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SCHIP REGULATION REVISIONS

On June 25, 2001, the Health Care Financing Administration/Center for Medicare and Medicaid Services (CMS) published an interim final rule revising the final SCHIP regulations.[1] This rule changes only some of the provisions from the January 11, 2001 final rule.[2] All provisions – both final and interim final – will become effective on August 24, 2001 (although states will not be found out-of-compliance with the regulations until their next *provider* contract cycle). **Comments on the interim final rule are due no later than 5pm on July 25, 2001.**

SECTION	FINAL RULE	INTERIM FINAL RULE	COMMENTS
STATE PLAN REQUIREMENTS: ELIGIBILITY, SCREENING AND ENROLLMENT			
Eligibility Standards **§ 457.320**	states may not require any applicant to provide a Social Security number (SSN) as a condition of eligibility	states may require SSNs of applicants as a condition of eligibility states may not require SSNs of non-applicants (parents, guardians, other household members) adds protections regarding use of SSN consistent with requirements in Medicaid regulations and 42 CFR part 431, subpart F	CMS changes its interpretation of the Privacy Act to conclude that a statutory exemption allowing states to require SSNs in "general public assistance programs" applies to SCHIP (despite the fact that "general public assistance" generally refers to state-funded cash/welfare assistance and not federal programs)
Eligibility Screening and Facilitation of Medicaid Enrollment **§ 457.350**	when a child is found potentially eligible or ineligible for Medicaid through a limited eligibility screening, states are required to provide families with information on eligibility, benefits, and how to apply for Medicaid	clarifies that states have flexibility to determine the format and timing of distribution of information about Medicaid; the information may be in the form of handouts, brochures, or other written material during the application process preamble: the change is an attempt to help avoid lengthy, complex eligibility notices that may be confusing to families	this change is likely to impede the timely distribution of information about Medicaid to applicants

[1] *See* 66 Fed. Reg. 33810 (June 25, 2001), http://www.access.gpo.gov/su_docs/aces/aces140.html.

[2] For provisions of the final rule, *see* 66 Fed. Reg. 2490 (January 11, 2001).

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PRESUMPTIVE ELIGIBILITY – § 457.355			
Separate Child Health Program	the Benefits Improvement and Protection Act (BIPA) gave states authority to implement presumptive eligibility under their separate child health programs if a child is enrolled in separate child health program under presumptive eligibility and then found: • eligible for the separate child health program, costs during presumptive eligibility were considered expenditures for child health assistance and enhanced FMAP available; • eligible for Medicaid, costs were considered Medicaid and no enhanced FMAP available; • ineligible for either separate child health program or Medicaid, costs considered expenditures for targeted low-income children as long as state implements presumptive eligibility in accordance with 1920A of Social Security Act (SSA) and regulations	for children enrolled in a separate child health program and later found eligible for either Medicaid or SCHIP or not eligible for either, the costs incurred for services provided during presumptive eligibility are considered expenditures for child health assistance and enhanced FMAP is available (these costs are not subject to the 10% limit on outreach and health services initiatives) preamble: this section provides technical changes to reflect BIPA as understood by this Administration	allowing the higher FMAP reimbursement for costs incurred during presumptive eligibility periods, may encourage states to expand presumptive eligibility to their separate child health programs
Infants	infants enrolled under a separate child health program are not statutorily entitled to automatic and continuous eligibility (as they are under Medicaid); implementing presumptive eligibility, pending completion of an application, offers one method of providing coverage if the infant is ultimately found ineligible for Medicaid, costs during presumptive eligibility period may be treated as health coverage for targeted low-income children (not subject to the 10% cap) regardless of whether infant is eligible for separate child health program	clarifies that when a child is presumptively eligible for a separate child health program pending a formal Medicaid eligibility determination, costs for presumptive eligibility period are considered child health assistance (not subject to 10% cap on administration and health services initiatives) as long as presumptive eligibility is implemented in accordance with the regulations	

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Pending Medicaid Application	if a child is found potentially eligible for Medicaid, the state has the option to provisionally enroll or retain current enrollment in a separate child health program for a limited period of time (specified by the state) pending a final Medicaid eligibility decision a child may not be found "eligible" for the separate child health program unless a Medicaid application is completed and a determination made that the child is ineligible for Medicaid	a child may be provisionally enrolled or retain current enrollment in a separate program, for a limited period of time, pending a final Medicaid or SCHIP eligibility determination the presumptive eligibility period begins on the date that a 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 the costs are considered child health assistance and are not subject to the 10% cap on administration and health services initiatives as long as presumptive eligibility implemented in accordance with the regulations	this provision extends the ability to provisionally enroll or may retain current enrollment in a separate child health program until either a Medicaid or SCHIP determination is completed
Suspending, Denying or Provisionally Denying Pending Applications	a state may suspend, deny, or provisionally deny a separate child health application for a child determined potentially eligible for Medicaid if the child is ultimately determined ineligible for Medicaid, the prior child health application should be reopened/reactivated and eligibility determined without requiring a new application the state can establish presumptive eligibility for a separate child health program to enroll the applicant pending a formal Medicaid eligibility determination	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 while strongly encouraging states to reactivate an application for a separate child health program if the child is found ineligible for Medicaid, the regulations delete the provision requiring the reopening/reactivation of separate child health application if Medicaid denied, so that	states may thus require a second child health program application if the child's original application was provisionally denied/suspended pending a determination of Medicaid eligibility and the child was found ineligible for Medicaid

