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These are comments on the final regulations implementing Title XXI of the Social Security Act. Title XXI authorizes a new State Children's Health Insurance Program (SCHIP).

The proposed rules were published on November 8, 1999 at 64 Fed. Reg. 60882 and the final rules were published on January 11, 2001 at 66 Fed. Reg. 2490. Interim final rules were published on June 25, 2001 at 66 Fed. Reg. 33810. In this memoranda, we comment on changes to the proposed rules that were made by the final rule, and changes to the final rule that were made by the interim final rule.

Part 431 - State Organization and General Administration

The final version of this part adds a new Section 431.636. This section, entitled "Coordination of the Medicaid with the State Children's Health Insurance Program (SCHIP)," provides the statutory basis for the section and describes the obligations of the State Medicaid agency (SMA). It requires the SMA to facilitate the Medicaid application process and enrollment of children. The SMA must ensure that applicants are not required to submit duplicate documentation to the SMA if it has already been submitted as part of a SCHIP application. It must also ensure that eligibility is determined in a timely manner. The SMA is required to promptly notify the agency responsible for determining eligibility under the SCHIP program when a child is determined eligible or ineligible for Medicaid and must adopt a process that facilitates enrollment in the SCHIP program when a child is determined ineligible for Medicaid.

Section 431.865 describes disallowance of Federal financial participation for erroneous State payments for annual assessment periods ending after July 1, 1990. The proposed rule excludes payments made for care and services covered under the state plan and furnished to children during a presumptive eligibility period. The final version contains no substantive changes and sets forth the entire rule including the addition included in the proposed rule.

Part 433 - State Fiscal Administration

The Proposed Rule amended the currently published version of Section 433.10 and added a new Section 433.11.

Section 433.10 deals with rates of FFP for program services. The proposed rule added a new subsection (c)(4) clarifying the special provisions for calculating FMAP described in the new Section 433.11. The final version of the rule is identical to the proposed rule.

Section 433.11 describes the enhanced FMAP rate for children. The final version is essentially the same as the proposed version of the rule.

Part 435 - Eligibility in the States, District of Columbia, The Northern Mariana Islands and American Samoa

Section 435.4 - Definitions and use of terms

This section contains definitions and use of terms. The final version of this section includes a definition of optional targeted low income children. The definition itself is extensive, defining children in terms of age, income level, lack of insurance coverage. The substance of this definition is essentially the same as the definition contained in proposed Section 457.310.

Section 435.229 - Optional targeted low-income children

The proposed version of the rule had added a new section 435.229 that briefly defined optional targeted low income children. The final version includes this section, which now simply provides that Medicaid may be provided to optional targeted low income children under age 19, or to reasonable categories of those children.

Section 435.910 - Use of social security number

Proposed section 435.910 had added a subsection (h) containing an exception that allowed the state to use a Medicaid identification number to a person who refused to obtain a Social Security Number because of "well-established religious objections." The final version has not been changed substantively, but has been reworded slightly, presumably for greater clarity.

Section 435.1001 - FFP for administration

This section contains provisions regarding FFP for administration and the final version is identical to the proposed version.

Section 435.1002 - FFP for service

This section contains provisions regarding FFP for services and the final version is identical to the proposed version.

Section 435.1007

This section contains an amendment adding an additional statutory reference to the rule, and the final version is identical to the proposed version.

Subpart L - Option for Coverage of Special Groups

Section 435.1100

This section provides the basis and scope for coverage for special groups and the final version is identical to the proposed version.

Section 435.1101 - Definitions related to presumptive eligibility for children

This section contains the definitions related to presumptive eligibility for children. A number of changes have been made in the final version of the rule. First, the proposed version contained a definition of the term "Applicable Income Level." This term has been replaced with "Presumptive Income Standard" in the final version. The definition itself is unchanged. Second, in the proposed version, the definition of "Application Form" set a minimum standard for a form, requiring that it at least have the characteristics of the application form used for the poverty-level related eligibility groups. The final version is similar, but specifies that the minimum-level form may also be a joint form for children to apply for the SCHIP program. Finally, the final version adds to the definition of "Qualified Entity." A qualified entity is one that is determined by the SMA to be capable of making presumptive eligibility determinations. The final version specifies that a qualified entity may, in addition to the four types of entities contained in the proposed version, also be: (1) an elementary or secondary school; (2) a state or tribal child support enforcement agency; (3) an organization providing emergency food and shelter under the Stewart B. McKinney Homeless Assistance Act; (4) a state or tribal office or entity involved in enrollment in Temporary Assistance to Needy Families, the Medicaid program or the SCHIP program; (5) an entity that determined eligibility for public or assisted housing receiving federal funds; or (6) any other entity the state chooses, as approved by HHS. Some of these additional types of entities are listed in the Medicaid Act definition of "qualified entity." See 42 U.S.C. § 1396r-1a(b)(3).

The June 25 revisions add more to the definition of "Qualified Entity," providing that a entity authorized to determine eligibility of a child Medicaid or SCHIP may also be a qualified entity. Interim final section 457.1101. This entity is also listed in the Medicaid Act definition of "qualified entity." 42 U.S.C. § 1396r-1a(b)(3).

Section 435.1102 - General Rules

This section contains the general rules for presumptive eligibility. Some changes have been made in the final version. First, the section has been reorganized into more subsections and is easier to read. Substantively, the final version now requires that the notification to parents and caretakers of determinations related to presumptive eligibility must be made not only in writing, but also orally "if appropriate," presumably, if the parent does not read. Section 435.1102(b)(2)(i), (iv). The proposed version only required that they be informed that they must apply for regular Medicaid because the period of presumptive eligibility would end. The final

version of Section 435.1102(b)(2)(ii) adds a requirement that parents must actually be given a regular Medicaid application form. Finally, the final version of Section 435.1102(c) requires that the SMA adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child in a given time frame. The proposed version had only provided that the SMA was allowed to set such reasonable methods.

Part 436 - Eligibility in Guam, Puerto Rico and the Virgin Islands

The final version makes a number of amendments to this section.

A definition of "Targeted Low Income Child" is added to section 436.3. The definition is identical to the one for children living in the states that is found at 435.4, which is discussed above.

A new section 436.229 is added in the final version. This section specifies that the SMA may provides Medicaid to all individuals under 19 who are optional targeted low income children or reasonable categories of those children. This section is identical to the provision regarding children living in the states that is found at 435.229, which is discussed above.

Final section 436.1001 describes the FFP for administration and final section 436.1002 describes the FFP for services. Both are identical to the provisions regarding payments for children in the states that are found at 435.1001 and 435.1002, discussed above.

Subpart L - Option for Coverage of Special Groups

Section 436.1100 - Basis and Scope

The final version of section 436.1100 provides the statutory basis and scope for the option for coverage of special groups describes the requirements for providing medical assistance to special groups that are neither categorically eligible nor medically needy under Medicaid.

Sections 436.1101 and 436.1102 - Definitions and General Rules

The final version of 436.1101 provides definitions related to presumptive eligibility for children and 436.1102 provides the general rules applicable to the programs. These sections are identical to final version 435.1101 and 435.1102, which contain the definitions and rules applicable to children living in the states.

The interim final revisions add more to the definition of "Qualified Entity," providing that a qualified entity is one that is authorized to determine eligibility of a child for Medicaid or SCHIP. Interim final section 457.1101.

Part 457 - Allotments and Grants to States

Subpart A - Introduction; State plans for Child Health Insurance Programs and Outreach Strategies

The final versions of Section 457.1 (Program Description); 457.2 (Basis and Scope of Subchapter D) are unchanged from the proposed versions.

Section 457.10, which includes the definitions and use of terms, has been re-organized significantly in the final version. A number of substantive changes have been made as well.

- The definition of "American Indian/Alaska Native" has been amended. The final version no longer provides that descendants of members of federally recognized tribes, bands or groups meet the definition, nor a person determined to be an Indian under regulations promulgated by the HHS Secretary. Only the Interior Secretary has the power to determine who is an Indian or Alaska Native under the final version.

- A definition has been added for "Applicant:" a child who has applied for SCHIP benefits.

- The definition of "Child Health Assistance" has been expanded. In the proposed version, the definition only referred to the definition in Section 457.402. The final version specifies that it means "payment for part or all of the cost of health benefits coverage provided to targeted low income children for the services listed at § 457.402."

- The definitions for "Contractor" and "Cost-effectiveness" have been removed. The definition for "Cost-effectiveness" appears in the final version of Section 457.1015.

- The final version includes a new definition of "Cost sharing," defined as premium charges, enrollment fees, deductibles, coinsurance, copayments or other similar fees that the enrollee has responsibility for paying.

- In the proposed version of the rule, the term "Creditable Health Coverage" was defined only by reference to another section. In the final version, there is still a cross-reference to 45 C.F.R. 146.113, and also a further clarification that it includes coverage that meets the requirements of Section 457.410, discussed in a separate memorandum, and is provided to a targeted low income child.

