TITLE XXI STATE CHILD HEALTH PLAN APPROVAL PROCESS A GUIDE FOR STATES AND PUBLIC/PRIVATE PARTNERS

PURPOSE: The passage of the Title XXI State Children's Health Insurance Program creates a new program that significantly increases the opportunities for States to provide meaningful health benefit coverage for targeted low income children. Title XXI of the Social Security Act requires that States submit plans for approval by the Secretary of the Department of Health and Human Services (DHHS) in order to receive the allotted funds to provide that health care coverage. The Secretary has delegated approval authority to the Health Care Financing Administration (HCFA) Administrator.

States are encouraged to work with DHHS in the development of their Title XXI plans. Central and Regional Office staff from HCFA and the Health Resources Services Administration (HRSA), as well as other DHHS components, are available to furnish guidance and technical assistance to States in preparing their plans. During the review process, DHHS will determine whether Title XXI State Child Health Plans comply with statutory requirements.

TIME FRAMES: The law at Section 2106(c) specifies that the Secretary must approve, deny, or request additional information for a Title XXI plan or amendment by the 90th day after receipt.

A. Submittal -- Title XXI plans and amendments are submitted by the State Governor, or designee, to the HCFA Center for Medicaid and State Operations, Families and Children Health Program Group (CMSO/FCHPG.) The Title XXI plan or amendment should be a stand alone document that fully addresses each relevant section of the application template. Although supporting documents may be referenced, please do not reference a document without providing a detailed response to the information requested in the template.

The State should forward twenty (20) copies of its Title XXI Child Health Insurance Plan or amendment to:

Health Care Financing Administration Center for Medicaid and State Operations 7500 Security Blvd. Baltimore, MD 21244 Attn: Family and Children Health Program Group Mail Stop C4-14-16

In addition, three (3) copies should be submitted to the servicing HCFA Regional Office. If the plan is submitted on disk or electronically, then the State will need to submit only three (3) hard copies to CMSO and one (1) hard copy to the Regional Office. Submission on disk or

electronically in WordPerfect 6.1 format, in addition to hard copy, is requested and strongly recommended as this will facilitate the Plan's distribution to reviewing components.

CMSO and the HCFA regional office will track the 90-day review period (or "90-day clock") which begins on the first full day following receipt by the HCFA central office and ends 90 days later. States are requested to include the name and phone number of their primary contact person for the Title XXI plan in the letter which transmits the plan to HCFA. This will help ensure an early and ongoing dialogue on the submittal.

B. Prompt Review of Title XXI Plans and Amendments -- DHHS will review and HCFA will either approve or disapprove the plan or amendment, or request additional information, in 90 days or less. Informal clarification and discussion between the State and the DHHS review team are permitted and encouraged during the review period and this does not stop the "90-day clock." The 90-day review period may be stopped by formal written requests for additional information and clarification. The 90day review period may be stopped in this manner as many times as necessary to obtain the complete information necessary to approve the plan. The 90-day period will resume when the finalized additional information is received by HCFA. For example, if the formal request for information is sent on day 45, the review will begin again at day 46 on the first full day following receipt of the requested information by HCFA.

REVIEW OF PLAN SUBMISSION: The review of Title XXI plans will be a DHHS team effort. The HCFA Central Office (HCFA/CO), appropriate Regional Office (HCFA/RO), HRSA, OMB, and other participating DHHS components will work together to evaluate Title XXI plans. The HCFA actuaries will review those Title XXI plans proposing to provide benchmark equivalent coverage. The HCFA/RO is responsible for obtaining input from DHHS components' field offices as appropriate, and for taking the lead on tasks designated as RO responsibilities on the attached chart, including preparation of any required documents. The HCFA/RO will appoint an individual to coordinate regional review activities for each State's Title XXI plan. The HCFA/RO will be the focal point for contact with States for requesting clarification of their plans and for arranging contact with the States and other HCFA and DHHS components for informal negotiations.

