

## **State Children's Health Insurance Program (SCHIP) Final Rules Delayed**

With a January 20<sup>th</sup> regulatory review memorandum, President Bush delayed all of the previous administration's new rules and regulations that had been published but had not yet taken effect. It is common for a new administration to halt all pending rules from the previous administration for further review. Due to the delay, the effective date for the final SCHIP rules has been pushed back 60 days to June 11, 2001.

Many of the new rules simply clarify language contained in the original Title XXI legislation. The SCHIP final rules as adopted by the Clinton Administration are supported by the AAP. On April 3, 2001, the Academy signed on to a letter of the Center on Budget and Policy Priorities (CBPP), urging the new administration to implement the final rules without change. Although the Bush Administration has not targeted any specific provisions, there is still a possibility that changes will be made before the rules go into effect.

Due to the size of these rules we are summarizing below a few specific areas of interest, gleaned from the Health Care Financing Administration (HCFA) summary. To see the HCFA SCHIP Final Rule Summary online, visit <http://www.hcfa.gov/init/fnlreg01.pdf> . To see the actual SCHIP Final Rule, visit <http://www.hcfa.gov/regs/hcfa2006fc/hcfa2006fc.htm>.

### **Summary of Important Provisions**

#### **Outreach**

These regulations require that a state describe in its state plan the procedures to implement outreach strategies intended to inform families of the availability of programs and to assist those eligible with enrollment. Provisions also include examples of outreach strategies such as public education and awareness campaigns, enrollment simplification activities, and application assistance strategies.

#### **Enrollment Assistance**

Provisions require that states make accurate, easily understood, linguistically appropriate information available to potential applicants and enrollees and provide assistance to families in making informed health plan decisions. It requires states to make available to applicants and enrollees information on benefits, cost sharing, the name and locations of participating providers, and circumstances under which enrollment caps or waiting lists may be instituted. The regulations further require states to inform families about physician incentive plans and the review process that is available for adverse determinations of eligibility or treatment.

#### **Civil Rights Assurance**

This provision requires a state to assure that it will comply under its state plan with all applicable civil right requirements including the Civil Rights Act, the Americans with Disabilities Act, the Rehabilitation Act, the Age Discrimination Act and relevant portions of the Code of Federal Regulations.

### **Notice of Timing of HCFA Action Amendments**

This provision specifies that the HCFA will provide written notification to the state regarding approval or disapproval of a state plan or plan amendment. It specifies the rules governing the 90 day period for HCFA review and action on a state plan or plan amendment.

### **Targeted Low-Income Child**

This provision defines the term "targeted low-income child." The definition states that a targeted low-income child must show that he/she meets the financial need standard and has no other coverage. Other eligibility standards that a state may or may not use are outlined as well.

### **Application for Enrollment in SCHIP**

The regulations require that states inform applicants of their rights and responsibilities as part of the application process and provide them an opportunity to apply without delay. States are required to provide information about eligibility requirements, state obligations under the program, and state rights to the review of enrollment matters. States must determine SCHIP eligibility within a period not to exceed 45 calendar days, except in circumstances that are beyond the state's control.

### **Eligibility Screening and Facilitation of Medicaid Enrollment**

Provisions require that states ensure that all applicants who are potentially eligible for Medicaid are identified and enrolled in Medicaid if found eligible. When children are identified as potentially Medicaid eligible, states must transmit the application information to the Medicaid agency, inform families of their potential Medicaid eligibility, and provide assistance in the completion of the Medicaid application process. The state must ensure that children have been appropriately screened prior to placing a child on a waiting list.

### **Presumptive Eligibility**

These regulations establish that states may provide presumptive eligibility for children in the separate SCHIP program pending a final determination of eligibility. In general, expenditures for coverage during a period of presumptive eligibility for the separate program will be eligible for the enhanced matching funds.

### **Access to Care**

Regulations require states to have plans that include a description of the methods the state will use to assure the quality and appropriateness of care and access to care. Specifically, it requires that the state assure access to well-baby and well-adolescent care and childhood and adolescent immunizations, access to covered services (including emergency), appropriate and timely procedures to monitor and treat enrollees with 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 necessary. Access to pediatric specialists is not mandated. Further, use of published guidelines such as the Academy's "Guidelines for Health Supervision of Infants, Children and Adolescents" is not specifically required.