- "Emergency Medical Condition" was defined in the proposed rule only by cross reference to section 457.402. The final version no longer has a cross-reference, but contains the identical definition to the one found in proposed section 457.402. It is defined as a medical condition manifesting itself by acute symptoms of severity that would alert a layperson that medical attention was necessary to prevent serious jeopardy to health, serious impairment of bodily function, organ or part. The same is true of the definition of "Emergency Medical Services:" the proposed version contained a cross reference to section 457.402. That definition appears here, in essentially the same form and identical substance, in the final version. Such services are defined as health care services furnished by a qualified provider and needed to treat or evaluate an emergency medical condition.

- The definition of "Employment with a Public Agency" has been omitted. "Public Agency" is now defined at Section 457.301.

- The final version adds a new definition of "Enrollee," (a child receiving SCHIP benefits), and "Enrollment Cap," (a state-established limit on the number of children permitted to enroll in the SCHIP program).

- A definition of "Health Benefits Coverage" appears in the final version, having been moved

from section 457.402 in the proposed version. It is defined as an arrangement under which enrolled individuals are protected from liability for the cost of specified health services.

- Definitions of "Health Care Services," "Health Insurance Services" and "Health Insurance Issuer" appear in the final version. No actual definition is included, only a cross reference to Section 457.402 (for "Health Care Services") and to 45 C.F.R. 144.103 ("Health Insurance Services" and "Issuer").

- A definition for "Health Services Initiatives" is added to the final version. They are defined as activities that protect public and individual health, improve a state's capacity to deliver public health services, or strengthen resources necessary to improve the health of children.

- A definition by cross reference to section 457.301 is added to the final version for "Joint Application."

- The definition of "Legal Obligation" that appeared in the proposed version is omitted.

- The proposed version only defined "Managed Care Entity" by cross-reference to section 457.902. The final version includes that same definition here.

- The definition of "Medicaid Applicable Income Level" is identical to the proposed version, which is noteworthy because it remains incomprehensible.

- Definition by cross-reference is added to the final version for "Optional Targeted Low-Income Child," (sections 435.4 for states and 436.3 for territories) and "Period of Presumptive Eligibility," (section 457.301) "Presumptive Income Standard (section 457.301) and Qualified Entity (section 457.301).

- The definition of "Premium assistance for employer sponsored group health plans" that appeared in the proposed version reappears in substance in the final version under "Premium assistance program"

- The final version of the definition of "State" includes a clarifying sentence indicating that the territories are excluded from the definition for the purposes of 457.740 which deals with state expenditures and statistics. This section is discussed more fully in another memorandum.

- The final version no longer has a definition of "State program integrity unit."
- The final version of "Uncovered Child" is now "Uncovered or Uninsured Child".

Section 457.30 - Basis, Scope and Applicability of subpart A

This section contains a subsection (a), describing the statutory basis for the regulations in subpart A; subsection (b) describing the scope of the regulations in subpart A; and subsection (c), dealing with the applicability of the subpart. The final version of this section contains only minor changes from the proposed version. First, the proposed version contained a description of Section 2101(a) of the statute establishing SCHIP, specifying the general purpose of the Act. This section has been omitted in the final version. The final version has a new description of section 2102(b) of the act, which "relates to eligibility standards and methodologies." Otherwise, the final version is identical to the proposed version.

Section 457.40 - State Program Administration

The final version is essentially identical to the proposed version of this rule, except for some minor changes in wording and punctuation.

Section 457.50 - State plan

The final version of this section is identical to the proposed version.

Section 457.60 - Amendments

The final rule expands significantly on the proposed version of this section. Both the proposed and final versions of the rule set for the circumstances under which a state *may* amend its state

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amend the plan.

must

The proposed version had only listed three instances when a state must amend its plan: (1) to reflect changes in federal law, regulations, policy interpretations or court decisions affecting the plan; (2) changes in state law, organization, policy or operation of the program; or (3) changes in the source of the state's share of funding. The final version provides greater specificity as to what changes in state law, etc., trigger the requirement for amendment of the plan. Under the final version, an amendment is necessary only when the changes in state law, organization, policy or operation of the program affect the following specified program elements of the plan: (1) eligibility standards, enrollment caps, and disenrollment policies; (2) procedures to prevent substitution of private coverage; (3) the type of health benefits coverage offered; (4) addition or deletion of specific categories of benefits under the state plan; (5) basic delivery system approach; (6) cost sharing; (7) screen and enroll procedures, and other Medicaid coordination procedures; (8) review procedures; or (9) "other comparable required program elements." The subsections describing changes in federal law or state funding that require reporting are unchanged.

In both proposed and final versions of the rule, when a state plan amendment would have a significant impact on an approved budget, the amendment must include an amended budget describing planned expenditures. The proposed rule had required that this amended budget set forth planned expenditures for a three year period, while the final version only requires a description of planned expenditures for a one-year period.

The interim final version eliminates some of the situations in which states are required to make a plan amendment. First, the final version had required that states submit a plan amendment when screening and enrollment procedures and other Medicaid coordination procedures were affected by state action, including those described in sections 457.350 (which contains all requirements pertaining to eligibility screening) and 457.353 (which requires that states monitor and evaluate the screen and enroll process). The interim final version eliminates the reference to section 457.353, therefore, states do not have to submit a plan amendment if state action affects only the monitoring and evaluation process.

In addition, the June 25 version makes significant changes to the applicant and enrollee protections of subpart K, which are discussed below. These changes affect section 457.60. In the final version of 457.60, states had been required to submit a state plan amendment when state action affected minimum requirements for review procedures described in sections 457.1130 (matters subject to review); 457.1160 (time frames); 457.1170 (continuation of

enrollment); 457.1180 (notice of determinations); and 457.1190 (application of review procedures when states offer premium assistance for group health plans). The interim final version omits all of these cross references, and only requires state plan amendments when section 457.1120 is affected. One of the major revisions the interim final regulations made was to section 457.1120. Previously the states had been required to adopt all of the minimum requirements in subpart K when designing the review process for the separate SCHIP program. However, HCFA decided to allow the states "greater flexibility in designing their review processes." 66 F.R. 33817, June 25, 2001. In the interim final version the states have the option of *either* meeting the minimum requirements of sections 457.1130 - 457.1180 *or* a process that complies with state review requirements in effect for all health insurance issuers. Interim final section 457.1120. Now, the interim final version of 457.60 only requires that states submit a plan amendment when state action affects section 457.1120.

This effectively means that states can now take state action that affects sections 457.1130, and 457.1160 through .1190 without having to submit a plan amendment, even if the state has adopted procedures that comply with those sections.

Section 457.65 - Effective date and duration of state plans and amendments

The final version of the rule contains more requirements in this area than did the proposed version.

First, both versions of the rule required that amendments relating to eligibility or benefits could not be in effect for longer than 60 days, unless an amendment was submitted to HCFA before the end of the 60 day period. The amendment could not take effect unless the state provided prior public notice of the proposed change, and this public notice was published before the requested effective date of the change. The final version adds a requirement that any amendments relating to enrollment procedures must also meet the requirements set forth in subsection (b). Such amendments include those that: (1) implement a period of uninsurance; (2) increase length of existing required periods of uninsurance; or (3) extends waiting lists, enrollment caps or closed enrollment periods. Final section 457.65(d).

In addition, the proposed version of the rule had provided that a state would not be required to submit a plan amendment for changes in "non-health care related revenues used to generate general revenue." Proposed section 457.65(d)(2). This exception has been omitted in the final rule.

Finally , the final version adds a provision to the subsection relating to continued approval, and now provides that a state plan does not continue in effect if a state withdraws its plan. Final section 457.65(f)(2).

Section 457.70 Program Options

This section provides that a state may offer health benefits under a Medicaid expansion program, a separate child health program or a combination program. Both the proposed and final versions provide that a Medicaid expansion program established under this section must meet a number of the requirements of the regulations governing SCHIP programs. The final version, however, omits some of the requirements listed in the proposed version. The proposed version provided that the state's Medicaid expansion program had to meet the definition of the targeted low income child found in Subpart C, which deals with eligibility, screening, applications and enrollment. This requirement does not appear in the final version because Medicaid rules govern the area addressed by this subpart. Also, the proposed version had required that the state Medicaid plan had to meet the requirements of subpart H (which provides that the state plan must ensure that health benefits coverage under SCHIP does not substitute for coverage provided under group health plans) if the state elected the eligibility group for optional targeted low income children and elected to pay for employer sponsored health insurance. The final version does not contain this requirement because Medicaid rules govern the area addressed by subpart H.

Finally, the proposed version of 457.70(c)(2) had required that a state choosing to provide SCHIP benefits through the Medicaid plan submit an approvable amendment to the state's Medicaid plan "as appropriate." The final version requires only that a Medicaid expansion need only be "consistent with the state's Medicaid State plan, or an approvable amendment to that plan..."

Section 457.80 - Current state child health insurance

The final version of this section includes a number of changes that provide additional detail. Both versions required that the state plan include a description of the extent to which children in the state have health insurance coverage, what type of coverage they have, what efforts that state is making to provide health coverage and the procedures the state uses to accomplish

coordination between SCHIP and other sources of insurance. The section discussing procedures has been expanded in the final version. The final version requires that the state plan describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children and relevant child health programs, such as Title V. The procedures must include those designed to increase the number of children with creditable health coverage, assist in SCHIP enrollment of Medicaid ineligible children and ensure that only targeted low income children are covered under SCHIP. This is not a change in substance from the proposed version.

