and maternal and child health programs, schools as well as other Federal and State agencies that serve low-income families;

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- ◆ Offer phone interviews, or have transportation vouchers to assist individuals in getting to face-to-face interviews;
- ◆ Expand outstationing opportunities;
- ◆ Increase staff with multi-lingual ability;
- ◆ Extend office hours so that applicants do not have to take off work to apply for benefits;
- ◆ Take advantage of new options like presumptive eligibility and 12 month continuous eligibility; and
- ◆ Try to reduce stigma of seeking public assistance by using techniques such as a different name for program (such as Arkansas' ARKids, Michigan's MIChild, and Connecticut's HuskyCare).

The Federal requirements for the application and enrollment process for Medicaid and for separate State CHIP programs provide a great deal of flexibility to States to design an application and enrollment process that is streamlined and simple, and avoids burdensome requirements for families that apply for benefits. For example, under Medicaid with the exception of obtaining documentation of immigration status for qualified alien applicants and the applicant's Social Security numbers, States have flexibility to determine documentation requirements, including self-declaration of income and assets. In addition, States with separate CHIP programs can streamline and coordinate their application and enrollment processes for CHIP and Medicaid in a number of ways to make it easier for families to apply, including use of a joint application.

The current application and enrollment requirements for Medicaid and separate State CHIP programs are listed in an attachment to this letter. They do not call for families to provide extensive amounts of documentation and information in order to file for benefits. For the most part, they deal in a very broad way with the basic elements of the application and enrollment process, and provide a great deal of flexibility to States to design a process that best suits their needs.

Enrolling America's uninsured children in Medicaid and CHIP is a national priority that requires an aggressive, sustained effort. There are many ways that States can, and are, modifying their processes to make them more user friendly. It is our hope that you will make, or continue to make, a firm commitment to simplify your application and enrollment processes in an effort to reduce barriers to enrolling uninsured children.

II. Clarification of Eligibility Requirements

Provision of Social Security Numbers (SSNs)

Attached to the January 23, 1998 outreach letter was a model joint CHIP/Medicaid application States could use in order to simplify the eligibility process for this new program. One of the pieces of information requested on the model application was a SSN for all family members, including those who were not applying for benefits. We wish to clarify that, under Section 1137

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of the Act, a SSN must be supplied only by applicants for and recipients of Medicaid benefits. In all other cases, including non-applicant parents of children applying for Medicaid and children applying for a separate State CHIP program (non-Medicaid), States are prohibited from making the provision of a SSN by another family member a condition of the child's eligibility. This also applies to other members of the household whose income might be used in making the child's eligibility determination.

A revised joint application form for CHIP/Medicaid children is enclosed. As you will see, the form now requires a SSN only for children applying for Medicaid benefits. For children applying for a separate State CHIP program (non-Medicaid) and members of the household not applying for benefits, the SSN is indicated as being optional.

Some States use parents' SSN as a means of verifying family income in the process of making an eligibility determination. While the statute does not require disclosure of the SSN for non-applicants, voluntary disclosure by the parent may facilitate the verification of income and contribute to a speedier and more accurate determination of the child's eligibility. States may advise parents and other household members of this as long as they do so in a manner that does not coerce provision of the SSN or deter application for benefits. Once more, we wish to clarify that States have no legal basis for denying an application based upon the failure to supply the SSN for verification purposes.

III. Establishing Citizenship and Immigration Status of Non-Citizens

Children who are citizens and who are applying for either Medicaid or a separate State CHIP program may establish their citizenship on the basis of self-declaration; States are permitted to require further verification as a condition of eligibility. Children applying for either program who are qualified aliens must present documentation of their immigration status, which States must verify using systems established for that purpose. The citizenship or immigration status of non-applicant parents (or other household members), however, is irrelevant to their children's eligibility. States may not require that parents disclose this information.

There are both statutory and programmatic bases for our policy. Under the statute (Section 1137 of the Act), there is no authority for requiring individuals other than those applying for benefits to provide their SSNs or to document their immigration status. Furthermore, the Privacy Act makes it unlawful for a State to deny benefits to an individual based upon that individual's failure to disclose the SSN, unless the disclosure is required by Federal law or was part of a Federal, State, or local system of records in operation before January 1, 1975. States may only seek the SSN of these individuals on a strictly voluntary basis. The CHIP law does not require applicants to provide SSNs and the Medicaid law only requires it for applicants and recipients of Medicaid benefits.

From a programmatic point of view, asking non-applicants for their SSNs or evidence of immigration status may discourage immigrant parents, who may not wish to disclose information

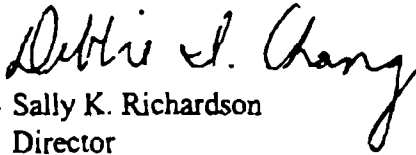
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about themselves, from applying for benefits on behalf of their children who are U.S. citizens. When this occurs, the children are, in effect, denied access to medical care that they both need and are eligible for under the law.

We encourage States to actively provide information to adults applying for benefits on behalf of their children to inform them that their children's eligibility for Medicaid or CHIP is not contingent on disclosure of a parent's SSN (or lack thereof), or on information about non-applicant parents' immigration status.

If you have questions or suggestions on any of these eligibility-related issues and the use or adaptation of the model form and guidance attached, please contact your HCFA regional office staff.

Sincerely,


for Sally K. Richardson
Director

Attachments

cc:

All HCFA Regional Offices

All PHS Regional Offices

HHS Regional Directors

Lee Partridge
American Public Human Services Association

Nolan Jones
National Governors Association

Joy Wilson
National Conference of State Legislators

Cheryl Beversdorf
Association of State and Territorial Health Officials

Mary Beth Senkewicz
National Association of Insurance Commissioners

MODEL JOINT APPLICATION FOR CHIP/MEDICAID FOR CHILDREN

[Revised 8/31/98]

Purpose: The attached model joint application can be used for both the Children's Health Insurance Program (CHIP) and children's Medicaid eligibility (under the children's poverty level related groups). States could allow individuals to use this form to apply for both programs and the information on this form would be sufficient for determining which program a child is eligible for. It includes only the information that is required in all circumstances, and it is provided as a base form that a State can adapt to meet its own needs. As presented, the form is suitable for completion by an intake worker. Modifications would be required to make the form suitable for direct completion by the applicant.

Screening: This application will meet the statutory requirement in Title XXI that States identify children who are eligible for Medicaid.

NOTE: Non-State employees cannot determine Medicaid eligibility. Therefore, in a State that has contracted out the process of CHIP eligibility determination (i.e., determinations are performed by non-State employees), this model application would have to be modified for use as a pure screening form (or a combination of an application for CHIP and a screening form) by removing all references to it as a Medicaid application. The statement about the use of the Social Security Number [33] still would be required. The inclusion of the section on rights and responsibilities [34] (but omitting any reference to Medicaid), however, would be at State option.

If the form were so modified, in order to permit the information on the form to be submitted for use in making a Medicaid determination, the eligibility workers could provide a separate page to be completed by those whom the screen indicates are Medicaid-eligible. On that page, the individual should consent to submission of the information as part of a Medicaid application, and accept the rights and responsibilities outlined in this model (including a statement under penalty of perjury that the information provided on the "attached screening form" or "attached CHIP application" is correct). Once this page is completed, the form could be forwarded to the State for a Medicaid eligibility determination.

Mandatory Information About Medicaid: If a State uses a joint CHIP/Medicaid application and denies the Medicaid application, then the State must thoroughly inform the individual about the availability of Medicaid and his or her right to apply for Medicaid on a basis other than as a poverty-level child. This includes an explanation of the Medicaid program and the various eligibility groups, the advantages of Medicaid over CHIP and information about how and where to apply for Medicaid.

Federal Verification Requirements: Under Federal law, there are no verification requirements pertaining to eligibility for the children under Medicaid other than those related to alien status of non-citizens, the post-eligibility requirements of §1137 pertaining to use of the individual's Social Security Number and an income and eligibility verification system. Eligibility of a citizen child may be established on the basis of self-declaration under penalty of perjury. States are permitted, however, to require further verification as a condition of eligibility.

