

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
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**Center for Medicaid, CHIP and Survey & Certification**

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SHO # 10-008  
CHIPRA # 19

October 1, 2010

**Re: CHIPRA Performance Bonus Payments**

Dear State Health Official:

This letter and the enclosed documents provide additional guidance on the implementation of section 104 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) which added section 2105(a)(3) to the Social Security Act. CMS provided information on the new opportunity for States to obtain Performance Bonus Payments (bonus payments) for Federal fiscal years (FYs) 2009 through 2013 in its December 16, 2009 letter to State Medicaid Directors and State Health Officials (SHO #09-015), available at [http://www.insurekidsnow.gov/images/sho\\_letter.pdf](http://www.insurekidsnow.gov/images/sho_letter.pdf).

Since the release of the SHO letter, we have processed the FY 2009 bonus applications and conducted several calls regarding bonus payment applications with States and other interested stakeholders in response to requests for additional policy guidance. The enclosed set of answers to frequently asked questions is intended to provide further guidance on our procedures and interpretation of the elements of the new statutory provision. Also enclosed are the templates States may use to apply for a FY 2010 bonus payment.

We hope that this guidance will assist States in applying for the bonus payments for FY 2010, as well as for subsequent years. We strongly encourage all States that believe they may qualify for a bonus payment in FY 2010 to apply **by October 15, 2010**, according to the process outlined in this guidance. Thank you for your continued commitment to increasing access to health coverage for eligible uninsured children in Medicaid and the Children's Health Insurance Program (CHIP). Questions regarding this guidance may be directed to Ms. Vikki Wachino, Director, Family and Children's Health Programs Group, who may be reached at (410) 786-5647.

Sincerely,

/s/

Cindy Mann  
Director

Enclosures:

Bonus Payment Request Template  
Bonus Payment Enrollment Template

cc:

CMS Regional Administrators

CMS Associate Regional Administrators  
Division of Medicaid and Children's Health

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## Enclosure

### **CHIPRA Performance Bonus Payments: Questions and Answers**

On December 16, 2009, the Centers for Medicare & Medicaid Services (CMS) released a letter to State Health Officials (SHO #09-015) describing the new funding opportunity for States created by section 104 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Section 104 of CHIPRA provides bonus payments to States that implement certain program features and increase enrollment of eligible uninsured children in Medicaid above baseline levels. The letter and enclosure can be accessed on the CMS Web site at: [http://www.cms.hhs.gov/CHIPRA/07\\_Guidance%20-%20continued.asp#TopOfPage](http://www.cms.hhs.gov/CHIPRA/07_Guidance%20-%20continued.asp#TopOfPage).

The following questions and answers are intended to further clarify bonus payment application procedures and CMS’ interpretation of the qualifying program features. CMS encourages States, as well as all interested stakeholders, to submit questions regarding the criteria for qualifying for a bonus payment to [CHIPRAbonuspayments@cms.hhs.gov](mailto:CHIPRAbonuspayments@cms.hhs.gov).

## APPLICATION FOR BONUS PAYMENTS

### **1. How do States apply for a CHIPRA bonus payment for Federal fiscal year (FY) 2010?**

In order to allow sufficient time for review of State information, CMS requests that States submit requests for a FY 2010 bonus payment no later than **October 15, 2010**. (Please note that this date is earlier than the deadline previously outlined in the CMS SHO letter released on December 16, 2009. We have revised the date to allow for additional time and communication with States so that CMS can adequately evaluate the States’ program features and ensure that all States that qualify for a bonus payment have an opportunity to receive one.)

Bonus payment requests should be submitted in two parts: 1) 5 of 8 program features; and 2) Medicaid enrollment data.

1) ***Program features***. A State applying for a CHIPRA bonus payment must describe each of the program features it believes qualify toward meeting the “5 out of 8” requirement for receiving a bonus payment (listed in section 2105(a)(4) of the Social Security Act). Also enclosed is a Bonus Payment Request Template (Word file) that States may find useful in submitting a request for a bonus payment. This template, as well as all other program feature information necessary to determine eligibility for a bonus payment, should be submitted electronically to the specially-designated CMS mailbox ([CHIPRAbonuspayments@cms.hhs.gov](mailto:CHIPRAbonuspayments@cms.hhs.gov)) **by no later than October 15, 2010**.