Section 457.90 - Outreach

This section requires that outreach procedure be described in a State plan and gives examples. The final version is the same as the proposed version, except that it includes an additional example of outreach strategies that the state may use, providing that the state may provide application assistance, including opportunities to apply for child health assistance under the plan through community-based organizations and in combination with other benefits and services available to children.

Section 457.110 - Enrollment assistance and information requirements

This section requires that the state disclose information to assist families in making health care decisions, and specifies some of the information that must be required. As the proposed version did, the final version requires that the state disclose: (1) the types of benefits and amount, duration and scope of benefits available and (2) names and locations of current participating providers. The final version of section 457.110(b) adds a number of requirements: (1) cost sharing requirements; (2) whether an enrollment cap or waiting lists are being used and a description of procedures related thereto; (3) information on physician incentive plans; and (3) review processes available to applicants and enrollees.

Section 457.120 - Public involvement in program development

The final version is unchanged from the proposed version, except that the final version specifies that the state must ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required.

Section 457.125 - Provision of child health assistance to American Indian and Alaska Native children.

The final version contains an additional requirement that the state official responsible for SCHIP consult with tribes and state organization in the state on the development and implementation of the procedures. Otherwise, the only changes from the proposed version are rewording and reorganizing that do not change the substance.

§ 457.130 Civil rights assurance.

This provision requires that the State plan provide assurance that the State will comply with all applicable civil rights requirements. While NHeLP supports the requirement, we believe that the regulation should also note that the State is obligated to ensure that contractors, subcontractors and grantees also comply with civil rights laws.

§ 457.160 Notice and timing of HCFA action on State plan material.

§457.160(b)(3) stops CMS' 90-day review period when CMS requests additional information from the State. The period resumes on the next calendar day after CMS receives all of the requested information. In NHeLP's comments to the proposed rules, we recommended that HCFA (now CMS) adopt the approach used in Medicaid which begins the 90-day review period when the requested information is received. Unfortunately, no changes were made to this regulation, which means that CMS will have a shorter window in which to review State plan materials in approving or disapproving the plan or plan amendments.

§ 457.170 Withdrawal process.

Under this section, the State may withdraw a proposed State plan or plan amendment or any portion of the State plan or plan amendment by providing written notice to CMS of the withdrawal. The final rules also allow the State to request withdrawal of an approved State plan

by submitting a State plan amendment to CMS in accordance with §457.60. NHeLP's recommendation to the proposed regulations that States be required to provide public notice and opportunity for public comment prior to withdrawal was not heeded.

§ 457.203 Administrative and judicial review of action on State plan material.

This section was added to the final rules in place of §457.190.

This provision allows States that are dissatisfied with the Administrator's action on the State Plan to request that the Administrator reconsider whether the State plan or plan amendments conforms with the requirements for approval. The Administrator is to notify the State of the time and place of a hearing for reconsideration within 30 days of receipt of the request. Upon a change in the Administrator's decision, CMS will pay the State a lump sum equal to any funds incorrectly denied. NHeLP supports the procedures outlined in the regulations.

§ 457.208 Judicial Review.

This provision gives States the right to judicial review if they are dissatisfied with the Administrator's final determination on the approvability of plan materials or compliance with Federal requirements.

Subpart C- State Plan Requirements: Eligibility, Screening, Applications, and Enrollment

This subpart now only applies to a separate child health program.

§ 457.310 Targeted low-income child.

This section defines a targeted low-income child as a child who does not qualify for Medicaid

under policies of the State plan or is not covered under a group health plan or health insurance coverage. The child is not considered to be covered under a group health plan if the child does not have reasonable access to care under the plan. Children who have access to State employee benefits cannot enroll in a separate child health program.

While children who are enrolled in limited scope dental or vision plans or covered under school health insurance policies with very restrictive coverage can receive health care coverage under a separate child health plan, children who have other health insurance coverage cannot obtain vision or dental services through a separate child health plan because it is not permitted by the statute.

Under this regulation, a child is not considered eligible if she is entitled to State health plan benefits based upon a family member's employment with a public agency, even if the family declines to accept coverage. Furthermore, the child is not eligible for a separate child health plan if the State or public agency makes a contribution toward the cost of an employee's dependents that is more than nominal. According to CMS, a contribution of \$10 per family per month toward dependent coverage is considered more than nominal.

NHeLP recommended that CMS define a nominal contribution as a percent of the total cost of dependent coverage rather than a finite dollar amount. Whether an employer contribution toward dependent coverage is nominal or not depends, in part, on the cost of the coverage. If the dependent coverage is expensive and the employer's contribution is only \$20, under the regulations' definition, income eligible SCHIP children would still be foreclosed from coverage. A more equitable way to define what constitutes a nominal contribution would be to express it as a percent of the total cost of dependent coverage rather than a finite dollar amount

§ 457.320 Other eligibility standards.

This provision sets forth eligibility standards that States can use and those that are prohibited. States may adopt eligibility standards relating to geographic areas served by the plan, age, income, resources, spenddowns, disposition of resources, residency, access to other health coverage, and disability status, provided that the standards do not restrict eligibility. States may *not*

cover children with higher family income over those with lower incomes; deny eligibility based upon preexisting medical condition; discriminate based upon diagnosis; exclude American Indian or Alaska Native children based upon their access to medical care funded by the Indian

Health Service; exclude individuals based on citizenship or nationality to the extent that children are U.S. citizens, U.S. nationals or qualified aliens.

One change to the regulations that was recommended by NHeLP is to add to the list of prohibited eligibility standards and methodologies those that discriminate on the basis of diagnosis. Additionally, CMS followed NHeLP's recommendation to amend §457.320(a)(10) to make clear that States are prohibited from establishing time limits for eligibility and lifetime caps, which are contrary to the objective of the program to give more low-income children access to health care.

NHeLP recommended the deletion of §457.320(c), which requires States to obtain proof of citizenship and verify qualified immigrant status. Instead, CMS modified the subsection to allow States to accept self-declaration of citizenship "provided that the State has implemented effective, fair, and nondiscriminatory procedures for ensuring the integrity of its application process."

While the regulations published on January 11, 2001 prohibited States from requiring that any individual, including the applicant child, to provide a social security number in order to qualify for SCHIP benefits, the regulations published on August 24, 2001 amended that provision to simply prohibit States from mandating that family members provide a social security number. This change is of serious concern to advocates. Asking applicants or family members to provide Social Security numbers is a strong deterrent for immigrant families to apply for and utilize public benefits.

§ 457.340 Application for and enrollment in a separate child health program.

This subsection establishes application procedures that States must follow when determining eligibility under a separate child health program. These include informing applicants orally and in writing about the application and eligibility requirements, the time frame for determining eligibility, the right to review of eligibility determinations and provide applicants an opportunity to apply without delay. States must establish time standards for determining eligibility, not to exceed forty-five calendar days and must provide applicants or enrollees a written notice of any decision on the application or other determination concerning eligibility. If eligibility is approved, the notice must include information on the enrollee's rights and responsibilities under the program, including the opportunity to review eligibility denials. If eligibility is denied, suspended or terminated, the State must provide notice in accordance with §457.1180.

NHeLP supports the provisions discussed above. By including the provision that individuals should be afforded an opportunity to apply without delay, CMS ensures that children are not deterred from obtaining benefits and sets a standard against which the processing of all applications can be evaluated. However, the Bush administration has recently added a subsection which permits States to require a social security number for each individual requesting services, which raises serious concerns for advocates. As mentioned above, requiring individuals to provide social security numbers, even for applicants, can deter immigrant families from applying for SCHIP benefits. Rather than encouraging applications for the SCHIP program and facilitating increased utilization of health services, this mandate is likely to reduce the number of family seeking enrollment in the program.

§ 457.350 Eligibility Screening and facilitation of Medicaid enrollment.

This section outlines screening procedures States must follow to ensure that applicants who are potentially eligible for Medicaid are identified and enrolled in the program if they are determined to be eligible. Additionally, the section explains what States must do if these individuals are found to be ineligible for Medicaid.

States are required to use screening procedures to identify, at a minimum, any applicant or enrollee who is potentially eligible for Medicaid under one of the poverty level groups, section 1931, or a Medicaid demonstration project and apply whichever standard and corresponding methodology generally results in a high income eligibility level for the age group of the child being screened. While this is a significant improvement over the proposed regulations which only required screening under the poverty level groups, it still does not require States to screen for eligibility under all possible categories. There is ample justification for requiring a more comprehensive screen. First of all, statutory language refers to "children found through the screening to be eligible for medical assistance under the State Medicaid plan under title XIX." If Congress had wanted to limit the eligibility screening to only certain Medicaid programs, it would have explicitly stated such in the statute. Secondly, States are already obliged to set up screening procedures that evaluate eligibility for all potential categories of coverage in the Medicaid application and redetermination process. Thus, mandating similar procedures in SCHIP would place no additional burdens over those in Medicaid.