Section 1137's requirement for furnishing a Social Security number applies only to the applicants for and recipients of Medicaid. It does not apply to the parents of Medicaid applicants, nor does it apply to a State-run Children's Health Insurance Program that is separate from the State's Medicaid program. The Privacy Act, § 7 of Public Law No. 93-579, 88 Stat. 1896, makes it unlawful for a State to deny benefits to an individual based upon that individual's failure to disclose the Social Security number unless the disclosure is required by federal law or was part of a federal, State, or local system of records in operation.

before January 1, 1975. Since the new CHIP program does not require that Social Security Numbers be supplied and the Medicaid program requires it only for applicants and recipients, States may seek these account numbers from applicants for a non-Medicaid CHIP program only on a strictly voluntary basis.

Additional Simplification of Medicaid Eligibility Determination: If the total gross income of the family is at or below the applicable Medicaid income standard, the questions in the shaded areas need not be answered. The individual is obviously income eligible for Medicaid without further information.

Explanation of Certain Fields: There are some questions on the application that may not elicit all the information needed to make a determination. Under certain circumstances, additional information will be required. For example:

- If the answer to the question about citizenship [18] is no, actual status will need to be determined, official documents submitted, etc.
- If the child has insurance [22] and is Medicaid-eligible, information about the insurance company and policy number will be needed; and
- If the child had medical bills in the last 3 months [32] and is Medicaid-eligible, eligibility information for the last three months will be needed to establish retroactive eligibility, in addition to information about the bills.

In addition, the question concerning employment by a public agency in the State [25] is only needed for CHIP eligibility and is not needed for Medicaid. This field does not ask directly about the availability and nature of health insurance, on the assumption that the eligibility worker would have access to a list of public agencies that offer State health insurance of the type that would preclude CHIP eligibility. If this is not the case in your State, this field would need to be expanded.

Examples of State Modifications:

- A State may wish to include voter registration; or
- A State may want to use this as an application for Medicaid for the adults, which would require additional information about the adults and stock affidavits concerning assignment of rights and pursuit of support.
- A State will need to add a question concerning each individual's resources (assets) if:
 - the State applies a resource test for the poverty level children; or
 - the State has not chosen to cover children born before 10/1/83 under the poverty level group AND the State applies a resource test for the optional group of categorically needy children ("Ribicoff children").

- SAMPLE -
CHILDREN'S HEALTH INSURANCE PROGRAM / MEDICAID
JOINT APPLICATION FORM [Revised 8/31/98]

I. Person Applying for the Child or Children					
Name [1]	FIRST	MIDDLE	LAST	Home Phone [2]	Work Phone [3]
Home Address [4] Street	Apt. # [5]	City [6]	State [7]	Zip [8]	County [9]
Mailing Address (if different from above) [10] Street	Apt. # [11]	City [12]	State [13]	Zip [14]	County [15]

II. Family Members Living in the Home (Attach extra sheet if needed)						
Children (under 19) living in the home NAMES [16]	Date of Birth [17]	Citizen (Yes or No -- If no, see also attachment) [18]	Social Security Number [required for applicants -- otherwise optional] [19]	Mother's Name [20]	Father's Name [21]	Covered by Health Insurance other than Medicaid [Yes or No] If yes, what insurance? [22]
Adults living in the home NAMES [23]	Social Security Number [optional] [24]		If employed by a public agency in the State, what agency? [25]			

III. Income and Child Care Payments				
List all the income received by family members listed above (Attach Extra Sheet if Needed)				
Name of person(s) working or receiving money* [26]	Who provides the money? [27] Employer, program or person	How Often? [28] Weekly, twice a month, monthly	What amount? [29] Before taxes or any deductions	
1.				
2.				
3.				
*Be sure to include all sources of gross income (before taxes) such as wages, dividends & interest, TANF, SSI annuities, pension, disability, child support, alimony, cash gifts, & other unearned income.				
List the payments made for child care (or care for an adult who cannot care for himself) so that someone in your household can work. [30]				
Name of person(s) who works	Name of Person Care For	Under Age 2?	How Often?	What amount?
		Yes ☐ No ☐		

IV. Medicaid Questions		
Is any child: [31] Pregnant: Yes ☐ No ☐	In an Institution: Yes ☐ No ☐	Do any of the children have unpaid medical bills from the last 3 months? [32] Yes ☐ No ☐

Social Security Number (SSN) [33]

If you are applying for Medicaid for a child, you are not required to provide your own Social Security Number (SSN), but we must have the child's SSN in order for the child to receive Medicaid. If you are applying for CHIP (State-specific program name) for a child, you are not required to provide either your own or the child's SSN. If you are applying for Medicaid for yourself, you must provide your SSN. This policy is dictated by section 1137(a)(1) of the Social Security Act and the Medicaid regulations at 42 CFR 435.910. The Medicaid agency will use the SSN to verify your income, eligibility, and the amount of medical assistance payments we will make on your behalf. It is possible that the Medicaid agency will also use the SSN to determine another person's right to Medicaid or to comply with Federal law requiring that we release information from Medicaid records. The information may be matched with the records in other agencies, such as the Social Security Administration or the Internal Revenue Service. These matches may be done by computer or on an individual basis.

Rights and Responsibilities [34]

I agree to the release of personal and financial information from this application form and supporting documents to the agencies that run these programs so that they can evaluate it and verify eligibility. I understand that the agencies that run the programs will determine confidentiality of this information according to the federal laws, 42CFR 431.300-431.307, and any applicable federal and state laws and regulations.

Officials from the programs that I, or members of my household, have applied for may verify all information on this form.

I understand that I must immediately tell the Medicaid agency about any changes in information on this form.

I understand that I may be asked to provide additional information.

I understand my eligibility will not be affected by my race, color, national origin, age, disability, or sex, except where this is required by law.

I understand that this application is an application for one kind of children's health benefits under Medicaid and is not a full Medicaid application. I understand that if I am not found eligible for this kind of children's health benefits under Medicaid, I may be eligible for Medicaid benefits on some other basis and have a right to complete a full Medicaid application.

I have the right to appeal any decisions made by a local Medicaid program. Information on the appeals process can be obtained from the local Medicaid agency.

I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth is committing a crime which can be punished under federal law, state law, or both. I understand that I may also be liable for repaying in cash the value of the benefits received and may be subject to civil penalties.

I certify under penalty of perjury that everything on this application form is the truth as best I know.

Signature [35]

Date

Date Received by Agency [36]

Application and Enrollment Requirements for Medicaid and Separate State CHIP

1. Requirements for Separate State (non-Medicaid) CHIP

If a State chooses to develop a separate State (non-Medicaid) CHIP program, the only Federal requirements for the application and enrollment process for CHIP are:

- ◆ A screening and enrollment process designed by the State to ensure that Medicaid eligible children are identified and enrolled in Medicaid; and
- ◆ For qualified aliens, verification of applicant's immigration status with INS.

2. Requirements for Medicaid

The Federal requirements for the application and enrollment process for Medicaid (including CHIP-related Medicaid programs) are explained in 42 CFR 435.900ff. Specifically, States must:

- ◆ Give individuals the opportunity to apply for Medicaid without delay. Pregnant women and infants must have the opportunity to apply for Medicaid at required outstation locations other than welfare offices.
- ◆ Require a written application on a form prescribed by the State Medicaid agency and signed under a penalty of perjury. The application must be filed by the applicant, an authorized representative, or if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.
- ◆ Provide written (or oral, if appropriate) information to all applicants on Medicaid eligibility requirements, available services, and the rights and responsibilities of applicants and recipients. The State also must have pamphlets or bulletins that explain the eligibility rules and appeal rights in simple, understandable terms.
- ◆ Obtain the Social Security number (SSN) of the applicant. (Note that the SSN cannot be required of other family members who are not applying for Medicaid).
- ◆ If the applicant is a qualified alien, obtain documentation of satisfactory immigration status and verify immigration status with INS. (Note that this requirement does not apply to parents if the parents are not applying for Medicaid).
- ◆ Take action on applications within a time standard set by the State (not to exceed 45 days for individuals who apply on a basis other than disability) and inform the applicant about when a decision can be expected.
- ◆ Record in each applicant's case record facts to support its eligibility decision.
- ◆ Send a written decision notice to every applicant. If the application is denied, the notice must include the reasons for the denial, the specific regulations supporting the action and an explanation of the applicant's right to a hearing.

