DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

August 17, 2007 SHO #07-001

Dear State Health Official:

This letter clarifies how the Centers for Medicare & Medicaid Services (CMS) applies existing statutory and regulatory requirements in reviewing State requests to extend eligibility under the State Children's Health Insurance Program (SCHIP) to children in families with effective family income levels above 250 percent of the Federal poverty level (FPL). These requirements ensure that extension of eligibility to children at these higher effective income levels do not interfere with the effective and efficient provision of child health assistance coordinated with other sources of health benefits coverage to the core SCHIP population of uninsured targeted low income children.

Section 2101(a) of the Social Security Act describes the purpose of the SCHIP statute "to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage." Section 2102(b)(3)(C) of the Act, and implementing regulations at 42 CFR Part 457, Subpart H, require that State child health plans include procedures to ensure that SCHIP coverage does not substitute for coverage under group health plans (known as "crowd-out" procedures). In addition, section 2102(c) of the Act requires that State child health plans include procedures for outreach and coordination with other public and private health insurance programs.

Existing regulations at 42 C.F.R. 457.805 provide that States must have "reasonable procedures" to prevent substitution of public SCHIP coverage for private coverage. In issuing these regulations, CMS indicated that, for States that expand eligibility above an effective level of 250 percent of the FPL, these reasonable crowd-out procedures would include identifying specific strategies to prevent substitution. Over time, States have adopted one or more of the following five crowd-out strategies:

- Imposing waiting periods between dropping private coverage and enrollment;
- Imposing cost sharing in approximation to the cost of private coverage;
- Monitoring health insurance status at time of application;
- Verifying family insurance status through insurance databases; and/or
- Preventing employers from changing dependent coverage policies that would favor a shift to public coverage.

As CMS has developed more experience and information from the operation of SCHIP programs, it has become clear that the potential for crowd-out is greater for higher income beneficiaries. Therefore, we are clarifying that the reasonable procedures adopted by States to prevent crowd-out pursuant to 42 C.F.R. 457.805 should include the above five general crowd-out strategies with certain important components. As a result, we will expect that, for States that expand eligibility above an effective level of 250 percent of the FPL, the specific crowd-out

strategies identified in the State child health plan to include all five of the above crowd-out strategies, which incorporate the following components as part of those strategies:

- The cost sharing requirement under the State plan compared to the cost sharing required by competing private plans must not be more favorable to the public plan by more than one percent of the family income, unless the public plan's cost sharing is set at the five percent family cap;
- The State must establish a minimum of a one year period of uninsurance for individuals prior to receiving coverage; and
- Monitoring and verification must include information regarding coverage provided by a noncustodial parent.

In addition, to ensure that expansion to higher income populations does not interfere with the effective and efficient provision of child health assistance coordinated with other sources of health benefits coverage, and to prevent substitution of SCHIP coverage for coverage under group health plans, we will ask for such a State to make the following assurances:

- Assurance that the State has enrolled at least 95 percent of the children in the State below 200 percent of the FPL who are eligible for either SCHIP or Medicaid (including a description of the steps the State takes to enroll these eligible children);
- Assurance that the number of children in the target population insured through private employers has not decreased by more than two percentage points over the prior five year period; and
- Assurance that the State is current with all reporting requirements in SCHIP and Medicaid and reports on a monthly basis data relating to the crowd-out requirements.

We will continue to review all State monitoring plans, including those States whose upper eligibility levels are below an effective level of 250 percent of the FPL, to determine whether the monitoring plans are being followed and whether the crowd-out procedures specified in the SCHIP state plans are reasonable and effective in preventing crowd-out.

CMS will apply this review strategy to SCHIP state plans and section 1115 demonstration waivers that include SCHIP populations, and will work with States that currently provide services to children with effective family incomes over 250 percent of the FPL. We expect affected States to amend their SCHIP state plan (or 1115 demonstration) in accordance with this review strategy within 12 months, or CMS may pursue corrective action. We would not expect any effect on current enrollees from this review strategy, and anticipate that the entire program will be strengthened by the focus on effective and efficient operation of the program for the core uninsured targeted low-income population. We appreciate your efforts and share your goal of providing health care to low-income, uninsured children through title XXI.

If you have questions regarding this guidance, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs, who may be reached at (410) 786-5647.

Sincerely,

/s/
Dennis G. Smith
Director

cc:

CMS Regional Administrators

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Income Eligibility Levels for Children's Regular Medicaid and Separate SCHIP Programs by Annual Incomes and as a Percent of Federal Poverty Level, 2006

	Medicaid Infants Ages 0-1	Medicaid Children Ages 1-5	Medicaid Children Ages 6-19	Separate SCHIP Program
United States	133%	133%	100%	NA
Alabama	133%	133%	100%	200%
Alaska	175%	175%	175%	NA
Arizona	140%	133%	100%	200%
Arkansas	200%	200%	200%	NA
California	200%	133%	100%	250%
Colorado	133%	133%	100%	200%
Connecticut	185%	185%	185%	300%
Delaware	200%	133%	100%	200%
District of Columbia	200%	200%	200%	NA
Florida	200%	133%	100%	200%
Georgia	200%	133%	100%	235%
Hawaii	300%	300%	300%	NA
Idaho	133%	133%	100%	185%
Illinois	200%	133%	133%	200%
Indiana	150%	150%	150%	200%
Iowa	200%	133%	133%	200%
Kansas	150%	133%	100%	200%
Kentucky	185%	150%	150%	200%
Louisiana	200%	200%	200%	NA
Maine	200%	150%	150%	200%
Maryland	200%	200%	200%	300%
Massachusetts	200%	150%	150%	300%
Michigan	185%	150%	150%	200%
Minnesota	280%	275%	275%	NA
Mississippi	185%	133%	100%	200%
Missouri	300%	300%	300%	NA
Montana	133%	133%	100%	150%
Nebraska	185%	185%	185%	NA
Nevada	133%	133%	100%	200%
New Hampshire	300%	185%	185%	300%
New Jersey	200%	133%	133%	350%
New Mexico	235%	235%	235%	NA
New York	200%	133%	100%	250%