The Bush administration recently made a significant change to the provision requiring that a notice be sent to the family to inform them that the child does not appear eligible for Medicaid based upon an initial review. States have been given the flexibility to determine the written

format and timing of the information provided regarding Medicaid eligibility, benefits and application process. NHeLP believes that this change will likely impede the timely distribution of information about Medicaid to applicants.

Another provision requires that States conduct a resource screen to make a more complete assessment of the child's potential Medicaid eligibility prior to enrolling the child in the separate child health program. The regulation also mandates that when a child is identified as potentially Medicaid eligible, the State must establish procedures in coordination with the Medicaid agency to facilitate enrollment in Medicaid. If the State does not use a joint application for its Medicaid and separate child health program, the State must promptly inform the family that their child is potentially eligible for Medicaid and provide the family any assistance in completing the Medicaid application process. The State must promptly transmit the application information to the Medicaid agency. If this child is later found to be ineligible for Medicaid, the State must determine eligibility for the separate program without requiring the family to submit a new application.

This subsection also requires that the State provide the child's family with information, in writing, about the State's Medicaid program, including benefits covered and restrictions on cost sharing as well as eligibility rules prohibiting individuals deemed eligible for Medicaid from enrolling in the separate child health program, to enable the family to make an informed decision about applying for Medicaid. Here, too, the Bush administration has permitted States to determine the written format and timing of information regarding Medicaid eligibility, benefits and application process. While we generally support this provision, we believe that a family must have access to information communicated in culturally and linguistically competent ways in order to make an informed decision. For that reason, we encouraged CMS to require States to communicate with families in a culturally competent and linguistically appropriate manner in our comments to the proposed regulations. Additionally, we requested CMS to clarify that in States using the joint application form, the date of application for SCHIP is the Medicaid application date. Unfortunately, neither recommendation was accepted.

Finally, while the rule strongly encourages States to reactivate an application for a separate child health program if the child is found ineligible, the regulation deletes the provision requiring the reopening/ reactivation of the separate child health application.

§ 457.353 Monitoring and Evaluation of the Screening Process.

States are required by this provision to monitor and evaluate the screen and enroll process to ensure that eligible children are appropriately enrolled in either Medicaid or SCHIP.

§ 457.355 Presumptive eligibility.

This section was added to the final rules as a result of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIA). The provision permits States to provide presumptive eligibility for children in the separate child health program pending a final determination of eligibility. Presumptive eligibility can also be provided for children found through the screening to be potentially eligible for Medicaid.

Technical changes were made to this section. Now, costs incurred for services provided during presumptive eligibility are considered expenditures for child health assistance and enhanced FCAP is available no matter if the child is later found eligible for Medicaid or SCHIP. This change may actually encourage States to expand presumptive eligibility to their separate child health programs. NHeLP strongly supports the addition of this section to the final rules as well as the technical change recently made by the Bush administration.

In terms of presumptive eligibility for infants, the interim final rule clarifies that when a child is presumptively eligible for a separate child health program pending a formal Medicaid eligibility determination, costs for the presumptive eligibility period are considered child health assistance as long as presumptive eligibility is implemented in accordance with the regulations. The costs are not subject to the 10% cap on administration and health services initiatives.

According to the interim final rule, the presumptive eligibility period begins on the date that the qualified entity determines that the child has family income below the applicable income level and ends on the day a Medicaid or separate child health program eligibility determination is made, or if an application is not filed, the last day of the month following the date presumptive eligibility began. These costs are also considered child health assistance and are not subject to the 10% discussed above. This provision extends the ability to provisionally enroll or retain current enrollment in a separate child health program until either a Medicaid or SCHIP determination is completed.

The interim final rule also outlines that a provisional denial or suspension of an application for a

separate child health program permits the child to be presumptively enrolled (for a limited period of time) pending outcome of a Medicaid eligibility determination.

§ 457.380 Eligibility verification.

Under this provision, States must establish procedures to ensure the integrity of the eligibility determination process. States may establish reasonable eligibility verification mechanisms to promote enrollment of eligible children.

§ 457.360 and § 457.361 have been incorporated into § 457.350 and § 457.340 respectively.

§ 457.365 has been removed.

Subpart D - State Plan Requirements: Coverage and Benefits

§ 457.402 Definition of Child Health Assistance.

This section defines "child health assistance" and outlines the services available to targeted low-income children. No additional services were included in the list. The definitions of "emergency services" and "emergency medical condition" were moved to § 457.10. We support the list of services set forth in this section. We are especially glad to see that medical transportation, enabling services are covered as they are crucial to effective access to health care for children. While NHeLP strongly supports the inclusion of prenatal care and pre-pregnancy family planning services and supplies, we are concerned that abortion is only covered if necessary to save the life of the mother or if the pregnancy resulted from rape or incest. Abortion services necessary to protect the health of the mother should also be covered.

§ 457.410 Health benefits coverage options.

This provision allows States to choose among four health benefits coverage options in designing their child health assistance programs. It also includes the statutory requirement that States obtain coverage for well-baby and well-child services, age-appropriate immunizations and emergency services.

Despite NHeLP's recommendation that CMS use the same definition for "well-baby and well-child care" that is used in §457.520 relating to cost sharing, this section allows States to define the term rather than mandating that they adopt the federal definition. While we support the requirement that States cover immunizations in accordance with recommendations of the Advisory Committee on Immunization Practices (ACIP), we encourage CMS to extend the Vaccines for Children (VFC) program to children enrolled in separate child health programs, as it provides immunizations free of charge and encourages providers to furnish age-appropriate vaccines.

§ 457.420 Benchmark health benefits coverage.

This section defines benchmark coverages as health benefits coverage that is substantially equal to the health benefits coverage in one of the following benefits plans: federal employees health benefit plan, state employee plan and health maintenance organization plan with the largest insured commercial non-Medicaid enrollment in the State. States are allowed to choose among these three options in designing their separate SCHIP program.

§ 457.430 Benchmark-equivalent health benefits coverage.

In designing a benchmark equivalent benefit package, States must adhere to the following requirements:

- □ The coverage must be actuarially equivalent to coverage under one of the benchmark packages discussed in § 457.420.
- □ Coverage must include inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and x-ray services; and may also include other services.
- □ If the benchmark package includes coverage for prescription drugs, mental health services, vision services, or hearing services, then the actuarial value of the coverage for each of these categories must be at least 75 percent of the value of those services under the

benchmark.

CMS followed NHeLP's recommendation to revise this section because the wording of the proposed rule was confusing. Unfortunately, CMS did not heed our suggestion that it should promulgate minimum benefits standards for benchmark-equivalent coverage on the grounds that the SCHIP plan could potentially offer far fewer services than the benchmark commercial plan because of the lower cost-sharing requirements and still pass actuarial muster.

§ 457.431 Actuarial report for benchmark-equivalent coverage.

This provision requires that States submit to CMS an actuarial report containing an actuarial opinion that the health benefits coverage meets actuarial mandates under §457.430.

§ 457.450 Secretary-approved coverage.

This section describes how a State may define Secretary-approved coverage for its separate child health program. The coverage may include:

- the same benefits provided to children under the Medicaid State plan;
- comprehensive coverage offered under an 1115 waiver
- coverage for full Early and Periodic Screening, Diagnosis and Treatment benefit or has been extended to the entire Medicaid population in the State;
- a benchmark plan plus any additional benefits;
- coverage that is the same as that provided under existing comprehensive State-based coverage; or
- coverage that is substantially equivalent to or greater than coverage under a benchmark health benefits plan through use of a benefit-by-benefit comparison that each benefit meets or exceeds coverage under the benchmark.

CMS revised the section to explicitly reference benefits provided to *children* under Medicaid, as recommended by NHeLP. We urged CMS to make this change because permitting States to define the SCHIP benefits package based upon a model of Medicaid benefits for adults would not only be medically inappropriate for children, but would undermine Medicaid's current

EPSDT package.

The Bush administration revised this regulation to clarify that this list is not exhaustive. Moreover, it added to the list coverage like that provided under existing comprehensive State-based coverage. Florida, Pennsylvania and New York have such coverage in place, but did have to expand their benefit packages in order to obtain CMS approval. The interim final rule also allows replication of existing 1115 demonstration projects in other states without requiring CMS approval.

§ 457.470 Prohibited coverage.

Under this section, States are not required to provide health benefits coverage for an item or service for which payment is prohibited under Title XXI even if the benchmark plan includes coverage for that item or service.

§ 457.475 Limitations on coverage: Abortions.

This provision explains that federal financial participation (FCP) is not available to pay for an abortion or to purchase health benefits coverage that includes coverage of abortion services unless the abortion services meet the conditions specified in the rule. Exceptions in which FCP is available to pay for abortion services are 1) when necessary to save the life of the mother, and 2) where the pregnancy resulted from an act of rape or incest. Partial federal funding is also not available to assist in the purchase in whole or part of health benefits coverage of abortions other than those listed above. For States wishing to have managed care entities provide abortions in other situations, those abortions must be provided under a separate contract using non-Federal funds. States may not set aside a portion of the capitate rate paid to a managed care entity to be paid with State-only funds, or append riders, attachments or addenda to existing contracts. Nothing in this provision prevents States, localities and private persons from paying for any abortion services or health benefits coverage that includes coverage of abortion services.