It also is important to note that the State's application and enrollment process must be consistent with our data collection requirements.

Federal law requires no verification of information pertaining to eligibility for children under Medicaid other than the requirement for verification of immigration status of qualified aliens, and the post-eligibility requirement in Section 1137 for an income and eligibility verification system (IEVS). Under IEVS, the State must request information from other Federal and State agencies to verify the applicant's income and resources. The applicant must be informed in writing, at the time of application, that the agency will be requesting this information.

Ground out

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Washington, D.C. 20201

FEB 13 1998

Dear State Health Official:

The Children's Health Insurance Program (CHIP) was created, with bipartisan support, to provide health insurance to uninsured children. The new law contains provisions explicitly designed to ensure that funds are targeted only to uninsured, and not already insured, children. Some of these provisions relate to Medicaid, while others are intended to prevent CHIP from substituting for private coverage. We are writing to provide guidance on the standards that the Department of Health and Human Services (DHHS) will use to evaluate State strategies to prevent this type of substitution of coverage. These strategies are necessary to maximize the use of Federal dollars and to provide more coverage to children who currently lack health insurance.

The Potential for Substitution

The potential for substitution of CHIP coverage for private group health coverage exists because CHIP provides reduced-price coverage that some individuals and employers currently purchase with their own funds. Specifically, employers with lower-wage employees could potentially save money if they stop offering dependent coverage (or if they reduce or eliminate their contributions for such coverage) and encourage their employees to enroll their children in the CHIP plan. At the same time, families that currently are making significant contributions towards dependent coverage (either through their employer plan or through an individual plan) could have an incentive to drop their current coverage and enroll their children in the CHIP plan as long as the benefits would be comparable and their out-of-pocket costs would be reduced. There also may be an incentive for States to substitute CHIP for Medicaid coverage, since CHIP has an enhanced matching rate.

Medicaid Substitution Provisions

Title XXI contains three provisions aimed at preventing CHIP from substituting for current Medicaid coverage. First, the State plan must include assurances that the State will coordinate its CHIP program with other public and private programs, including Medicaid. Second, there are "maintenance of effort" provisions for Medicaid eligibility. In a State that chooses to create a non-Medicaid CHIP program, the State cannot adopt income and resource methodologies for Medicaid children that are more restrictive than those in effect on June 1, 1997. In a State that chooses to create a Medicaid CHIP program, children are not eligible for enhanced matching under CHIP if they would be eligible for Medicaid in their State under the standards in effect on March 31, 1997. Third, any child who applies for CHIP must be screened for Medicaid eligibility and, if found eligible, enrolled in Medicaid.

HHS Review of Strategies to Protect Against Substitution of Private Coverage

The Balanced Budget Act of 1997 requires that States submitting applications to operate a State program with Federal funding through the Children's Health Insurance Program (CHIP) include a description of the procedures to ensure that coverage provided under CHIP does not substitute for coverage under either Medicaid or private group health plans. DHHS will review State CHIP plans to determine if the State has included procedures designed to address any potential substitution concerns. We believe that there are two distinct cases that need to be addressed: (1) insurance coverage provided directly through CHIP or Medicaid; and (2) using CHIP funds to subsidize coverage provided through employer-sponsored group health plans.

We will apply particular scrutiny to States whose State CHIP programs furnish coverage through employer-sponsored group health plans because we believe there is a greater potential for substitution of public for existing private spending on health insurance in these types of arrangements. First, we believe that this approach may increase the likelihood that families currently covered by employer-sponsored plans will seek the publicly subsidized coverage since these families could get premium assistance while still remaining in their existing group coverage plan. Many families may be reluctant to split up their family's health insurance to cover their children through CHIP, but could be more likely to choose CHIP if they would not have to disenroll their children from their current plans. Second, employers with low-wage workers may have incentives to reduce or eliminate their premium contributions for dependent coverage if the CHIP assistance replaced that contribution. The Department will review State CHIP plan submissions as follows:

◆ Insurance Coverage Provided Directly through CHIP or Medicaid

States that provide insurance coverage through a children's only and/or a State plan (as opposed to subsidizing employer-sponsored coverage) or expand through Medicaid will be required to describe procedures in their State CHIP plans that reduce the potential for substitution. The crowd out concerns increase at higher levels of poverty, and the Department will be applying greater scrutiny in these cases. After a reasonable period of time, the Department will review States' procedures to limit substitution. If this review shows that they have not adequately addressed substitution, the Department may require States to alter their plans.

◆ Subsidizing Employer-Sponsored Group Health Plans

States that use CHIP funds to subsidize employer-sponsored group health plans should incorporate provisions in their State CHIP plan that are substantially equivalent to each of the following five provisions. We will work with States that have other methods to prevent crowd out to ensure that they are substantially equivalent to these requirements.

1. To ensure that coverage is targeted to children in families that previously were unable to afford dependent coverage, children in a family will not be eligible for subsidies through an employer-sponsored group health plan if the family had employer-sponsored group coverage for these children within the previous six months. States will have the option to require a longer period of uninsurance, but that period could not exceed 12 months. Exceptions would be allowed if the prior coverage was involuntarily terminated (by other than a current employer). Newborns who are not covered by dependent coverage would not be subject to any such waiting period.
2. To discourage employers from lowering their existing contributions for dependent coverage, States only will be permitted to make subsidies available for the purchase of dependent coverage through employer-sponsored group health plans in cases where the employer contributes at least 60 percent of the cost of family coverage, which is the median employer contribution nationwide. We can consider a somewhat lower level if States have additional provisions to limit employers' ability to lower contribution levels. For ease of administration, the State may establish a minimum dollar employer contribution or some other method that is equivalent to the 60 percent requirement to assure that employers continue to pay a meaningful share of the costs in these programs.
3. To ensure that the provision of child health assistance through employer-sponsored group health plans is cost effective and that the State is not inappropriately subsidizing coverage for the adults in a family, a State's payment for a child enrolled in an employer-sponsored group health plan can be no greater than the payment that the State would make for the child if they were enrolled in a separate CHIP plan offered by the State (or in Medicaid if appropriate). If the State subsidizes children's coverage only, there is no need for a State to seek a family coverage waiver under Section 2105(c)(3). If the State intends to cover any adults, however, the State must seek a waiver under this section.
4. To promote cost effectiveness, families electing to receive child health assistance through an employer-sponsored group health plan will be required to apply for the full premium contribution available from the employer. This contribution will reduce the CHIP contribution toward the premium.
5. To demonstrate cost effectiveness, the State will be required to collect information and conduct an evaluation that examines the amount of substitution (if any) that has occurred under the program and the effect of these provisions on access to the program. States must assess the prior insurance coverage of enrolled children. Information on prior coverage can be obtained through the enrollment process, separate studies of CHIP enrollees, or other means that reliably gather information about prior health insurance status. To determine the level of substitution, States

are encouraged to analyze the number of families who choose to enroll in CHIP who might have retained or bought private insurance had they not received CHIP funding for employer-sponsored insurance. States will conduct this evaluation within a specified time period. Based on the State evaluations, the Department will reevaluate its position on these requirements for States that subsidize employer-sponsored group health plans.

States that choose to subsidize children's coverage through employer-sponsored group health plans would report in their State Child Health Plan their compliance with these guidelines. Including this information in the Plan will be deemed as meeting the requirement in the law that insurance provided under the State child health plan does not substitute for coverage under group health plans.

Summary

This guidance is intended to contribute to our national goal that CHIP provides coverage to uninsured children rather than children who are already covered.

