August 6, 1998

Dear State Health Official:

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

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

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

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

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

States and Congress on legislative proposals that will meet States' needs in this regard.

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

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

Sincerely yours,

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

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

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Attachment One

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

TYPES OF EXPENDITURES LIMITED BY THE 10 PERCENT CAP

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

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

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

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

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

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

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

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

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

eligibility determination, performance measurement, outreach and coordination, and public involvement.

ISSUES RELATED TO RECEIVING A VARIANCE

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

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

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

What is a community-based delivery system?

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

to working with States as they design their community-based delivery systems.

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

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

CALCULATION OF STATE SPENDING ABOVE THE 10 PERCENT CAP

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

The statute provides for a variance only "to the extent" that certain conditions, including cost-effectiveness, are met. The amount of additional spending allowed under the variance cannot result in the elimination of cost-effectiveness. In order to determine the level of spending above the 10 percent cap that can still receive match, the following methodology will be

used. States are allowed to spend, on a per child basis, the difference between the cost of services provided through the community-based system and the cost of coverage that would have been paid otherwise to provide insurance for the child under Title XXI. In order for States to receive substantial additional funds under this option, the community-based health delivery system must be able to provide substantial savings while providing comparable services. In other words, application of cost effectiveness means that the savings accrued from the coverage side are added to the total amount of the 10% spending limit. While this methodology is relatively easy to implement under a managed care system, a fee-for-service system may make this type of analysis more complicated. HCFA will work closely with States that seek a 10 percent variance under a fee-for-service delivery system, as well as under a managed care system.

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

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

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

In order to calculate the level of spending that the State can receive for match above the 10 percent cap, the State would take $1000 (the lower price of the two available non-community based provider plans) less $900 dollars (the cost of the community-based provider plan.) This means that, by enrolling a child in a community based provider plan, the State has saved $100. Since there are 4,000 children enrolled in the community-based provider system, this means that the State has saved a total of $400,000. As a

result, the State could exceed the 10 percent cap by, and receive match for, an additional $400,000 before the overall cost of this approach is no longer cost-effective. If the 10 percent cap level in this State was estimated to be $1,000,000 with the community-based delivery system implemented, then the variance under this scenario would increase the estimated cap level to $1,400,000.

Attachment Two

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

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

FLEXIBILITY TO CLAIM ADMINISTRATIVE AND OUTREACH EXPENDITURES UNDER MEDICAID OR CHIP

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

These States can elect to claim FFP under the Title XXI at the Title XXI enhanced matching rate for all Title XIX administrative and outreach activities related to providing health insurance coverage for targeted low-income children under Sections 1905(u)(2) and 1905 (u)(3) of the Social Security Act and provision of medical assistance to a child under Title XIX during a presumptive eligibility period under Section 1920A of the Act. States pursuing this option must continue to claim all such expenditures under Title XXI until the 10 percent limit is reached or until the available

CHIP allotment funds for that fiscal year are expended. These States may then begin to claim the CHIP related Title XIX administrative and outreach expenditures that are above the 10% limit under the Medicaid program and receive reimbursement at the applicable Medicaid matching rate.

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

DELAYED CLAIMING OF ADMINISTRATIVE EXPENDITURES

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