NHeLP recommended that the provision requiring a separate contract for States wishing to have managed care entities provide abortions be deleted because it is especially burdensome on States and may deter them from providing services they are entitled- and under some State

constitutions, required- to provide and fund themselves.

§457.480 Preexisting condition exclusions and relation to other laws.

This section describes the applicability of the preexisting condition exclusion and parts of HIAA, EISA, the Mental Health Parity Act, and the Newborns and Mothers Health Protect Act that apply to SCHIP.

§ 457.490 Delivery and utilization control systems.

States implementing a separate child health program must describe in their State plan methods of delivery of child health assistance and utilization control systems designed to ensure that enrollees receive only appropriate and medically necessary health care.

§ 457.495 State assurance of access to care and procedures to assure quality and appropriateness of care.

Proposed § 457.495 was removed and incorporated into a new subpart K which contains provisions regarding grievance and appeals. Proposed § 457.735 has been predesignated as

§ 457.495.

A State plan must describe methods for assuring quality and appropriateness of care, including how the State will assure:

- access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations;
- access to covered services, including emergency services;
- appropriate and timely procedures to monitor chronic, complex or serious medical

conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is inadequate for the enrollee's medical condition;

- decisions related to prior authorization are made according to the patient's medical needs, within 14 days after receipt of request for services, with a possible extension of 14 days if requested by the enrollee or if the physician or health plans needs additional information, or according to existing State law regarding prior authorization of health services.

The last provision in this section was recently added by the Bush administration. While some States may have shorter time frames which would benefit enrollees, this change would allow States to use longer time frames if authorized by State law.

In comments regarding the proposed regulations, NHeLP recommended that CMS establish quality standards with respect to those areas designated in the rule and identify methodologies for monitoring those standards in the rule itself. Also, we urged CMS to require that States describe how they will ensure that children have access to pediatricians and other health care providers with expertise in meeting the health care needs of children. Unfortunately, CMS ignored our recommendations.

Subpart E - State Plan Requirements: Enrollee Financial Responsibilities

§ 457.505 General State plan requirements.

The State plan must describe:

- amount of cost-sharing imposed;
- methods States uses to inform public of cost-sharing amounts;
- protections for enrollees being disenrolled for failure to pay cost-sharing;
- when premium assistance is provided, procedures used to ensure that eligible children are not charged copayments, coinsurance, deductibles or similar fees on well-baby and well-child services and that American Indian and Alaska Native children are not charged copayments, coinsurance, deductibles or similar fees, and that cost -haring charges do not exceed the 2.5% or 5% cap; and
- procedures that do not primarily rely on a refund given by the State for overpayment on behalf of an eligible child.

NHeLP supports this provision and we are particularly pleased that CMS requires States to describe methods for informing the public about various cost-sharing charges.

§457.510 Premiums, enrollment fees, or similar fees; State plan requirements.

The State plan must describe the amount of premium, enrollment fee or similar fee, the time period for which it is imposed, the group(s) subject to the premium or fee, the consequence of failing to pay and disenrollment protections, and methodology used to ensure that total cost-sharing for a family does not exceed the cumulative maximum outlined in § 457.560.

We are very pleased to see that CMS revised this section to require States to describe disenrollment protections in their State plans, as suggested by NHeLP. Unfortunately, CMS did not follow our recommendation to revise the preamble to mandate that States develop a tracking mechanism that do not rely on the beneficiary demonstrating to the State that he or she has met the cumulative cost-sharing maximum.

§ 457.515 Co-payments, Coinsurance, Deductibles, or Similar Cost-Sharing Charges: State Plan Requirements.

NHeLP supported the proposed language limiting cost-sharing to amounts specified in State plans and prohibiting different co-payment amounts for emergency out-of-network services. NHeLP also suggested that the rules specify that an enrollee may not be denied emergency services based on an inability to pay a co-payment and that the regulations include a discussion of the obligations of service providers under EMTALA.

The final rules retain, while rewording, § 457.515(f), which requires that an enrollee's financial responsibility for emergency services will be the same, regardless of whether the services were obtained in- or out-of-network. CMS declined to discuss EMTALA requirements; however, the agency affirmed that patients may not be turned away solely because of an inability to pay. The final rules also now require at § 457.515(d) that the State plan describe the disenrollment protections required under § 457.570.

In the comments to this subsection, CMS notes that unlike under the Medicaid program, CMS does not have the authority under SCHIP to prevent providers from denying services to enrollees who do not pay their co-payments, nor can the agency prevent a provider from billing an enrollee for cost-sharing charges. Patients should not be charged a different amount of out-of-network emergency services than if those services were obtained from an in-network provider. The need for emergency services is governed by the prudent layperson standard. The rule does not prevent a provider from denying services to a patient who has not paid co-payments that are due.

§ 457.520 Cost Sharing for Well-Baby and Well-Child Care

NHeLP supported provisions prohibiting cost-sharing for well-baby and well-child care.

The final rules keep the prohibition against cost-sharing for well-baby and well-child care. The included services are better defined under the final rule. The included services are now those "covered under the State plan," rather than "as defined by the State." This change indicates that changes will require a State plan amendment. Routine physical examinations are now those "recommended and updated by the American Academy of Pediatrics (AAP) 'Guidelines for Health Supervision III' and described in 'Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.'" Covered laboratory tests are now those "associated with the well-baby and well-child routine physical examinations." Previously, no cost-sharing was allowed for immunization and related office visits as recommended under the AAP guidelines. In the final version, the Advisory Committee on Immunization Practices (ACIP) replaced the AAP guidelines for immunizations and related office visits. The final rules retain the prohibition of cost sharing on routine dental services, when states provide dental coverage. CMS comments indicate that States must reflect updates to the guidelines in any cost-sharing policies. Families should not be charged co-payments for well-baby, well-child, and routine dental services. No co-payments are allowed for immunizations and laboratory tests associated with the well-baby and well-child visits. These rules include adolescents.

§ 457.525 Public schedule

NHeLP supported this subsection and urged that the public schedule include information about enrollees' rights.

CMS incorporated some of the due process protections NHeLP suggested into the disenrollment protections into an expanded subsection 457.570. A revised subsection 457.525(a) requires that the public schedule include "[m]echanisms for making payments for required charges" and the disenrollment protections found in § 457.570. The final rules specify that both applicants and enrollees, not just the latter, be informed of the consequences of not paying a charge. Under § 457.525(b)(1), the State must make the public schedule available to people reenrolling after a redetermination of eligibility, not just to initial enrollees.

The CMS comments to this section note that the State retains responsibility for making the public schedule available to providers, although the SCHIP providers actually distribute it. While there is no specific provision for providing the public schedule to adolescents seeking services on their own or that the schedules be in language(s) tailored to target populations, CMS encourages dissemination of the public schedule with these aspects in mind.

§ 457.535: Cost-sharing protection to ensure enrollment of American Indians and Alaska Natives.

Under the final rule, enrollees may self-certify their AI/AN status. Only AI/AN children from Federally recognized tribes are included. If states expand coverage to include adults, the cost-sharing exemption does not apply to AI/AN adults since the statutory exemption only speaks of exempting AI/AN children from cost-sharing.

§ 457.540: Cost-sharing Charges for Children in Families at or Below 150 Percent of the Federal Poverty Level

NHeLP commented to § 457.550 (incorporated into this section) that co-payments not exceed \$5.00 per visit, regardless of the number of services furnished during the visit.

CMS eliminated § 457.550 and moved provisions of that section, with minor wording changes, into (d) and (e) of this section. Those subsections still allow only one cost-sharing charge on a service and one co-payment based on the services provided in a single office visit.

CMS did not accept NHeLP's suggested of a \$5.00 maximum for any type of service, but the comments indicate that the one charge per office visit rule does not distinguish between managed care and fee-for-service systems. The provider is limited to charging what is permitted under the State plan. The comments say that lab tests performed at another site or prescriptions obtained at a pharmacy may be subject to additional co-payments. According to CMS's comments, a provider may deny services to enrollees who cannot pay the associated co-payment.

The rule continues to limit monthly fees for families at or below 150% of the FPL to the charges permitted for families on Medicaid. While the statute gives the Secretary power to adjust those charges for inflation, the CMS comments indicate that the Secretary has declined to make that adjustment. The comments state that enrollees may be charged more for non-emergency, out-of-network services that were not approved or authorized by the enrollee's managed care entity.

§ 457.555: Maximum allowable cost-sharing charges on targeted low-income children between 101 and 150 percent of the FPL.

We encouraged CMS to recognize that cost-sharing is not required for managed care and to discourage it as unnecessary. We also suggested that the maximum allowable cost-sharing be set lower than permitted under proposed § 457.555(b).

CMS addressed NHeLP's comments by stating that the SCHIP statute contemplated and permitted the application of cost-sharing to SCHIP enrollees. The maximum amounts were arrived at by adjusting the Medicaid cost-sharing amounts for inflation. CMS encourages states to set cost-sharing at levels lower than the maximums.