Sincerely,


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


Claude Earl Fox, M.D., M.P.H.
Acting Administrator
Health Resources and Services Administration

All HCFA Regional Offices
All PHS Regional Offices
HHS Regional Directors

Ms. Lee Partridge
American Public Welfare Association

Ms. Jennifer Baxendell
National Governor's Association

Ms. Joy Wilson
National Conference of State Legislatures

Brent Ewig
Association of State and Territorial Health Officials

Mary Beth Senkewicz
National Association of Insurance Commissioners

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MAY 11 1998

Dear State Health Official:

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

This letter is intended to provide detailed guidance regarding coverage of immunization under Title XXI and the Vaccines for Children (VFC) program. Ensuring that all children receive appropriate immunizations is a priority for the President, the First Lady and Secretary Shalala. The unique nature of funding for vaccines create special challenges and options for covering vaccines for CHIP-covered children, as described below.

States must ensure coverage for childhood vaccinations under CHIP. Section 2102(a)(7) of the Children's Health Insurance Program requires States to "assure the quality and appropriateness of care, particularly with respect to ... immunizations" provided under the State child health plan. The standard for appropriate care with respect to childhood immunizations, used in the Medicaid and the VFC programs, is the schedule of immunizations recommended by the Federal Advisory Committee on Immunization Practices (ACIP). All State CHIP plans must provide coverage for all ACIP-recommended vaccines to enrollees. The Department expects that children will be immunized with vaccines purchased using funds provided through their Title XXI plans.

The VFC program was established in 1993 to serve children defined as "federally vaccine eligible" under section 1928(b)(2), which includes both "uninsured" and "Medicaid eligible" children. American Indian, Alaskan Native children and children whose insurance does not cover immunizations are also eligible for VFC. States will continue to receive federal funding for reduced-price vaccines under this program.

Children who are newly eligible for Medicaid under Title XXI are federally vaccine eligible, as are all other children eligible for Medicaid. However, because of Title XIX restrictions on eligibility for VFC, States that have designed a separate State health insurance program under CHIP (S-CHIP) may not treat children enrolled in such a program as federally vaccine eligible.

Page 2 -- State Officials

Children enrolled in a separate State insurance program are neither Medicaid eligible nor uninsured as required under Title XIX and, therefore, they are not federally vaccine eligible. However, to ensure that States choosing to expand through S-CHIP have the same opportunity for reduced-price vaccines as States expanding through Medicaid, States have two options for funding.

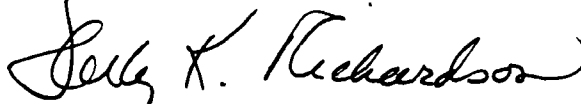
First, States may define these children as "State vaccine eligible" under Section 1928(b)(3) and purchase vaccine at the federal contract price for these children without these expenditures being subject to the 10 percent cap on expenditures for other child health assistance, health services initiative, outreach, and administration. To do this, States must retain responsibility for the provision of benefits to Title XXI children and sub-contract portions of the benefit package to insurers, except the purchase of vaccine. States must distribute vaccine purchased through the federal contract to their Title XXI providers so that they may administer the vaccine to children. Because the State is paying for the vaccine, contracts with insurers must not include payment for vaccine costs, although any fees or costs associated with the actual vaccination of children may be included in the sub-contract.

Second, States may choose to contract with insurers for the provision of vaccine as they do for other services. States electing this approach will have to pay private sector market prices for vaccine. Under both options, State expenditures are matched at the CHIP enhanced matching rate.

States are encouraged to work through their State Health Departments and their State Immunization Programs to determine the most effective manner in which to purchase vaccines for S-CHIP children. Also, as part of the State's program evaluation strategy, States are strongly encouraged to track the percentage of children in Title XXI who are receiving age-appropriate vaccinations and how those vaccinations are being delivered.

I hope this guidance will be helpful. If you have any questions regarding coverage of immunization under Title XXI, please contact your HCFA regional office staff.

Sincerely/yours,



Sally K. Richardson

Director

Center for Medicaid and State Operations

cc: State Immunization Program Managers



Washington, D.C. 20201

FEB 13 1998

Dear State Official:

The Balanced Budget Act of 1997 (Public Law 105-33), established the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act (the Act.) This new Title enables States to expand health insurance coverage for uninsured children. The Department of Health and Human Services has issued several letters to provide policy and State plan guidance on the implementation of the Children's Health Insurance Program (CHIP).

This letter is intended to provide additional detailed guidance regarding the implementation of CHIP provisions related to cost-sharing, described in section 2103(e) of the Act. It reflects preliminary policies which we intend to incorporate into proposed regulations, subject to public comment, and into appropriate State manual instructions.

If a State implements CHIP as a *separate, non-Medicaid program*, then the following requirements apply. Under the statute, the State child health plan must include a description of the amount of premiums, deductibles, coinsurance, and other cost sharing imposed under CHIP; and any such charges must be imposed according to a public schedule. Its CHIP plan must also describe methods that will be used to ensure that total cost-sharing liability does not exceed the aggregate cap for families with income above 150 percent of poverty, described below. With regard to cost-sharing policy, States may vary premiums, deductibles, coinsurance and other cost sharing based on family income, provided that lower income families pay less than higher income families. However, States are prohibited from imposing deductibles, coinsurance, or other cost-sharing on well-baby and well-child care, including age-appropriate immunizations.

Additionally, the Act includes several restrictions on cost-sharing under CHIP that differ based on whether the income of the child's family is above or below 150 percent of the Federal poverty line. These limitations, applicable only to non-Medicaid CHIP programs, are described below.

If a State has chosen to implement CHIP as an *expansion to its Medicaid program*, then cost-sharing obligations imposed by the State under Medicaid are applicable to CHIP. Federal Medicaid rules are described in regulations at 42 CFR 447.50-59. We note that these rules permit the imposition of enrollment fees, premiums, or similar charges on children under certain circumstances, but prohibit cost-sharing in the form of deductibles, coinsurance, copayments, or similar charges on services to children.

Targeted low-income children in families with incomes at or below 150 percent of poverty:

Under section 2103(e)(3)(A) of the Act, a State may impose enrollment fees, premiums, or similar charges on children with family income at or below 150 percent of poverty, but if it does so, the maximum amounts it imposes are limited by the maximum amounts it may impose under Medicaid under section 1916(b)(1) of the Social Security Act for a Medicaid-eligible family of the same size and income. Specific rules, described in Medicaid regulations at 42 CFR 447.51, require premiums to be based on an income-related sliding scale, and to be limited to no more than a specified monthly amount per family. For example, the maximum amount for a family with \$1000 monthly income is \$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. Lower maximum premium amounts are prescribed for families with less income.

In the case of cost-sharing other than premiums for children below 150 percent of poverty, Section 2103(e) of Title XXI specifies the maximum amounts that a State may impose under CHIP for deductibles, cost sharing, or similar charges are limited to amounts considered to be nominal, consistent with regulations implementing section 1916(a)(3) for persons covered under Medicaid, "with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable." Because the Child Health Insurance Program is designed for families with incomes above the Medicaid eligibility levels, the Department of Health and Human Services has determined preliminarily that it would be reasonable to increase the limits for CHIP cost-sharing consistent with our concern that access to services not be compromised. Therefore, the Secretary currently intends to propose regulations to increase the limits on coinsurance, copayments, or similar charges for services under CHIP as follows: \$1.00 for services of \$15.00 or less, \$2.00 for services between \$15.01 and \$40.00, \$3.00 for services between \$40.01 and \$80.00, and \$5.00 for services over \$80.00. These proposed changes only will affect separate, non-Medicaid CHIP State programs.

Targeted low-income children in families with incomes above 150 percent of poverty:

CHIP cost-sharing rules under section 2103(e)(3)(B) of the Act are more flexible for children above 150% of poverty. States may impose premiums, deductibles, cost sharing or similar charges in any amount, provided that cost-sharing for higher income children is not lower than cost-sharing for lower income children. However, the total annual aggregate cost-sharing (including premiums, deductibles, copayments, and any other charges) for all targeted low-income children in a family may not exceed 5% of total family income for the year. In addition, States must inform families of these limits and provide a mechanism for families to stop paying once the cost-sharing limits have been reached.