2) ***Medicaid enrollment data***. In order to enable CMS to determine whether a State meets the enrollment goals and, if it does meet those goals, to calculate the amounts of the bonus payments for FY 2010, States should submit the enclosed Bonus Payment Enrollment Template (Excel file), providing the monthly average unduplicated number of qualifying

children for FY 2010, to the same CMS mailbox ([CHIPRAbonuspayments@cms.hhs.gov](mailto:CHIPRAbonuspayments@cms.hhs.gov)) by **no later than November 1, 2010**.

States experiencing problems with the CMS electronic mailbox or any other problems with electronic submission to CMS may call the Family and Children’s Health Programs Group (FCHPG) Director’s office at 410-786-5647 and request assistance with submitting a bonus payment application.

CMS will acknowledge receipt of all requests. Any State submitting a request for a performance bonus that does not receive an acknowledgement may contact us directly at the number listed above as quickly as possible.

**2. Will States that received a bonus payment in FY 2009 automatically qualify for a FY 2010 bonus payment?**

No. States must actively apply for a bonus payment for each Federal FY under consideration. States that continue to have program features in place that were accepted by CMS for FY 2009 need only indicate that there have been no changes to the application of the program feature since the previous year and confirm that the practice remained in effect for FY 2010.

However, States that have modified program features in any manner that affects beneficiaries must fully describe the modification in order for CMS to determine whether that program feature continues to meet the criteria for receipt of a bonus payment. States seeking qualification for new program features not previously accepted for purposes of the performance bonus must provide a full description of the program feature, along with all necessary supporting documentation. The enclosed template may be used for this purpose.

**3. Are States that informally submitted information to CMS regarding program features they have implemented for FY 2009 required to resubmit this information to be considered for a FY 2010 bonus payment?**

Yes. The FY 2010 request must contain all information required to determine eligibility for a bonus payment for FY 2010. States that are reapplying for bonus payments, as well as States that are initially applying for a FY 2010 payment will be given equal consideration. As noted above, States that officially submit bonus payment applications for FY 2010 will receive written confirmation from CMS upon receipt of the application.

**IMPLEMENTATION OF PROGRAM FEATURES**

**4. Can CMS clarify what is considered a “full year of implementation” for purposes of qualifying for a bonus payment in FY 2010?**

As described in the December 16, 2009, SHO letter, CMS interprets the statutory requirement that the State be “implementing” a program feature “throughout the entire fiscal year” by reference to the following milestones:

- a. **October 1, 2009** – The last day by which the State must have effective legislation (if necessary) authorizing the State to implement the program features for which the State seeks “credit” in FY 2010.
- b. **April 1, 2010 – September 30, 2010** – Program features must be fully operational in the State. In order for a State to qualify for a program feature that is a required element of the Medicaid/CHIP State Plan, the State must have submitted the necessary State plan amendment with an effective date of April 1 of the FY in question.

**Note:** States that receive “credit” for implementing a program feature in a particular fiscal year are expected to continue implementing this program feature throughout the subsequent fiscal year in order to continue receiving “credit” for this program feature. Also, not all program features must be included in the approved State plan in order for the State to receive “credit” for the practice.

**5. Can CMS clarify whether States must implement an application/eligibility simplification program feature for all children eligible for Medicaid and CHIP in order to qualify for a bonus payment?**

States will have to implement program features for most, but not necessarily all, children eligible for Medicaid and CHIP. Application/eligibility simplification program features should apply to all children covered under CHIP and to those children covered under Medicaid in an eligibility group for which being a “child” is a requirement of eligibility (under both the Medicaid State plan and any section 1115 demonstrations or waivers). States are not required to apply these program features to children covered in Medicaid under eligibility groups that are not linked to age (e.g., disability) because we recognize that eligibility rules do not allow children to be treated differently than other individuals enrolled in the same eligibility group.