The maximum amounts for cost-sharing in § 457.555(a) are amended to include emergency, non-institutional care. CMS added (c) to limit institutional emergency service co-payments to \$5.00. Cost-sharing for emergency services remains the same, regardless of whether the services are sought in- or out-of-network. The comments note that the States have the responsibility to assure that adequate numbers of providers are available so that families do not need to seek routine care in emergency rooms. Subsection (b) is amended to clarify that co-payments for institutional (presumably non-emergency) services may not exceed 50% of the

payment the State would have made under Medicaid fee-for-service for the first day of care in the institution.

§ 457.560 Cumulative cost-sharing maximum

NHeLP gave support to the 2.5% cap for families with incomes below 150% of the FPL.

CMS retained the 2.5% cap for families with incomes below 150%, and the 5% cap for families above 150% of the FPL. This cap includes cost-sharing charges associated with out-of-network services that a health plan has authorized and cost-sharing for emergency services out-of-network. States do not need to count charges associated with nonemergency, unauthorized, out-of-network services. In the proposed rule, the caps were based on a family's income over a twelve-month period. In the final rule, the State must calculate the cost-sharing maximum based on the period of time for which the child is eligible. The final rule keeps the provision that cost-sharing charges that a family is legally obligated to pay, but may not in fact have paid, count toward the cap. Section (a) which defines "legal obligation" contains some minor changes to the definition and incorporates the wording from section (b)(2) of the proposed rules.

In the Bush Administration's revisions to the rules, CMS has removed (a), including the concept of "legal obligation to pay." With this deletion, States could count only cost-sharing that a family has actually paid, thus raising the costs of health care for these families.

The revisions also remove (b) containing the 2.5% cap on cost-sharing for families with income below 150% of FPL, and the revised rule sets a 5% cap for all families, regardless of income up to 200% of the FPL. States may offer a lower cap for lower income families, but they can offer one cap up to 5% for all families. Only cost-sharing for the children is counted towards the cumulative cost-sharing total. Parents' health care costs cannot count toward the total.

§ 457.570 Disenrollment Protections

NHeLP supported the inclusion of the requirements, but did not think that the rule went far

enough to protect enrollees from disenrollment and other sanctions. NHeLP listed a number of due process protections that the rule failed to address.

The final rule adds section (b), which requires the State to afford the enrollee an opportunity to show that the family's income has declined before disenrolling. The State must facilitate enrolling the enrollee in Medicaid, if appropriate, or lower the cost-sharing based on a showing of less income. New section (c) requires States to afford enrollees an opportunity for impartial review to address disenrollment in accordance with § 457.1130(a)(3).

CMS notes that some states have adopted lockout provisions to promote the appropriate use of SCHIP, while other states have discontinued lockout provisions and found no significant increase in enrollees only signing up when an illness occurs. The comments suggested that third-party premium payers also receive copies of premium payment notices, but CMS left such notices up to the States.

Subpart G--Strategic Planning, Reporting, and Evaluation

§ 457.710 State plan requirements: Strategic objectives and performance goals.

NHeLP urged CMS to specify a minimum set of national strategic objectives. We suggested four strategic objectives of national significance. We urged CMS to designate a core set of performance goals related to the strategic national objectives. We also asked the Secretary to ensure that any designated measures or standards be made publicly available.

CMS agreed that there should be a common core of performance measure and performance goals. In this regard, the final rule has an added (e) for the Secretary to develop core elements. CMS intends to convene a working group to develop the core elements of performance measures and goals. The CMS comments indicate that States will not be required to collect encounter data. Rather, CMS will permit States to choose other methods of collecting data related to their strategic objectives.

§ 457.740 State Expenditures and Statistical Reports

NHeLP supported the rule, but urged CMS to include reporting of sex, race, ethnicity and primary language of SCHIP enrollees. We also asked for reporting of disenrollment and enrollment in Medicaid numbers.

The final rules include reporting the number of children enrolled in Medicaid, including a Medicaid expansion program, and in the separate SCHIP. Reports must also include the gender, race, and ethnicity of children. These categories must also be included in the State's unduplicated counts. Primary language is reported in the Annual Report, so CMS amended § 457.750 to reflect this requirement. CMS's comments note that States cannot require families to report these data; thus, the information must be collected on a voluntary basis.

One commenter noted the difficulties of collecting Medicaid data for SCHIP reports where the two programs are run by different state agencies. CMS points out that the SCHIP statute anticipates that Medicaid and SCHIP agencies will coordinate their work and share information. Furthermore, federal requirements are not specific to a Medicaid agency or to a SCHIP agency, but to a State, regardless of how the State chooses to administer the programs internally.

§ 457.750 Annual Report

NHeLP recommended posting the reports on the Internet. We also recommended that States be required to collect and report information on grievances and other consumer satisfaction, progress in addressing barriers, cultural competency, continuity of care, attention to underserved or under-identified populations, and systemic integration with schools and community groups.

CMS added information collection on primary language in the annual reports at (b)(7). The other types of data that NHeLP suggested will be reviewed for inclusion in the FY 2001 reports. CMS noted that several States included some of this data in their State evaluations.

CMS declined to require the reports to contain information on utilization measures pertaining to children with special needs. Rather, § 457.495(b) requires States to provide assurances of appropriate and timely procedures to monitor and treat enrollees with special needs.

The revisions entirely remove the requirement at (b)(7) to report the enrollees' primary language in the annual report. CMS' rationale is that the head of household's primary language is more relevant, yet nowhere does CMS require reporting of this data. CMS says that States already collect this information in other ways such as on applications and through statewide surveys.

Subpart H--Substitution of Coverage

§ 457.805 State plan requirement: Procedures to address substitution under group health plans.

NHeLP supported CMS's approach to substitution, although we noted that the problem might be exaggerated.

After review of the States' March 31, 2000 evaluations, CMS agrees that evidence of substitution is less than anticipated. CMS's comments clarify that eligibility-related substitution provisions, such as periods of uninsurance, may not be applied to the optional targeted low-income children because such application would be inconsistent with entitlement to Medicaid. Such a rule could only apply if a State gets approval through an 1115 waiver. CMS encourages states to propose strategies other than periods of uninsurance to limit substitution.

§ 457.810 Premium assistance programs: Required protections against substitution

NHeLP supported establishing stricter standards when public dollars are funneled through employer-sponsored plans. We saw this as the riskiest area for substitution. We discouraged waiting periods that discourage health care coverage for uninsured children, and we proposed barring waiting periods where loss of employer-sponsored coverage was clearly unrelated to substitution.

CMS added exceptions to the waiting period, including involuntary loss of health coverage when an employer terminates coverage for all employees and dependents, economic hardship,

change to employment that does not offer dependent coverage, and other reasons that the State may propose.

The proposed rule at (a)(2) permitted an exception if the child's coverage was involuntarily terminated by an employer. The final rule permits "reasonable" exceptions for involuntary loss of coverage due to employer termination of coverage for all employees and dependents, economic hardship, change to employment that does not offer dependent coverage, and other reasons for which the State gets approval. The Secretary now also has the discretion to waive the waiting period. The waiting period does not apply to children losing coverage under a group health plan through Medicaid under Section 1906 of the Social Security Act (42 U.S.C. § 1396e). The comments indicate that this also applies when a HIPP program pays for Medicaid coverage through an employer-based plan.

The CMS comments clarify that in states with premium assistance programs and waiting periods, the State still may opt to cover these children during the waiting period under a separate child health program or Medicaid. The required period of uninsurance only applies to SCHIP coverage provided through group health plans. Waiting periods are not allowed in Medicaid expansion programs, unless the State does so through an approved 1115 waiver. Under subsection (b), an employee still must apply for the full premium contribution available from the employer. However, the final rule removes the requirement that an employer make a substantial (at least 60%) contribution to the cost of family coverage.

The final rules expand on the cost effectiveness provisions in subsection (c). The proposed rule required that the State's payment for a child under an employer-sponsored plan couldn't exceed the cost under other SCHIP coverage. The final rule clarifies that the "cost for coverage for children" cannot exceed "the cost of other SCHIP coverage for these children." The final rule, thus, shifts the cost comparison from looking at the cost of covering an individual child to looking at coverage for children in premium assistance programs as a group. The rule, in fact, allows a state to compare costs either on a case-by-case basis or in the aggregate.

A commenter asked about substitution and coordination with a State's Child Support Program. CMS clarified that the rules do not require that children be denied SCHIP coverage if a noncustodial parent has insurance that could cover the child.

Subpart I--Program Integrity

§ 457.915 Fraud detection and investigation

The final rule at (b), like the proposed rule, gives the States the option to establish an administrative agency to monitor the integrity of the separate child health program. Amended section (c) requires procedures for referring cases to the State program integrity unit "if such a unit is established." Procedures would include referring cases to "appropriate" (new language) law enforcement officials.

The comments indicate that because of Medicaid statutory provisions, a State may not use existing Medicaid fraud control units to conduct SCHIP fraud and abuse investigations. A State may use the same agency for investigations, but it would need to have separate personnel who are funded by SCHIP funds to perform the SCHIP investigations.