If there are any questions regarding the CHIP cost-sharing provisions, please contact your HCFA regional office staff.

Sincerely,



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



Claude Earl Fox, M.D., M.P.H.
Acting Administrator
Health Resources and Services Administration

All HCFA Regional Offices
All PHS Regional Offices
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Ms. Lee Partridge
American Public Welfare Association

Ms. Jennifer Baxendell
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National Conference of State Legislatures

Brent Ewig
Association of State and Territorial Health Officials

Mary Beth Senkewicz
National Association of Insurance Commissioners

CHTP FY 1999 Budget
proposals

FY 99 BUDGET PROPOSALS

Remove Presumptive Eligibility from CHIP Cap

Summary

The budget would eliminate the requirement that States subtract the costs of presumptive eligibility from the Children's Health Insurance Program (CHIP) allotment for States with Title XXI plans. Instead, these costs (both administrative and benefit) would be matched as a regular Medicaid State plan option. This would increase the amount of CHIP funds available for coverage to targeted low-income children.

Status

The language for this proposal has been drafted as part of the "Children's Health Outreach and Eligibility Amendments of 1998" bill. The language was sent to OMB for comment and their passback was received on May 11th. The bill has not been transmitted to the Hill (see DRAFT Speaker letter at the end of this section).

Hill Action

Language that would implement this proposal is included in the McCain Tobacco bill which was recently passed by the Senate Finance committee.

Budget Impact

	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>99-03</u>
\$ in millions	10	10	10	*	*	30

FY 99 BUDGET PROPOSALS

Increase and Expand Use of TANF Outreach Funding

Summary

States would be permitted to expand the use of a special \$500 million Medicaid fund now aimed at outreach for children losing welfare, to fund outreach to other children eligible for Medicaid and to new children eligible for CHIP. In addition, the fund would be increased by \$25 million over five years. Finally, the proposal would remove the sunset on the fund, currently scheduled for 2000.

Status

The language for this proposal has been drafted as part of the "Children's Health Outreach and Eligibility Amendments of 1998" bill. The language was sent to OMB for comment and their passback was received on May 11th. The bill has not been transmitted to the Hill (see DRAFT Speaker letter at the end of this section).

Hill Action

Language that would implement this proposal is included in the McCain Tobacco bill which was recently passed by the Senate Finance committee.

Budget Impact

	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>99-03</u>
\$ in millions	40	50	80	80	80	330

FY 99 BUDGET PROPOSALS

Simplify Enrollment

Summary

This proposal would simplify the enrollment process for Medicaid by streamlining the application process and encouraging the use of simple, mail-in or phone-in applications. This proposal does not require any new legislation and produces no savings or costs.

Hill Action

None

Budget Impact

None

Medicaid Program Integrity

Summary

This proposal would transfer \$5 million a year from the HCFAC account to set up a fund from which grants would be made to states to build Medicaid error rate baselines and develop Medicaid performance measures. This proposal does not require new legislation and produces not savings or costs.

Hill Action

None

Budget Impact

FY 99 BUDGET PROPOSALS

State Option to Cover Legal Immigrant Children

Summary

The budget would give States the option to extend either Medicaid or the Children's Health Insurance Program (CHIP), or both, to legal immigrant children who entered the country after August 22, 1996. State Medicaid expenditures under this option would be matched as a regular Medicaid expenditure. A State choosing the CHIP eligibility option would cover and receive Federal matching for eligible legal immigrants on the same basis as other children covered under CHIP. This proposal would fill a significant gap created by the enactment of welfare reform, which denies Medicaid to immigrant children who entered after August 22, 1996 and who have resided in the U.S. for less than five years. This proposal would restore eligibility to this population, permitting coverage for recent and future immigrant children as soon as they qualify. Since immigrant children will grow up to be full participants in American society, it is in the best interests of the children themselves as well as society at large for them to get the best possible start in life, the same as children born in the U.S. This proposal also takes into account the interests of the States, which administer Medicaid and CHIP, by offering them an option rather than a Federal mandate.

Status

The language for this proposal has been drafted as part of the "Medicaid Children's Health Improvement Amendments of 1998" bill. The language was been through two rounds of OMB comment. We got their last passback was received on May 21st. The bill has not been transmitted to the Hill (see DRAFT Speaker letter at the end of this section).

Hill Action

None

Budget Impact

	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>99-03</u>
\$ in millions	25	35	50	55	65	230

FY 99 BUDGET PROPOSALS

Cost Allocation Savings

Summary

The FY 1999 Budget proposes legislation to address projected Federal cost increases in the Food Stamp and Medicaid programs arising from changes in the way States charge costs to the Federal Government to administer the Food Stamps, Medicaid, and Temporary Assistance for Needy Families (TANF) programs.

Prior to the enactment of welfare reform, States charged most costs that were common to the administration of the three public assistance programs to TANF's predecessor, the open-ended Aid to Families with Dependent Children (AFDC) program. The creation of the capped TANF grant in 1996 consolidated cash welfare assistance and related programs, built administrative costs common to the three programs into the TANF block grant, and placed limitations on the amount of funds that may be used for administrative purposes. Because of these limitations, many States have sought to change the way they allocate administrative costs among the three programs by charging more of their expenses to Food Stamps and Medicaid (which still provide open-ended matching funds for State administrative costs) and less to TANF.

To date, the Department of Health and Human Services has not approved requests from States to change their cost allocation plans to increase administrative reimbursements in the Food Stamp and Medicaid programs. Such cost increases -- which are projected to exceed \$500 million per year -- were not envisioned in the crafting of the welfare reform law.

Effective in FY 1999, the Administration intends to allow States to change their cost allocation plans to charge a greater share of common administrative costs to the Food Stamp and Medicaid programs. To prevent Federal costs from rising due to the new cost allocation approaches, the Budget proposes legislative changes in Food Stamps and Medicaid to reduce total Federal expenditures by the amount costs are expected to rise as a result of the new cost allocation plans. The Budget reduces the matching rates for administrative costs in Food Stamps and Medicaid from 50 percent to 47 percent.

Status

(What we can say)

Officially the President's budget still includes the proposal to reduce the administrative match rate from 50% to 47%. However, the administration is considering a different approach that would make a state by state determination of the 'overpayment' amounts and take the reductions on a state by state basis. This approach would be very similar to that contained in the Agricultural Research Bill.

(Not for public disclosure)

Officially, the President's budget still includes the proposal to reduce the admin match rate from 50 to 47 percent. However, S. 1150, the Agricultural Research bill, is progressing steadily toward final passage and enactment (it's gone through conference and has been passed by the House). This bill directs the Secretaries of Agriculture and Health and Human Services to make an individual determination for each state, as to how much 'extra' Medicaid *and* Food Stamp

administrative money is included in their TANF block grants. The Agriculture bill has provisions which reduce each state's Food Stamp allotment by the amounts determined by the Secretaries and uses the savings to pay for agricultural research.

The Agriculture bill does not reduce the Medicaid allotments, however, if the Agriculture bill passes, HHS will have to do all the work to determine what the reductions for Medicaid should be. OMB has asked OGC to draft language that would parallel the Agriculture bill, provide for the Medicaid allotments to be reduced and capture the savings. NGA has indicated that it prefers the Agriculture approach to the across the board cut in admin match that is in the President's budget. We believe that the Agriculture bill will likely pass and if it does, OMB will substitute the new proposal that uses the Agriculture method to capture the savings from Medicaid.

Hill Action

The savings created by the admin match rate reduction proposal was included as an offset in the Transportation bill for a while. In addition, CBO was asked to score a proposal that would have block granted most of Medicaid admin costs (only family planning and mechanized systems improvement were left out of the block grant). The baseline was identified as FY 1997 and the block grant would have been increased by CPI each year. The savings from this proposal were also to be used as an offset for the Transportation bill. After a hue and cry from the staffs of the authorizing committees and a veiled veto threat from the White House, the provisions were removed from the bill that was passed.

Earlier last week Rep. Kasich had released a GOP House budget that included block granting Medicaid acute care to generate about \$4.8 billion in savings to reduce the 'marriage penalty' tax. Rep. Kasich has withdrawn that budget document, the newly released budget does not include Medicaid cuts.