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SECRETARY APPROVED COVERAGE			
§ 457.740	provides examples of Secretary-approved coverage	clarifies that the examples listed are not exclusive CMS will consider other benefit packages that differ from benchmarks, including comprehensive coverage for children under a Medicaid 1115 demonstration project and coverage that is the same as provided by FL, NY, and PA (under their existing comprehensive state-based coverage programs)	while FL, NY and PA programs are acknowledged in the SCHIP statute as providing "appropriate coverage" for children, these states had to expand their benefit packages to obtain approval; the regulations do not recognize this it is confusing as to whether the interim final rule could be interpreted to allow replication of existing 1115 demonstration projects from one state to another without requiring CMS approval
STATE ASSURANCE OF ACCESS TO CARE AND PROCEDURES TO ASSURE QUALITY AND APPROPRIATENESS OF CARE			
§ **457.495(d)**	prior authorization of services must be completed in accordance with the medical needs of the patient, but no later than 14 days after receipt of a request for services	prior authorization must occur either within standards established in the regulations or existing state law procedures preamble: "Allowing States to use their existing State laws will reduce the administrative burden of these regulations for States with premium assistance programs"	while some states may have shorter timeframes that would benefit enrollees, the interim final rule would allow states to use longer timeframes if authorized by state law
STATE PLAN REQUIREMENTS: ENROLLEE FINANCIAL RESPONSIBILITIES			
Computation of the Cumulative Cost-Sharing Maximum **§ 457.560(a)**	cost-sharing maximum determined by counting all cost-sharing amounts that a family has a "legal obligation to pay" Note: "legal obligation to pay" was defined as amounts a provider actually charges the family for covered services, and any other amounts for which payment is required under applicable state law for covered services to eligible children, even if the family never pays those amounts	removes the concept of "legal obligation to pay" provides states with flexibility to define how it counts cost-sharing amounts against the cumulative cost-sharing maximum	this differs from the Medicaid program which counts expenses when incurred if states implement procedures to count cost-sharing only when paid (rather than when incurred), the financial implications may be difficult for some families who may have to delay and/or forego care

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Cumulative Cost-Sharing Maximum (for Targeted Low-Income Children) § **457.560(b)**	if the family income is < 150% of FPL, the cumulative cost-sharing is limited to 2.5% of total family income for the length of the child's eligibility period if family income is between 150% and 200% of FPL, cumulative cost sharing is limited to 5%	removes 2.5% limit cumulative cost-sharing is 5% for all children enrolled in SCHIP, regardless of family income states may apply a lower cumulative cost-sharing maximum to children in lower income families or may place the same limit on children in families in all income levels	for low-income families with little or no disposable income, the failure to count the health-related expenses of all family members rather than just the children may force the family to incur higher debts and delay and/or forego care
Cost-Sharing for Family Coverage **§ 457.560(b)**	cost sharing for the entire family is limited to the cumulative cost-sharing maximum (i.e. cost-sharing amounts paid by any enrolled family member count towards the cumulative total)	cost sharing only for the children is counted towards cumulative cost-sharing maximum; adults excluded preamble: the statute only specifies that cost-sharing for the children in the family must count towards the maximum	the change could result in a low-income family facing high health care costs because the cumulative cost-sharing maximum does not include the adults' expenses
Annual Report **§ 457.750**	states must annually report the primary language of enrollees	deletes this reporting requirement entirely preamble: "States may find that primary language of the head of household rather than the child applicant/enrollee is more useful. . .we find that providing States with flexibility to decide what information to collect about primary language, and how to collect it, will best serve the needs of the program and that withdrawing this provision will not inhibit the Federal government from effectively evaluating the program."	while the preamble notes the need for flexibility to collect the primary language of either the child or head of household, the regulations do not require reporting of primary language data for either Note: the regulatory provision requiring quarterly reports including race, ethnicity and gender of enrollees has been maintained
PROGRAM INTEGRITY			
Procurement Standards § **457.940**	all SCHIP contracts must include provisions that define a sound and complete procurement contract, in accordance with the procurement requirements of 45 CFR Part 74	states may use procurement requirements of either 45 CFR § 74.43 or 45 CFR § 92.36, as applicable	currently, states must use 45 CFR § 74.43 HHS is revising 45 CFR Part 92; when these regulations are finalized, states must use 45 CFR § 92.36