§ 457.930 Full Investigation, Resolution, and Reporting Requirements

NHeLP suggested that CMS require States to have written procedures for fraud and abuse investigations.

CMS did not incorporate NHeLP's suggestion. CMS agreed that States should have written procedures for investigating and resolving suspected and apparent instances of fraud and abuse. CMS reserved the right to review a State's program and to request that the procedures be described in writing as part of ongoing monitoring.

§ 457.940 Procurement Standards

CMS changed the basis on which States must establish their payment rates. The payment rates must still be based on public or private payment rates for comparable services, but they must also be "for comparable populations, consistent with principles of actuarial soundness as defined at § 457.902." States still must support their payment rates with actual data. States may establish higher rates if necessary in order to ensure sufficient provider participation, "provider

access" (new language), or to enroll providers who offer exceptional services or quality.

Under section (e), States need no longer show that the payment rates themselves will provide SCHIP services in an effective and efficient manner (though the program overall must still be conducted in this manner.) Payment rates must still be based on free and open competition and the principles in the previous paragraph. If requested, a State must also show how it developed any higher rates of payment. The final rule (e) removes the points in time when CMS may request this information.

States may not only use the procurement standards found at 45 C.F.R. § 74.43, but in the alternative, they may use the requirements at 45 C.F.R. § 92.36, which is currently under revision. After the revisions to 45 C.F.R. § 92.36 become final, State will need to use that section for procurement. The significance here is that the latter CFR section allows States to use their own procurement standards when purchasing services with Federal grant money.

§ 457.960 Reporting Changes in Eligibility and Redetermining Eligibility

NHeLP urged CMS to provide guidance to the States regarding the redetermination process. States should not require a re-application, nor should they ask for unnecessary information. An enrollee should also have adequate time to respond to the State's request for information. If a SCHIP-enrolled child becomes eligible for Medicaid, the State must provide assurances and describe in the State plan how that child will be transferred to the Medicaid program without a break in coverage.

CMS notes that the screening and enrollment procedures in subpart C apply to both eligibility and redetermination processes. CMS declined to issue rules on methods of redetermination or a specific redetermination process.

§ 457.970 Eligibility and Income Verification

NHeLP noted that the rule should explicitly state that eligibility and income verification procedures should minimize barriers and encourage SCHIP enrollment. NHeLP also asked that

the rule specifically allow for self-declaration of income and assets. NHeLP suggested better wording for "good cause" in terminations and suggested additional notice protections.

The rule was removed to subpart C to become § 457.380.

§ 457.985 Integrity of professional advice to enrollees

NHeLP submitted lengthy comments on the grievance and appeals process that were eliminated from the final rule. Grievances and appeals now appear in new subpart K. NHeLP supported the inclusion of access requirements that are drawn directly from the Medicare+Choice regulations.

The final rule changes the title of the rule and deletes sections (a) through (d) regarding grievances, complaints, and appeals. New subpart K contains regulations on program reviews. Section (e) constitutes the entirety of the final rule.

Former section (e)(1) [now section (a)] incorporated all of rule § 422.206 of the Medicare+Choice regulations, including § 422.206(b) which has a "conscience protection" provision that would allow plans to refuse to provide services with which the plan has a moral or religious objection. The final rule (a) does not incorporate § 422.206(b), but only § 422.206(a), which prohibits interference with medical communications between health care professionals and patients. CMS comments that not all providers are required to offer all services in the SCHIP benefit package; however, the State retains the responsibility to assure that enrollees are informed of and have access to all included services, consistent with § 457.495. This section also now requires that "professionals provide information about treatment in an appropriate manner." The additional wording is not explained in the comments.

Former section (e)(2) [now section (b)] required compliance with Medicare+Choice regulations at §§ 422.208 and 422.210(a). The final version of this section requires compliance with §422.208 and the entirety of § 422.210.

Subpart J--Allowable Waivers: General Provisions

§ 457.1003 CMS review of waiver requests

The entire rule is new. The rule states that "CMS will review the waiver requests under this subpart using the same time frames used for State plan amendments, as specified in § 457.160." That time period is 90 days. CMS comments that the 90-day time frame does not apply to CMS review of section 1115 SCHIP demonstration proposals.

§ 457.1005 Waiver for cost-effective coverage through a community-based health delivery system

NHeLP suggested amending the section to cross-reference the cost-sharing protections in subpart E as well as other beneficiary protections. We also suggested incorporating a definition of "health services initiatives," and pointing out that all immigrant children, regardless of their immigration status or date of entry, can receive services from health services initiatives.

CMS added the requested definition of "health services initiatives" at § 457.10. CMS noted in the comments that these services can be available to all immigrant children and can be targeted to low-income, immigrant communities. Amended § 457.1005(b) requires waivers to meet the requirements of Part 457, including both subparts D and E. Therefore, all SCHIP protections will apply under a community-based delivery system waiver so that children will receive the same protections, regardless of where they receive services.

CMS increased the period of waivers in (c) from two years to three years. In the same section, rather than setting forth how States may apply for waiver extensions, the new wording indicates that a waiver remains in effect "for no more than 3 years." The increase to three years was made to coincide with the statutory time frames for the expenditure of allotments and to give more time to determine cost-effectiveness.

In the comments, CMS notes that the cost-effectiveness calculations in (b)(2) do not preclude a State from adjusting payments for the care of special needs children to provide for higher payment for their care.

§ 457.1010 Waiver for purchase of family coverage

NHeLP urged CMS to require states to exercise their options for expanding health coverage to lower-income adults in non-SCHIP programs before granting a family coverage waiver. We also suggested that CMS should not define "family" in the regulations at this time.

CMS's comments noted NHeLP's first suggestion, but did not say that an expansion of coverage to lower-income adults first would be required. CMS states that there is no statutory authority for requiring States to meet certain goals such as first covering lower-income adults before approving a family coverage waiver.

CMS did not offer a definition of "family" and left the task of defining that term to the States' discretion. One commenter suggested including pregnant women in a family definition. CMS noted that a pregnant woman could be covered in a family coverage waiver only if she also had a SCHIP-eligible child in her family.

Subpart K--Expanded Coverage of children Under Medicaid and Medicaid Expansions

This subpart was deleted in its entirety and replaced with a new subpart K.

New Subpart K--State Plan Requirements: Applicant and Enrollee Protections

This new subpart K includes some of the grievance and privacy protections that previously appeared in other sections of the regulations.

CMS will allow States to either meet the requirements of this subpart (§§ 457.1130-457.1180) or demonstrate that participating providers comply with the state-specific grievance and appeals requirements currently in effect for health insurance issuers. This move effectively eviscerates

the minimum standards.

§ 457.1100 Basis, scope and applicability.

The entire section is new. Subsection (c) states that this subpart K only applies to separate child health programs. This subpart includes how a State plan must include a description of the methods used to assure access to covered services, including emergency services, as well as the State's methods for establishing and continuing eligibility and enrollment. The subpart includes minimum standards for privacy protection and for procedures for review of eligibility, enrollment, and health services matters.

The new regulations do not have definitions of grievances or appeals. The entire process is now referred to as the "review process." The definition of "contractor" has now moved to § 457.10. CMS commented that it chose not to adopt the Medicaid approach to review processes, but it did attempt to use consistent terminology as appropriate.

Since this section only pertains to separate SCHIP programs, advocates can make sure that their States apply Medicaid protections to enrollees in Medicaid expansion programs. Advocates can also urge their States to adopt Medicaid procedures and protections for enrollees in the separate SCHIP program.

§ 457.1110 Privacy Protections (originally proposed as § 457.990)

NHeLP strongly supported the inclusion of the Medicaid privacy protections in the SCHIP program. In order to avoid confusion, we recommended that the protections be harmonized with privacy standards proposed in October 1999 and security standards proposed in August 1998.

The final rule still requires compliance with the Medicaid privacy provisions (subpart F of part 431.) In the proposed rule, States were required to include the privacy protections in all contracts. In the final rule's preamble, States must establish and implement procedures to ensure the protections, without specifically requiring that assurances appear in the State plan.

The proposed rule (b) covered "information and data pertaining to beneficiaries" while the final rule's preamble covers "individual medical records and any other health and enrollment information maintained with respect to enrollees, that identifies particular enrollees (in any form)."

The proposed rules require compliance with Federal and State confidentiality laws as well as CMS policies regarding electronic transmission of information. The final rules make no specific mention of electronic transmission of information, but require that the State ensure compliance with State and Federal confidentiality laws. However, the final rule requires protection of the privacy of individually identifiable health information. CMS comments that requiring compliance with State and Federal rules includes laws and regulations (such as the HIPAA regulations) that are not yet finalized or developed. CMS does not intend the rules to preempt greater local or tribal privacy protections, but those protections may be preempted if the State or Federal laws require preemption.

Both rules require compliance with State and Federal laws regarding confidentiality and privacy of information about minors.