Budget Impact (admin match rate reduction)

	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>99-03</u>
\$ in millions	-500	-500	-600	-600	-700	-2,900

Update on cost allocation -- S. 1150

- **S. 1150 -- Status:** This bill, "Agriculture, Research, Extension, and Education Act of 1998," pursues the same goals as the Administration's proposal -- to prevent a windfall to States as a result of the inclusion of Medicaid and Food Stamps administrative costs in their TANF block grants. However, the bill employs a different approach to determining the amount of the reductions.

The bill was presented for the President's signature on 6/12/98. The President is expected to sign it.

- **Bill content:**

- Reduces Food Stamp administrative match to States for 1999-2002.
- Amount of reduction would be determined by the Secretary of DHHS based on the following:
 - > administrative costs common to determining eligibility for Food Stamps, AFDC, and Medicaid in a base year before TANF,
 - > amounts attributable to common costs to all three programs that were paid as AFDC administrative match, and
 - > the portion of those common costs that would have been paid as Food Stamps administrative match if Federal matching funds had been allocated equally among the three programs.

- States could appeal the Secretary's determination to the Departmental Appeals Board.

- **Implications:** The formula approach in S. 1150 will result in reductions in variable amounts by States, based on spending allocations in a State in a base year. This will entail significant administrative effort. By contrast, the Administration's proposal to reduce administrative match rate from 50% to 47% would have applied equally to all States and been simple to apply.

- **Problems with S. 1150 and potential solutions:**

- Secretary of DHHS and HHS programs would be governed by Food Stamps law.
- No provision for comparable reductions for excess TANF administrative allocations that were based Medicaid administrative costs.
- DHHS is working on bill language that follows the general policy laid out in S. 1150, but corrects these problems.

FY 99 BUDGET PROPOSALS

Increase CHIP Allotment for Territories

Summary

CHIP funding would be increased by a total of \$153 million over five years to be distributed among Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, allocated proportional to their current CHIP allotments. The Balanced Budget Act of 1997 (BBA) set aside 0.25 percent of total CHIP funds for the Territories, an amount that is inadequate to meet the health needs of the many uninsured low-income children in the Territories. The President, in his BBA signing statement, pledged to work with Congress to provide more equitable funding for children's health care in the insular areas. This proposal would provide the Territories with that additional funding.

Status

The language for this proposal has been drafted as part of the "Medicaid Children's Health Improvement Amendments of 1998" bill. The language was been through two rounds of OMB comment. We got their last passback was received on May 21st. The bill has not been transmitted to the Hill (see DRAFT Speaker letter at the end of this section).

Hill Action

None.

Budget Impact

	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>99-03</u>
\$ in millions	34	34	34	24	24	150

CHIP ISSUES

State Enhanced Match/MOE Issues (MD)

Last week we provided technical assistance to Maryland in their efforts to get enhanced match for the children between 133% and 185% FPL that are currently eligible for the Kids Count 1115 demonstration expansion. We talked with Alice Barton in Barbara Shipmuck's (? spelling) office. There was also a follow up call to John Folkener. We were responding to a direct request from them and they were pleased with our answer. They did not indicate the manner or the timeframe in which they were going to proceed.

You recall that the Kids Count program does not include coverage for hospital services. Maryland wants to expand coverage up to 200% of FPL, but under current law they cannot get an enhanced match for kids who are currently eligible for the 1115 expansion.

Maryland has submitted a CHIP plan to expand eligibility to 200% FPL. A copy of what we provided to them follows.

105TH CONGRESS
2D SESSION

S. 2013

To amend title XIX of the Social Security Act to permit children covered under private health insurance under a State children's health insurance plan to continue to be eligible for benefits under the vaccine for children program.

IN THE SENATE OF THE UNITED STATES

APRIL 30, 1998

Mrs. FEINSTEIN introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XIX of the Social Security Act to permit children covered under private health insurance under a State children's health insurance plan to continue to be eligible for benefits under the vaccine for children program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. PERMIT CHILDREN COVERED UNDER PRIVATE**
2 **HEALTH INSURANCE UNDER A STATE CHILD**
3 **HEALTH PLAN TO CONTINUE TO BE ELIGIBLE**
4 **FOR BENEFITS UNDER THE VACCINE FOR**
5 **CHILDREN PROGRAM.**

6 (a) **IN GENERAL.**—Section 1928(b)(2)(A)(ii) of the
7 Social Security Act (42 U.S.C. 1396s(b)(2)(A)(ii)) is
8 amended by inserting “, except that for purposes of this
9 paragraph a child who is only insured under title XXI
10 shall be considered as being not insured” after “not in-
11 sured”.

12 (b) **EFFECTIVE DATE.**—The amendment made by
13 subsection (a) shall take effect as if included in the enact-
14 ment of the Balanced Budget Act of 1997.

○

105TH CONGRESS
2D SESSION

H. R. 3837

To amend title XXI of the Social Security Act to permit States to use funds under the State Children's Health Insurance Program for coverage of uninsured pregnant women.

IN THE HOUSE OF REPRESENTATIVES

MAY 12, 1998

Mr. HYDE (for himself and Mrs. LOWEY) introduced the following bill; which was referred to the Committee on Ways and Means

A BILL

To amend title XXI of the Social Security Act to permit States to use funds under the State Children's Health Insurance Program for coverage of uninsured pregnant women.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Safe and Healthy
5 Motherhood Act of 1998".

1 **SEC. 2. OPTIONAL COVERAGE OF LOW-INCOME, UNIN-**
2 **SURED PREGNANT WOMEN UNDER A STATE**
3 **CHILD HEALTH PLAN.**

4 (a) **IN GENERAL.**—Title XXI of the Social Security
5 Act is amended by adding at the end the following new
6 section:

7 **“SEC. 2111. OPTIONAL COVERAGE OF LOW-INCOME, UNIN-**
8 **SURED PREGNANT WOMEN.**

9 “(a) **OPTIONAL COVERAGE.**—Notwithstanding any
10 other provision of this title, a State child health plan may
11 provide for coverage of pregnancy-related assistance for
12 targeted low-income pregnant women in accordance with
13 this section.

14 “(b) **DEFINITIONS.**—For purposes of this section:

15 “(1) **PREGNANCY-RELATED ASSISTANCE.**—The
16 term ‘pregnancy-related assistance’ has the meaning
17 given the term child health assistance in section
18 2110(a) as if any reference to targeted low-income
19 children were a reference to targeted low-income
20 pregnant women, except that the assistance shall be
21 limited to services related to pregnancy (which in-
22 clude prenatal, delivery, and postpartum services)
23 and to other conditions that may complicate preg-
24 nancy and shall not include prepregnancy services
25 and supplies.

1 “(2) TARGETED LOW-INCOME PREGNANT
2 WOMAN.—The term ‘targeted low-income pregnant
3 woman’ has the meaning given the term targeted
4 low-income child in section 2110(b) as if any ref-
5 erence to a child were deemed a reference to a
6 woman during pregnancy and through the end of the
7 month in which the 60-day period (beginning on the
8 last day of her pregnancy) ends.

9 “(c) REFERENCES TO TERMS AND SPECIAL
10 RULES.—In the case of, and with respect to, a State pro-
11 viding for coverage of pregnancy-related assistance to tar-
12 geted low-income pregnant women under subsection (a),
13 the following special rules apply:

14 “(1) Any reference in this title (other than sub-
15 section (b)) to a targeted low income child is deemed
16 to include a reference to a targeted low-income preg-
17 nant woman.

18 “(2) Any such reference to child health assist-
19 ance with respect to such women is deemed a ref-
20 erence to pregnancy-related assistance.

21 “(3) Any such reference to a child is deemed a
22 reference to a woman during pregnancy and the pe-
23 riod described in subsection (b)(2).

1 “(4) The medicaid applicable income level is
2 deemed a reference to the income level established
3 under section 1902(l)(2)(A).