### **Cost Sharing**

A provision requires that cost sharing not be imposed on enrollees for well-baby or well-child care services. For purposes of cost sharing, these well-baby and well-child visits will include those in the Academy's "Guidelines for Health Supervision for Infants, Children and Adolescents," which means there can be no copayment, deductible, or any other form of cost sharing on such visits. Limits for cost sharing charges were placed on children in families at or below 150% of the federal poverty level (FPL). For families above 150% of the FPL, all forms of cost sharing cannot exceed 2.5% of total family income.

### **Disenrollment Protections**

Provisions require states to give enrollees a reasonable opportunity to pay past due cost-sharing amounts prior to disenrollment from SCHIP. States must also allow an enrollee the opportunity to demonstrate that the family's income has declined, making the child eligible for Medicaid or a lower level of cost-sharing in SCHIP. Further, the state must provide the enrollee with an opportunity for an impartial review of the decision to disenroll a child.

### **State Plan Requirements**

A provision requires that states describe their objectives, performance goals, and performance measures in their state plans. Strategic objectives must include a common core of national performance goals and measures to be developed by the Secretary of Health and Human Services (HHS). Further, state plans are required to provide an assurance that the state will collect data, maintain records, and furnish reports to the Secretary of HHS at the times and in the format the Secretary may require in order to monitor and evaluate state program administration and compliance and to compare the effectiveness of plans under Title XXI. Requirements for quarterly and annual reports are provided.

### **Substitution of Coverage**

The final provisions on this issue do not require a specific method of ensuring that SCHIP services will not substitute for coverage under a group health plan. As is stated in the preamble to the final rule, for coverage other than that provided through premium assistance, states will no longer be required to have a substitution prevention strategy for families with incomes below 250% of the FPL. Instead, states will be required to monitor the occurrence of substitution below 200% of the FPL. Between 200-250% of the FPL, HHS will work with the states to develop procedures, in addition to monitoring, to prevent substitution, should a significant level of it be taking place. States will be required to have a substitution mechanism in place for children in families above 250% of the FPL.

Mechanisms to prevent substitution of coverage for premium assistance will not fall within the above requirements. Instead, a period of six months of uninsurance (not to exceed 12 months) will be required. There are allowed reasonable exceptions to this requirement.

### **Procurement Standards**

Provisions require that states provide for free and open competition in the bidding of contracts for Title XXI services; or "use payment rates based on public or private

payment rates for comparable services for comparable populations, consistent with principles of actuarial soundness" as are defined in an earlier provision. States are permitted to set higher rates as necessary to ensure sufficient provider participation or provider access. The state must provide to HCFA, if requested, a description of the manner in which rates were developed in accord with stated standards. Conditions necessary to contract as a managed care entity are also given.

### **Verification of Enrollment and Provider Services Received**

A provision requires that states have methodologies in place to verify the accuracy of provider billing and must maintain systems to verify enrollment.

### **Waiver for Purchase of Family Coverage**

This provision describes a waiver that allows the state to provide coverage to an entire family. To receive payment of family coverage, the state must establish that the cost of covering the family will cost no more than to cover the individual child and must demonstrate that such coverage will not substitute for other health insurance.

### **Review Process**

Provisions indicate that there are two matters subject to review: (1) eligibility or enrollment and (2) the provision of health services. States must ensure that applicants or enrollees have the opportunity for review of a denial of eligibility, a failure to make a timely determination of eligibility, or a suspension or termination of enrollment. For health services matters, a state must ensure that an enrollee has an opportunity for the 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. Provisions regarding impartiality and timeliness are also included.

### **Coordination with Medicaid**

Provisions require that the state Medicaid agency have procedures in place to facilitate the Medicaid application process for children that have applied for a separate child health program and have been screened as potentially eligible for Medicaid. A provision also requires the Medicaid agency to adopt a process that facilitates enrollment in a SCHIP program when a child is determined ineligible for Medicaid at initial application or redetermination.