Under the proposed rules, medical records and other information may only be released or accessed in accordance with law, court orders, or subpoenas and only to authorized individuals. Under the final rule, this provision is loosened to specify and make available to any enrollee (who requests it): "(1) The purposes for which information is maintained or used; and (2) To whom and for what purposes the information will be disclosed outside the State."

CMS comments indicate that the privacy protections in this rule apply to services provided under a separate child health program, even if the SCHIP funds are used for a premium assistance program.

§ 457.1120 State plan requirement: Description of review process

In its comments to the proposed rule § 457.985(b), NHeLP noted that the rule fails to provide sufficient guidance and safeguards in instances in which States opt not to use the Medicaid fair

hearing process. NHeLP urged that there should be a single point of entry for grievances and appeals.

This entirely new section requires a State plan to comply with all of the regulations in this subpart that follow this regulation. (But, see changes below.) CMS notes that requiring inclusion of the review process in the State plan ensures the opportunity for public input.

In the proposed rule, the State plan needed to specify whether the State was choosing to use the Medicaid rules and systems. States could elect to follow the rules in Part 431, subpart E regarding Medicaid due process requirements. CMS removed this provision, but notes that it may be more efficient for some States to use the Medicaid fair hearing processes rather than create two parallel and sometimes duplicative processes.

CMS clarified in the comments that applicants and enrollees in a Medicaid expansion program are entitled to all of the Medicaid protections. CMS does not require a single point of entry for reviews.

States must choose between options: To establish a review process that meets the requirements of these regulations (which would include the option of using the Medicaid fair hearing process); or, to require providers to comply with state-specific grievance and appeal requirements currently in effect for health insurance issuers.

§ 457.1130 Matters subject to review [from proposed §§ 457.361(c), 457.365, 457.495, 457.565, 457.970(d), and 457.985(a)]

NHeLP commented that limited or delayed eligibility determinations or requests for covered services should be reviewable. We also urged CMS to include situations in which services are terminated or denied in whole or in part. We urged CMS to take the lead in defining "grievance," "complaint," and "appeal," as the definition vary considerably in State and Federal regulations and across the private sector. In comments to proposed § 457.565, NHeLP supported inclusion of grievance and appeal procedures for people disenrolled for nonpayment of cost sharing. In comments to proposed § 457.970(d), NHeLP requested that CMS eliminate the provision allowing States to terminate eligibility for "good cause."

This entirely new section outlines which matters are subject to review under a separate child health program. The terms "grievance," "complaint," and "appeal" are completely removed from the rules. A state must ensure that an applicant or enrollee has an opportunity for review consistent with the two subsequent sections. Matters subject to review would be: Denial of eligibility, failure to make a timely determination of eligibility, and suspension or termination of enrollment (including disenrollment for failure to pay cost sharing.)

In subsection (b), a State must also ensure that an enrollee has an opportunity for external review of a delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services. The external review must also include failure to approve, furnish, or provide payment for health services in a timely manner. CMS noted that the range of health services covered in this rule is narrower than the range of matters included in the proposed definition of a "grievance."

In subsection (c), review is not required if the sole basis for the decision is a provision requiring an automatic change in eligibility, enrollment, or coverage affecting all or a group of applicants or enrollees without regard to individual circumstances. In the comments CMS notes that if a State closes enrollment to new applicants because the State had spent all of its allotted funds, that decision would not be subject to the review process. However, if the State with limited funds amended its State plan to enroll only new applicants with special health care needs, denied applicants must have the opportunity for review in order to establish that they meet the State's enrollment criteria.

CMS comments that a State may use the same or different processes for reviews of eligibility and health services. The final rule contains no provision for terminating eligibility for "good cause."

The revisions amended this section as well as §§ 457.1140, 457.1150, 457.1160, 457.1170, and 457.1180 by prefacing the section headings with "Program specific review process:." This revision was made in order to clarify that the requirements apply to the review process [now at § 457.1120(a)], but do not apply to the State review requirements currently in effect for all health insurance issuers in the State [now § 457.1120(b)].

CMS comments that the State law may not use the same terminology as § 457.1130, but State

law must be consistent with the intent of this section. States without laws that are consistent with this section must identify how they will provide an opportunity for review of the areas that State law does not cover.

§ 457.1140 Core elements of review

NHeLP commented to proposed § 457.985(a) that the responsibility for providing notice should rest on both the State and the providers. We stated an outline of what should be the minimum requirements of the State's process, including timely appeals and determinations; decisions made by an impartial hearing officer or person; and hearings are held at reasonable times and places. Beneficiaries should also have the right to timely review of their files and other applicable information necessary to prepare for the hearing, be represented or represent oneself, and present testimony and evidence.

The entirely new section requires a State to ensure that an impartial person or entity conducts reviews. Review decisions must be timely according to the time frames in § 457.1160, and those decisions must be in writing. Both applicants and enrollees have a right to represent themselves or have a representative of their choosing, timely review of their files and other applicable information, and fully participate in the review process, whether it is conducted in person or in writing, and including presentation of supplemental information during the process. Applicants and enrollees also have a right to receive continued enrollment according to § 457.1170.

The final rule placed the entire responsibility for the notice requirement on the State. The final rule includes NHeLP's suggestions for an impartial reviewer, timely review of files and applicable information, and representation by self or by another. Some of the other comments (e.g. timeliness, impartial review) are explained more in subsequent sections.

§ 457.1150 Impartial review (proposed § 457.985(b))

The entirely new rule gives further explanation of how impartiality pertains to the matters subject to review in § 457.1130. For an eligibility or enrollment matter, a person or entity that has not been directly involved in the matter under review conducts the review. For a health services matter, the State must ensure that an enrollee has an opportunity for an independent external

review. External review must be done by the State, or by a contractor other than the one responsible for the matter subject to review.

§ 457.1160 Time frames (proposed §§ 457.361(c), 457.985(b), and 457.995(g)(2))

NHeLP urged CMS to adopt strict timetables for review and determination. We opposed requiring enrollees to exhaust internal plan grievance processes.

CMS comments that § 457.1120 requires a State to include its time frames for the review process in the State plan. Proposed § 457.995(g)(2) required that reviews be conducted and resolved in a timely manner consistent with the standard health insurance practices in the State. The final rule omits this reference to standard health insurance practices.

For eligibility or enrollment matters, a State must complete the review "within a reasonable amount of time." The rule contains no specific time limit for this type of review alone. A State "must consider" the need for expedited review when there is an immediate need for health services.

For health services matters, the State "must ensure that reviews are completed in accordance with the medical needs of the patient." Unless a person's medical needs dictate a shorter time period, an external review must be completed within 90 calendar days of when an enrollee requests either internal or external review. If the enrollee has a choice of an external and an internal review, both reviews must be completed within the 90 calendar days. States must also provide for an expedited review that is completed within 72 hours. An enrollee can get an expedited review "if the enrollee's physician or health plan determines that operating under the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function." If the enrollee has access to both internal and external reviews, each level of review in an expedited review may take no more than 72 hours. As the CMS comments indicate, this would be a total of 144 hours. If the enrollee requests an extension, the State may extend the 72-hour time frame up to 14 calendar days.

CMS left it up to States to decide whether to require exhaustion of internal review processes before an enrollee could pursue an external review processes.

§ 457.1170 Continuation of enrollment [proposed § 457.985(c)]

A State must ensure the opportunity for continued enrollment pending completion of a review of a suspension or termination of enrollment, including a decision to disenroll for failure to pay cost sharing. The proposed rule's language incorporated only the possibility that a State could choose the Medicaid fair hearing process, which provides for aid paid pending.

CMS notes that not all matters are subject to continuation of coverage. Matters included in § 457.1130(c), which pertains to a change in the State plan, or State or Federal law requiring an automatic change in eligibility, enrollment, or coverage, do not trigger continuation of coverage. Continuation of coverage is also not required during review of health services matters.

§ 457.1180 Notice [proposed §§ 457.361(c), 457.902, 457.985(a), and 457.995(g)]

NHeLP agreed that enrollees and applicants should receive written notice. We urged CMS to specify the content of the notice.

The State must provide enrollees and applicants with timely written notice for determinations subject to § 457.1130. The notice must contain: The reasons for the determination; an explanation of applicable rights to review of the determination; the standard and expedited time frames for review; the manner in which a review can be requested; and the circumstances under which enrollment may continue pending review.

CMS's comments indicate an intent to leave it to the States to decide who should provide the notice, the State or the provider or both.

§ 457.1190 Application of review procedures when States offer premium assistance for group health plans

If a State has a premium assistance program that provides coverage through a group health plan that does not meet the requirements of this subpart concerning review of health services matters, the State must give enrollees and applicants the opportunity to obtain health benefits coverage other than through that group health plan. The State must provide the opportunity to make this choice at initial enrollment and at each redetermination.

Although the rule is not clear on this point, CMS's comments indicate that the alternative plan offered to the applicant or enrollee must contain the procedural protections found in this subpart.

In a premium assistance program, a group health plan that meets the requirements of either this subpart K or the state-specific review requirements for health insurance issuers does not require the State to offer families a second choice. If the group health plan does not meet either of these standards, then the State must notify families of this fact and allow them to enroll their children in the State's direct coverage plan.