In the request for a bonus payment, States should clearly indicate when a particular program feature does not apply, or applies differently, to certain populations of children. CMS will evaluate these applications of the program feature to ensure it is consistent with this guidance.

Please note that the premium assistance subsidy program feature does not necessarily need to apply to both title XIX- and title XXI-funded children. A State may qualify as having met this program feature if it offers a premium assistance subsidy under section 2105(c)(10) or section 1906(A) of the Act, and need only provide information on the appropriate title XIX or title XXI program.

Any State having questions on whether a particular group of children should be covered for purposes of qualifying for a bonus payment may refer to the list of child eligibility groups in Appendix II of the December 16, 2009, SHO letter.

### Continuous Eligibility

- 6. Are States that disenroll children from CHIP for non-payment of premiums or other permissible reasons under title XXI automatically disqualified from meeting the criteria for continuous eligibility?**

No. States that elect continuous eligibility in CHIP may disenroll a child for who required premiums are not paid, after applying the appropriate grace period. (See SHO #10-001 for additional information about the CHIPRA premium grace period requirements, available at <http://www.insurekidsnow.gov/professionals/CHIPRA/chiprapremiumgraceperiod.pdf>.)

### Same Application/Renewal Forms and Procedures

- 7. Does the term “same application and renewal forms and procedures for Medicaid and CHIP” mean that States must have a joint application for Medicaid and CHIP?**

No. This program feature does not require a joint program application for Medicaid and CHIP enrollment. States may meet this program feature by using a joint program application, or by using Medicaid and CHIP program forms interchangeably, when determining a child’s eligibility for either program (i.e. “no wrong door”). In order to meet the requirements of this program feature, States must allow the use of the same application forms and procedures for initial eligibility determinations for Medicaid and CHIP, as well as the same renewal forms and procedures for redeterminations of eligibility for Medicaid and CHIP.

### Automatic/Administrative Renewal

- 8. Are States required to implement both administrative and ex parte renewal procedures to satisfy the criteria for automatic/administrative renewal? Can CMS clarify how States can meet the criteria for automatic/administrative renewal?**

No. In order to qualify for the automatic/administrative renewal program feature, States can implement one or both of two renewal procedures that are designed to rely on information available to the State and to have no, or minimal, involvement from the beneficiary: (a) administrative redeterminations; and (b) ex parte redeterminations. The objective of this program feature is to ensure that States have made the renewal process as simple and efficient as possible for families. These procedures provide for redetermination without an in-person interview, but also involve other practices to minimize burden on families.

Practices that qualify as automatic/administrative renewal:

- *Administrative Redeterminations* – The State sends a form pre-populated with all eligibility information available to the State to the family in advance of the renewal date. Then the State will either:

- i. Continue the child’s coverage based on the information available unless the family responds with more current information, or the State otherwise obtains such information that affects eligibility (e.g., through data matches); or
- ii. Require the parent/representative to confirm the accuracy of the information by returning a signed copy of the pre-populated form with any changes in information noted on the form.

No additional action is required by the parent/representative for continuation of the child’s coverage.

- *Ex parte Redeterminations* – The State performs the eligibility redetermination based on information contained in the individual's Medicaid or CHIP file, or by obtaining information available to the State through other sources. Then the State will either complete the redetermination based on the information available and notify the parent/representative that the child’s coverage will continue, as appropriate, or complete the redetermination to the maximum extent possible using all available electronic means and contact the parent/representative for *only* the information the State is unable to obtain or verify. (Note that a signed application or renewal form is not required under Federal law for renewals.) For more information about CMS policy on ex parte redeterminations, please see the State Medicaid Director letter, released on April 22, 1997, available at <http://www.cms.hhs.gov/smdl/downloads/SMD042297.pdf>.