HCFA/CO will be responsible for obtaining input from DHHS/CO components and OMB and for taking the lead on tasks designated as CO responsibilities on the attached chart, including preparation of any required documents. The HCFA/CO will assign an individual, or "project officer," to assume primary responsibility for coordination of the review of each State's Title XXI plan.

While HCFA may take the full 90 days to render a final decision, DHHS's initial analysis of the plan or amendment would generally be completed by the 45th day after receipt. Our guidelines indicate that the State would be contacted by HCFA by Day 45 if additional information is necessary in order to proceed with approval. It is important that States respond to informal requests for clarifications as soon as possible, since these requests do not stop the 90-day clock.

The attached chart outlines the review and approval process for Title XXI plans currently being considered. The exact review process may vary based on the unique circumstances of each Title XXI plan submitted, and may be modified based on overall experience.

ACTION ON PLANS AND AMENDMENTS: Plans and amendments will be considered approved unless, within 90 days, HCFA takes one of the following actions:

Approval: The HCFA Administrator exercises delegated authority to approve Title XXI plans and amendments. Letters of approval will be signed by the HCFA Administrator, following concurrence from the HRSA Administrator and Departmental components.

Request for Additional Information: The 90-day time period may be stopped by a formal written request for additional information. If DHHS has concerns regarding an initial plan or amendment submission, which are significant enough to prevent approval, but can reasonably be expected to be resolved, HCFA may make a formal request in writing for additional information. The request will include issues that need clarification, additional information required, and resolution of any inconsistencies. Because a formal request for information stops the 90-day approval period, it usually will be made only when the concerns involve required information that may take a significant amount of time for the State to develop, or issues that may take a significant amount of time to resolve. In order to assure that the additional information submitted by the State in response to the formal request will be sufficient for approval to proceed, States are encouraged to work with their Regional Offices during the time period when the review process has stopped. When the State's formal response to this request is received, HCFA will resume the 90-day review period at the point at which it had been stopped. States are requested to submit these responses electronically or on disk in WordPerfect 6.1 format, in addition to hard copy, to the designated HCFA project officer with a copy to the Regional Office for their area.

Disapproval: The HCFA Administrator may issue a disapproval for plans or amendments that are determined to not meet the requirements of the statute.

As explained below (see "Effective Dates") the statute permits retroactive effective dates for Title XXI plans and amendments. However, any State that implements a Title XXI plan or amendment that has not been approved risks that the plan or amendment will not be approved as implemented. In the event the plan is not approved as implemented, the State will be provided a reasonable opportunity for correction prior to the imposition of any financial sanctions [2106(c)(3)]. HCFA plans to issue regulations describing this opportunity for correction.

The HCFA Administrator or the CMSO/FCHPG will formally notify the State of any action taken.

Informal Clarifications: In addition to the actions described above, HCFA may informally request additional information through meetings or telephone contact. Because this type of request does not stop the 90-day approval time frame, it is usually made only when the concerns involve clarifications of information presented in the plan and those clarifications are expected to resolve the concerns preventing approval in a timely manner. It is important that States' responses to these requests are provided to HCFA as soon as possible. The use of electronic submittals or same-day or overnight delivery services may be appropriate in many cases.

EFFECTIVE DATE(S): Title XXI specifies effective dates for initial plans and amendments to plans. It also places limits on the length of time that an amendment may be in effect without submittal of a Title XXI plan amendment to HCFA, although the amendment must be approved before federal matching funds will be made available. In addition, these effective dates must be considered in relation to the effective date for the Title XIX State plan amendment if the State is planning to expand eligibility under Medicaid and receive enhanced matching funds under Title XXI for that expansion.

A. Initial Title XXI Plans -- States have the flexibility to choose any effective date(s) but it can be no earlier than October 1, 1997, and the State must be providing health coverage for targeted low income children as of that date [Section 2106 (a) (2) (B)]. The effective date may be either prospective or retrospective in relation to the submittal date; however, in order to access allotted funds for federal fiscal year 1998, the Title XXI plan must be submitted and approved before the end of the federal fiscal year (September 30, 1998.) It is strongly suggested that States submit their plans by no later than June 1, 1998 in order to allow enough time for approval. A State must have an approved plan by the end of the fiscal year to access their reserved allotment for that fiscal year. Should a State not submit a State plan for fiscal year 1998, they are strongly urged to submit their plan by no later than June 1 of the fiscal year for which they seek funding.