North Carolina	200%	200%	100%	200%
North Dakota	133%	133%	100%	140%
Ohio	200%	200%	200%	NA
Oklahoma	185%	185%	185%	NA
Oregon	133%	133%	100%	185%
Pennsylvania	185%	133%	100%	200%
Rhode Island	250%	250%	250%	NA
South Carolina	185%	150%	150%	NA
South Dakota	140%	140%	140%	200%
Tennessee	185%	133%	100%	NA
Texas	185%	133%	100%	200%
Utah	133%	133%	100%	200%
Vermont	300%	300%	300%	300%
Virginia	133%	133%	133%	200%
Washington	200%	200%	200%	250%
West Virginia	150%	133%	100%	220%
Wisconsin	185%	185%	185%	NA
Wyoming	133%	133%	100%	200%

SOURCE: Kaiser State Health Facts, June 2006

Senate and House CHIP Reauthorization Side-by-Side

	Senate – S. 1893 (embedded in HR 976)	House – HR 3162 (the "CHAMP" Act)
New Funding:	$35 billion	$50 billion; $90 billion in total
Payment:	GAO will study Medicaid and CHIP payment rates and their links to access to care	Children's Access and Payment Equality Commission (similar to MACPAC)
Medical Home:	$20 million in grants to evaluate provider-based models that improve the delivery of services to children, including care management for children with chronic conditions and the use of evidence-based approaches to improve the effectiveness, safety and efficiency of health care for children.	Modifications to Medicare medical home demonstration
Quality	Requires establishing and collecting data on core pediatric measures, developing electronic medical record for children. Also, grants to address childhood obesity	Requires establishing quality and performance measures; creates children's payment advisory committee for CHIP and children's Medicaid
Citizenship documentation:	Now applies to CHIP as well. Allows state option to accept Social Security Number and match with SSA to verify ID and citizenship. If no match confirmed, person has 90 days to produce documentation before denied coverage.	States may opt to return to pre-DRA rules for proving citizenship for children. Allows additional types of documents to serve as proof of citizenship for adults and for states that choose to continue DRA requirement for children.
How is it paid for?:	61-cent increase in federal tobacco tax	45-cent increase in federal tobacco tax; phases out Medicare Advantage (MA) overpayments
Children Covered:	~4 million who would otherwise be uninsured	~5 million who would otherwise be uninsured
Eligibility		
• **Children:**	Up to 300% FPL get enhanced match, states that already go > 300% FPL retain enhanced match, new states going >300% FPL get Medicaid match for kids >300% FPL	Does not limit income eligibility limits for SCHIP. Includes a new option for states to extend Medicaid and CHIP coverage until age 21.
• **Pregnant women:**	Allowed with state plan amendment, no waiver needed	Allowed with state plan amendment, no waiver needed

Senate and House CHIP Reauthorization Side-by-Side

• **Parents:**	No new waivers. States with CHIP-funded parent coverage must pay for from "set-aside" CHIP pool starting in 2010. No enhanced match after 2010, but get higher than Medicaid match for parents if meet outreach and enrollment targets for kids.	No new waivers unless state can prove that it is attempting to reach all children under 200% FPL and that no children would be denied coverage in order to cover adults. Makes no changes to existing waivers.
• **Childless adults:**	No new waivers. Currently enrolled childless adults transitioned from CHIP to Medicaid by FY2009.	Maintains current law prohibiting HHS from approving new waivers for childless adults. Allows states that currently have waivers to continue them.
• **"ICHIA" (the Legal Immigrant Child Health Improvement Act):**	Not included	Included (Allows states to provide coverage to legal immigrant children and pregnant women in the US less than five years.)
Financial incentives to enroll children:	Has Incentive Pool that gives states a per-child bonus for all children over enrollment baseline (baseline is defined in legislation).	States that adopt 5 of 7 enrollment best practices and meet enrollment goals receive a performance bonus. The bonus is for newly enrolled children in CHIP and Medicaid who are eligible, but not enrolled today.
Other outreach & enrollment policies:	$100 million in grants to national ($10m), Indian health ($10m) and other state and local groups ($80m) to improve outreach and enrollment	No comparable outreach funding, but encourages states to adopt culturally appropriate enrollment practices.
Express Lane Eligibility:	Included as a 3 year, 10-state demonstration project	Included as permanent state option
Premium Assistance:	Allows PA for cost-effective coverage, requires benefits and cost-sharing wrap-around, allows for coverage of parents in some cases, allows states to obtain data on employers sponsored coverage from employers, requires employers to notify employees about availability of PA	No changes included. Bill prohibits future Health Savings Account demonstration projects.
Benefits:	Grants to improve dental care, adds mental health parity to CHIP.	Dental as a guaranteed benefit, mental health parity, states can cover family planning services without a waiver. Strengthens benchmark benefit package standards.