4 “(5) Subsection (a) of section 2103 (relating to
5 required scope of health insurance coverage) shall
6 not apply insofar as a State limits coverage to serv-
7 ices described in subsection (b)(1) and the reference
8 to such section in section 2105(a)(1) is deemed not
9 to require, in such case, compliance with the require-
10 ments of section 2103(a).

11 “(6) There shall be no exclusion of benefits for
12 services described in subsection (b)(1) based on any
13 pre-existing condition.

14 “(d) NO IMPACT ON ALLOTMENTS.—Nothing in this
15 section shall be construed as affecting the amount of any
16 initial allotment provided to a State under section
17 2104(b).

18 “(e) APPLICATION OF FUNDING RESTRICTIONS.—
19 The coverage under this section (and the funding of such
20 coverage) is subject to the restrictions of section
21 2105(c).”.

22 “(b) EFFECTIVE DATE.—The amendment made by
23 subsection (a) shall take effect on the date of the enact-

1 ment of this Act and shall apply to allotments for all fiscal
2 years.

○

105TH CONGRESS
2D SESSION

H. R. 3713

To amend title XXI of the Social Security Act to prevent conflicts of interest in the use of administrative vendors in the administration of State Children's Health Insurance Plans.

IN THE HOUSE OF REPRESENTATIVES

APRIL 22, 1998

Mr. STARK (for himself, Mr. WAXMAN, Mr. MATSUI, Mr. MILLER of California, Mr. BROWN of Ohio, Ms. ESHOO, and Mr. LANTOS) introduced the following bill; which was referred to the Committee on Ways and Means

A BILL

To amend title XXI of the Social Security Act to prevent conflicts of interest in the use of administrative vendors in the administration of State Children's Health Insurance Plans.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "State Children's
5 Health Insurance Program Integrity Act of 1998".

1 **SEC. 2. LIMITATION ON USE OF ADMINISTRATIVE VENDORS**
2 **IN THE ADMINISTRATION OF STATE CHIL-**
3 **DREN'S HEALTH INSURANCE PLANS.**

4 (a) IN GENERAL.—Section 2105(c) of the Social Se-
5 curity Act (42 U.S.C. 300aa-5(c)) is amended by adding
6 at the end the following new paragraph:

7 “(8) LIMITATION ON EXPENDITURES FOR AD-
8 MINISTRATIVE VENDORS.—Amounts expended by a
9 State for the use of an administrative vendor in
10 marketing health benefits coverage to low-income
11 children under this title or in administering other-
12 wise part or all of the State child health plan under
13 this title shall be considered, for purposes of sub-
14 section (a)(2)(D), to be reasonable costs to admin-
15 ister the plan but only if the following conditions are
16 met with respect to the vendor:

17 “(A) The vendor is independent of any en-
18 tity offering the coverage and of any health
19 care providers (whether or not any such pro-
20 vider participates in the plan under this title)
21 that provide coverage of services in the same
22 State in which the vendor is conducting enroll-
23 ment or administrative activities.

24 “(B) No person who is an owner, em-
25 ployee, consultant, or has a contract with the
26 vendor either has any direct or indirect finan-

1 cial interest with such an entity or health care
2 provider or has been excluded from participa-
3 tion in the program under this title or title
4 XVIII or XIX or debarred by any Federal
5 agency, or subject to a civil money penalty
6 under this Act.”.

7 (b) EFFECTIVE DATE.—The amendment made by
8 subsection (a) shall apply to expenditures made on or after
9 the date of the enactment of this Act.

○

SEC. ____ AMENDMENT TO ALLOW MARYLAND TO PROVIDE CHILDREN'S
HEALTH ASSISTANCE TO CHILDREN COVERED UNDER THE
MARYLAND KIDS COUNT WAIVER.

Section 1905(u)(2)(B) of the Social Security Act is
amended—

(1) by inserting "(i)" after the subparagraph
designation "(B)";

(2) by inserting before the period "or who would
qualify for such medical assistance only under a
demonstration described in clause (ii)"; and

(3) by adding at the end the following new clause:

"(ii) For purposes of clause (i), a demonstration
is described in this clause if—

"(I) it was approved under section 1115(a);

"(II) it was implemented on or before March
31, 1997; and

"(III) it does not include hospital services
as a covered benefit.".

NOTE: This assumes that the 1115 demonstration is in effect. If the State chooses to end the demonstration before the CHIP expansion is in effect, issues regarding Maintenance of Effort would be raised.

NOTE TO: Debbie
FROM: Jennie
DATE: May 28, 1998
SUBJECT: **DRAFT CHIP AMENDMENT FOR IOWA**

As you know, Hope Hegstrom and Ted Totman of Sen. Grassley's office called us to request technical assistance on how to draft an amendment relating to Iowa's CHIP program. They wanted to be able to allow Iowa to access their CHIP allotment despite the fact that they had eliminated a work transition period for a specific eligibility group in October of 1997. We had told them that without legislation this would violate the CHIP maintenance of effort requirement that eligibility not be restricted from where it was on June 1, 1997.

Attached is the draft amendment. They sent it over to us for review and we made the suggestions that are noted on the amendment. We never sent them anything, but rather went over the comments verbally.

I called Hope today for an update on the status of their amendment. She said they tried to get the amendment on the IRS bill and a child support enforcement bill. They were not successful in either case.

Version #1
WTP

AMENDMENT NO. _____

Calendar No. _____

Purpose: To authorize payments under the State children's health insurance program under title XXI of the Social Security Act to a State that has eliminated a work transition waiver under the medicaid program.

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

H.R. 2676

To amend the Internal Revenue Code of 1986 to restructure and reform the Internal Revenue Service, and for other purposes.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. GRASSLEY

Viz:

1 At the end of subtitle H of title III, add the following:

2 SEC. ____ AMENDMENT TO THE SOCIAL SECURITY ACT.

3 (a) IN GENERAL.—Section 2105(d) of the Social Se-

4 curity Act (42 U.S.C. 1397ee(d)) is amended by adding

5 at the end the following:

6 ^{Exception}“(3) ~~RULE OF CONSTRUCTION.~~ Paragraph (1)

7 ~~shall not be construed as prohibiting payment under~~

8 subsection (a) to any State that eliminated a 4

9 month work transition period that allowed an indi-

Notwithstanding paragraph
payment would not
be prohibited
under subsection



NOTE TO: Debbie
FROM: Jennie
DATE: May 28, 1998
SUBJECT: **TORRICELLI AMENDMENT**

On May 20th, ASL requested that we develop technical and policy issues with a draft amendment that Sen. Torricelli wanted to offer to the tobacco legislation. Attached are the draft comments that we developed. We just gave ASL the technical concerns. We thought the policy concerns should be vetted first.

I asked Sharon Clarkin for an update. She reported that the White House eventually weighed in on the amendment. They suggested that Jane Horvath tell the staff that "we can't support it right now." We have not heard anything since that time.

SENATOR TORRICELLI AMENDMENT TO TOBACCO LEGISLATION

Summary of amendment

This amendment would provide that 15 percent of the State Litigation Settlement Account be used to establish a Medicaid Performance Bonus Fund. This fund would exist for the first 5 years after implementation of the tobacco legislation. To be eligible, States must demonstrate to the Secretary that they are implementing the following outreach activities:

- (1) Streamlined eligibility process
 - (a) shortened and simplified application;
 - (b) eliminating the assets test for children;
 - (c) using income tests that are easily understood by applicants; and
 - (d) allowing mail-in applications.
- (2) 12-month Continuous Eligibility
- (3) Presumptive Eligibility
- (4) Comply with outstationing requirements (Section 1902(a)(55))

In addition, the State must report to the Secretary on the number of full-year equivalent children that are determined eligible for Medicaid as a result of: (1) presumptive eligibility; and (2) submitting an application for Medicaid through an outstationed eligibility worker.

Eligible States will receive an increase of 4 percent in their Federal Medical Assistance Percentage for the total amount expended that is attributable to children. Each State's portion of the allotment will be based on the State's portion of overall Medicaid costs. Amounts allocated will remain available for three years. The Secretary will determine a process for redistribution of allotments to States that have fully expended the amount of their allotment.