B. Title XXI Amendments -- States can amend their approved Title XXI plans in whole or in part at any time through the submittal of an amendment to HCFA [2106(b)(1)]. Generally, amendments are effective on the date or dates specified in the amendment [2106(b)(3)(A)]. There is an exception in the case of amendments that eliminate or restrict eligibility or benefits. These amendments cannot take effect unless the State certifies that it has provided prior public notice of the proposed change in a form and manner provided under applicable State law. The notice must be published prior to the requested effective date of the change [2106 (b)(3)(B)(i)]. In the amendment request, the State should describe the public notice process and provide a summary of comments received in response.

C. Term of Amendments -- There are restrictions on the time periods in which amendments can remain in effect if they are not submitted to HCFA [2106 (b)(3)(B)(ii)]:

1 An amendment that eliminates or restricts eligibility or benefits cannot be effective for longer than a 60-day period unless the amendment is submitted to HCFA before the end of that 60-day period.
2 Any other amendment can remain in effect only until the end of the State fiscal year in which it

becomes effective (or, if later, the end of the 90-day period in which it becomes effective) unless the amendment is submitted to HCFA before the end of the period.

If an amendment is implemented but is not submitted within the required time frame, the State runs the risk of being found out of compliance with their Title XXI plan which potentially could result in financial sanctions.

D. Title XIX Expansion Amendments -- Medicaid rules apply to expanded coverage provided under Title XIX State Medicaid plans [2101(a)(2)]. The effective date of these State plan amendments cannot be earlier than the first day of the quarter in which an approvable plan amendment is submitted to HCFA [42 CFR 430.20(b)]. It is, therefore, important for States to note that they must submit a Title XIX State plan amendment either prior to or during the calendar quarter in which they want it to take effect. The State must also submit an abbreviated title XXI plan in order to qualify for an allotment and enhanced match.

Medicaid State plan amendments (SPAs) will be reviewed using the established process for Title XIX. Every effort will be made to coordinate the approval of the SPA with the approval of the Title XXI plan.

APPROVAL OF TITLE XXI PLANS: In order to be approved, Title XXI plans must contain all the information required by statute, as described in the model application template. The Title XXI plan should be a stand alone document that does not rely on referring the reader to other sources to find the required information. DHHS will work with States to assure that complete information is included or obtained and the approval process can proceed. Because Title XXI is a new program, it is difficult to anticipate all circumstances under which plans may be approved or disapproved. The following criteria, however, represent the minimum statutory requirements that must be met in order for approval to occur:

The plan serves targeted low income children [2102(b)(3)(A)];

The plan covers lower income children before covering higher income children and does not deny eligibility based on preexisting conditions [2102(b)(1)(B)(i-ii)];

The proposed benefit package meets the requirements of the statute [2103(a)(1-4)];

Any proposed cost-sharing meets the requirements of the statute [2103(e)(1-4)];

The plan does not use Federal funds or cost-sharing in determining the amount of non-Federal contributions [2105(c)(4-5)];

The proposed program will not substitute for other available coverage [2102(b)(3)(B-E) and 2105 (c)(6)];

Medicaid income and resource standards are no more restrictive than they were on June 1, 1997 for coverage provided under Title XXI [2105(d)(1)], or on March 31, 1997 for eligibility expansions under Title XIX [4911(a)(2)(A)];

Assurances are present that reporting requirements will be met [2107(b)(1-3)]; and

The program budget is described as required [2107(d)].

As DHHS gains experience with Title XXI plans, these criteria may be revised to reflect additional statutory requirements and policy determinations.

In addition, Section 2105(c)(2) permits waivers of the 10% limitation on the use of funds in order to provide the benefit package through direct contracting with a community-based delivery system and waivers to purchase family group coverage. DHHS will develop further guidance and criteria for approval of these waivers in the future.