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Verification of Enrollment and Provider Services Received § **457.980**	states must establish methodologies to verify whether beneficiaries have received services for which providers have billed	removes provision requiring verification methodologies states have flexibility in establishing a program integrity system that identifies, reports and verifies the accuracy of claims preamble: provision was unnecessary to comply with applicable statutory requirements or effective and efficient program evaluation	according to the preamble, states did not want to be held responsible for the internal workings of managed care plans and § 457.980(b) is adequate to address program integrity
APPLICANT AND ENROLLEE PROTECTIONS – SUBPART K			
Overview of Enrollee Rights	states must implement a grievance and appeals process pursuant to Subpart K states must adhere to the Consumer Bill of Rights and Responsibilities	CMS expects states to have adequate consumer protections but will not require that a state's review process adhere explicitly to the requirements outlined in the regulations states can either meet the requirements of Subpart K (§§ 457.1130-457.1180) or demonstrate that participating providers comply with state-specific grievance and appeal requirements currently in effect for health insurance issuers	without imposing minimum standards, states may choose what type of a grievance and appeals system to implement the question arises as to whether allowing states to implement their own procedures would comply with the requirements of *Goldberg v. Kelly*
Review Process § **457.1120**	defined minimum requirements to provide enrollees in separate child health programs with opportunity for independent external review preamble: all SCHIP-eligible children should be afforded a minimum set of consumer protections regardless of the state within which they reside; state laws applicable to commercial plans may or may not apply to separate child health programs and thus without minimum requirements, enrollees would be subject to different degrees of protection	states are expected to have external independent review but states may choose to require providers to comply with either the requirements established in the regulations or state-specific grievance and appeal requirements currently in effect preamble: most states have existing laws that govern the private insurance market and many SCHIP providers are subject to this law; providers may elect not to participate in SCHIP if they are subject to additional protections for enrollees	by allowing state-specific procedures, the regulations do not ensure that all enrollees have a minimum set of enforceable rights

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Review Processes §§ **457.1130-457.1180**	matters subject to review included eligibility, enrollment and health services matters an appropriate "review process" would address the matters subject to review and include all of the following components: core elements of review, impartial review, time frames, continuation of enrollment, and notice review process must meet specified minimum requirements in each of the specified areas	states must to provide an opportunity for review of all the matters listed in § 457.1130 (outlining specific eligibility, enrollment and health services matters) states may choose one of three options: • establish review process in accordance with the regulations; • require providers to comply with state-specific grievance and appeal requirements currently in effect for health insurance issuers; or • use the Medicaid fair hearing process	while state terminology may differ, a state choosing to use its own grievance and appeal requirements must demonstrate consistency with the intent of the regulations; states with inconsistent laws must identify a method for providing an opportunity for review for those items not covered
Premium Assistance Programs § **457.1190**	states may offer premium assistance plans that do not meet the review standards as long as families are not required to enroll their children in these plans and may enroll in the state's direct coverage plan rationale: states' SCHIP programs may not have direct authority over group health plans that may be providing coverage under premium assistance programs but there is no basis for providing children fewer procedural protections because they may be enrolled in premium assistance	states may enroll eligible children in group health plans that provide procedures that comply with either subpart K or the state-specific review requirements for health insurance issuers if a health plan is not subject to either the program-specific review or the state-wide standard review, the state must notify enrollees that the plan does not necessarily comply with review procedures and must provide an option to obtain health benefits coverage through the states' direct coverage plan	
TECHNICAL REVISIONS AND CLARIFICATIONS			
Definitions Related to Presumptive Eligibility §§ **435.1101, 436.1101**	inadvertently omitted one of the qualified entities that may perform presumptive eligibility under Medicaid	adds entities authorized under section 803 of BIPA to determine Medicaid or SCHIP eligibility as qualified entities	

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Definitions and Use of Terms § **457.301**	inadvertently omitted one of the qualified entities that may perform presumptive eligibility inadvertently omitted definition of a state health benefits plan	state health benefit plan is defined as "a plan that is offered or organized by the State government on behalf of State employees or other public agency employees within the State. The term does not include a plan in which the State provides no contribution toward the cost of coverage and in which no State employees participate, or a plan that provides coverage only for a specific type of care, such as dental or vision care."	definition of "state health benefit plan" was revised from the proposed rule to eliminate plans with no state contribution toward the cost of coverage and in which no state employees participate as a state health benefit plan
Amendments § **457.60 (b)(2)**		adds reference to the requirement regarding substitution of coverage found in §§ 457.805, 457.810	
Amendments § **457.60 (b)(7), (b)(8)**		removes cross-references to sections of part 457 that have been removed or revised	
General State Plan Requirements § **457.505(d)**	uses "enrollee" and "enrollees" when defining cost-sharing for coverage obtained through premium assistance for group health plans	changed to "eligible child" and "eligible children" to clarify that these provisions apply only to cost sharing imposed on the children in a family	
Basis, Scope and Applicability § **457.1000;** Waiver for Cost-Effective coverage through a community-based delivery system § **457.1005**		removed the term "waiver for" to clarify that states need only obtain approval for an amendment to their existing state plan and do not need to submit a section 1115 demonstration project or "waiver" request to implement these sections	