Policy concerns:

- ◆ This amendment would commit a large amount of resources to States for implementing process standards rather than outcome measures.
- ◆ This amendment would result in the Federal government "buying out the base" of current Medicaid programs. According to the Center on Budget and Policy Priorities, 24 States use mail-in applications, 29 States have shortened their applications and 36 States have eliminated the assets test for children.
- ◆ This amendment would reward States for doing outreach activities that many of the "good" States would do anyway.
- ◆ This amendment would reduce the State Litigation Settlement Account by 15 percent. This means that States would have less money to use toward State match of CHIP outreach activities.

FY 99 BUDGET PROPOSALS

Expand Qualified Presumptive Eligibility Providers

Summary

This provision would expand the qualified entities that can determine children to be presumptively eligible for Medicaid. Current law limit these entities to providers of health care items and services under the Medicaid State plan and any entity authorized to determine eligibility for Head Start, Child Care and Development Block Grant and WIC. Under this proposal, States would be permitted to allow entities such as public schools, child care resource and referral centers, child support enforcement agencies and CHIP eligibility workers to determine presumptive Medicaid eligibility for children. Child care resource and referral centers help families find appropriate child care and also help connect families to other resources and services. They routinely request income information that could be used to identify children who may be eligible for Medicaid. Similarly, the public school system is a logical entity for identifying uninsured children and linking them to Medicaid.

Status

The language for this proposal has been drafted as part of the "Children's Health Outreach and Eligibility Amendments of 1998" bill. The language was sent to OMB for comment and their passback was received on May 11th. The bill has not been transmitted to the Hill (see DRAFT Speaker letter at the end of this section).

Hill Action

Language that would implement this proposal is included in the McCain Tobacco bill which was recently passed by the Senate Finance committee.

Budget Impact

	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>99-03</u>
\$ in millions	60	90	120	130	140	540

The Honorable Newt Gingrich
Speaker of the House
of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Enclosed for the consideration of the Congress is the Administration's draft bill, the "Children's Health Outreach and Eligibility Amendments of 1998". The bill supports the President's Budget for FY 1999.

The bill would amend the Medicaid statute (title XIX of the Social Security Act) to give States the option of expanding the list of entities that are qualified to make Medicaid presumptive eligibility determinations for children. The proposal would allow States to treat as qualified entities: (1) entities that determine eligibility for benefits under Medicaid, the Temporary Assistance for Needy Families Program (TANF), and the Children's Health Insurance Program (CHIP); (2) staff members of public schools, child care resource and referral centers, and child support enforcement agencies; and (3) other entities designated by the State. The bill would leave unchanged State agencies' authority to determine whether a qualified entity is capable of making presumptive eligibility determinations and the Secretary's authority to limit the list of qualified entities. We believe that this proposal would allow States greater flexibility in identifying children who are eligible for Medicaid.

The bill would also amend the CHIP statute (title XXI of the Social Security Act) to eliminate the requirement that the administrative and benefit costs of presumptive eligibility determinations be subtracted from State CHIP allotments. Instead, these costs would be treated as expenditures under Medicaid. This proposal would increase the amount of CHIP funds available for coverage to targeted low-income children.

Finally, the bill would amend the Medicaid statute to expand the use of a fund that was established by the welfare reform legislation to defray Medicaid administrative costs of eligibility determinations for children losing cash assistance as a result of the elimination of the Aid to Families with Dependent Children Program. The bill would authorize use of the fund for costs of determining children's eligibility for Medicaid or CHIP benefits, for outreach to children likely to be eligible for such benefits, and for similar eligibility-related activities. In addition, the fund would be increased by \$25 million, and the sunset date would be eliminated.

Page 2 - The Honorable Newt Gingrich

The Omnibus Budget Reconciliation Act of 1990 (OBRA) requires that all revenue and direct spending legislation meet a pay-as-you-go (PAYGO) requirement. That is, no such bill should result in an increase in the deficit; and if it does, it could contribute to a sequester if it is not fully offset. This proposal would affect direct spending as shown below; therefore, it is subject to the PAYGO requirement.

FISCAL YEARS

(dollars in millions)

	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>99-03</u>
Outlays	110	150	210	210	220	900

This proposal is fully offset in the President's FY 1999 Budget and should be considered in conjunction with all other PAYGO proposals in the Budget. The Administration will work closely with the Congress on this and other PAYGO legislation to avoid a sequester of mandatory programs.

We urge the Congress to give the draft bill its prompt and favorable consideration.

The Office of Management and Budget has advised that there is no objection to the submission of this legislative proposal to the Congress, and that its enactment would be in accord with the program of the President.

Sincerely,

Donna E. Shalala

Enclosure

The Honorable Newt Gingrich
Speaker of the House
of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Enclosed for the consideration of the Congress is the Administration's draft bill, the "Medicaid and Children's Health Improvement Amendments of 1998". The bill supports the President's Budget for FY 1999.

The bill would amend titles XIX and XXI of the Social Security Act to give States the option to extend benefits under Medicaid or under Medicaid and the Children's Health Insurance Program (CHIP), to legal immigrant children who entered the United States on or after August 22, 1996. This proposal would fill a significant gap in health care coverage for low-income working immigrant families who entered the United States on or after August 22, 1996, who are now denied Medicaid and CHIP eligibility under welfare reform rules.

Also, the bill would amend title XXI of the Social Security Act to provide more equitable CHIP funding to our Nation's territorial jurisdictions, a measure that the President said he would work with the Congress to make when he signed the Balanced Budget spending bill last year. The Administration had initially proposed that 1.5 percent of the new program's funding be allocated to these areas -- a share approximately equal to their percentage of our country's population. The law enacted last year only allotted a very inequitable share of .25 percent. The bill would provide \$153 million over five years (and \$283 million over nine years) in additional funds to be distributed among the territories in proportion to their CHIP allotment percentage, to effectively increase this share to a more equitable 1.05 percent.

The Omnibus Budget Reconciliation Act of 1990 (OBRA) requires that all revenue and direct spending legislation meet a pay-as-you-go (PAYGO) requirement. That is, no such bill should result in an increase in the deficit; and if it does, it could contribute to a sequester if it is not fully offset.

This proposal would affect direct spending as shown below; therefore, it is subject to the PAYGO requirement.

FISCAL YEARS

(dollars in millions)

	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>99-03</u>
Outlays	59	69	84	80	90	382

This proposal is fully offset in the President's FY 1999 Budget and should be considered in conjunction with all other PAYGO proposals in the Budget. The Administration will work closely with the Congress on this and other PAYGO legislation to avoid a sequester of mandatory programs.

We urge the Congress to give the draft bill its prompt and favorable consideration.

The Office of Management and Budget has advised that there is no objection to the submission of this legislative proposal to the Congress, and that its enactment would be in accord with the program of the President.

Sincerely,

Donna E. Shalala

Enclosure

CHIP ISSUES

Feinstein VFC bill

S. 2013 To amend title XIX to permit children covered under private health insurance under a State children's health insurance plan to continue to be eligible for benefits under the vaccine for children program.

Introduced on April 30th, referred to Finance. Rep. Harman has a mirror proposal in the House. Feinstein has no co-sponsors, Harman has 20 including Waxman, Matsui, Stark, Pelosi, and Eschcoo.

Hyde Coverage for Pregnant Women under CHIP

H.R. 3837 To amend title XIX to permit States to use funds under the State Children's Health Insurance Program for coverage of uninsured pregnant women up to 200% of FPL. This bill would simply insert the words 'or pregnant women' where ever the definition of a targeted and/or low income child appears in the CHIP legislation.

Introduced by Hyde on May 12th, referred to Ways and Means. There are nine cosponsors; Lowey, Dooley, Matsui, Schumer, Gejdenson, Shays, Hilliard, Hinchey, Sandlin.

Stark Administrative Integrity Act

H.R. 3713 To amend title XXI to prevent conflicts of interest in the use of administrative vendors in the administration of the State Children's Health Insurance Plans.

Introduced on April 22nd, referred to Ways and Means. There are eight co-sponsors including, Matsui, Eschcoo, Waxman and Becerra.