Example: The State Medicaid Agency makes an eligibility redetermination based on information already in its files or based on information that it obtains through interagency “Memoranda of Understanding” with other State agencies. Such interagency agreements can promote overall efficiency by ensuring that family/beneficiary household data pertinent to redetermining eligibility (e.g., address, household members, gross earned income, child care expenses, etc.) are available without requiring the beneficiary to separately report that data to the State Medicaid agency.

- If the State has sufficient information to determine eligibility for continued coverage, the renewal is complete. The State need not require a signed renewal form or any further information from the family. Alternatively, the State may require the family to confirm the accuracy of the information through phone, e-mail, fax, or postal mail, but coverage will not be interrupted pending confirmation.
- If the State needs additional supporting information to complete the redetermination, the State contacts the parent/representative to provide only the information the State was unable to obtain from other sources. For example, the State may have information that there is a new adult in the household (i.e., a change in household members), but cannot reasonably obtain information on the new household member from other sources. In this case, the parent/representative is not asked to complete a new application but only to provide the supplemental information necessary to complete the renewal. In this example, even though the family was required to provide information, this practice satisfies ex parte

requirements because the State relied on information from other sources to the fullest extent possible.

Practices that do *not* qualify for automatic/administrative renewal:

- a. Sending blank renewal form(s) to the parent/representative to fill out and return to the State in order for the child’s coverage to continue.
- b. Requiring the family to complete renewal forms and/or respond with information that is already available to the State through other sources.
- c. Requiring the parent/representative to return proof of current income or other supplemental information when that information could be obtained by the State through other sources and when there is no basis to believe that the information the State has available is incorrect.
- d. Attempting to obtain beneficiary information through electronic means *only after* it requests information (e.g., current income) from the parent/representative and receives no response.

### **Presumptive Eligibility**

#### **9. How can States with separate CHIP programs that charge premiums or similar cost-sharing implement presumptive eligibility?**

States can implement presumptive eligibility for CHIP children and still require beneficiary cost sharing upon full enrollment. However, States may not require payment of premiums, enrollment fees, or similar cost-sharing charges while the child’s CHIP eligibility determination is pending. States would apply presumptive eligibility rules in the same manner as applied to children not subject to cost sharing during the presumptive period.

### **Express Lane Eligibility**

#### **10. Can an integrated eligibility system that processes TANF, Medicaid, and CHIP be used to implement Express Lane eligibility (ELE)?**

Yes, but an integrated eligibility system by itself does not automatically constitute an ELE process. For example, the fact that the TANF agency makes Medicaid or CHIP eligibility determinations does not by itself qualify the State’s process as an ELE process. States that utilize a combined application form for multiple programs, such as TANF, SNAP, Medicaid, and CHIP, will not necessarily qualify as having an ELE process unless all other requirements for ELE are met, including the requirement that the State also have “regular” procedures for determining eligibility that are used if a finding from the Express Lane agency would result in a determination that a child does not satisfy an eligibility requirement for Medicaid or CHIP. The ELE process is an alternative to the regular Medicaid eligibility determination process, rather than the regular Medicaid eligibility process itself. There are circumstances in which States could design an ELE process using a TANF agency as an Express Lane agency. We encourage States to explore how this might work in their State.



Enrolling children through a determination authorized under section 1931 of the Act does not automatically constitute an ELE process, even when that determination is similar to a TANF determination or takes into account the TANF determination. Also, as mentioned above, in order to qualify for bonus payments, program features should apply to those children in a Medicaid eligibility group for which being a “child” is a requirement of eligibility, and should apply to all children covered under CHIP.

Four States (Alabama, Iowa, Louisiana, and New Jersey) currently have approved State plan amendments to offer Express Lane Eligibility. We would be happy to work with additional States interested in pursuing this option. For additional information about Express Lane Eligibility, please see SHO #10-003, available at [http://www.insurekidsnow.gov/professionals/federal/express\\_lane.pdf](http://www.insurekidsnow.gov/professionals/federal/express_lane.pdf).

## Premium Assistance

### **11. How can a State convert its currently approved Medicaid or CHIP premium assistance program to the new CHIPRA premium assistance State plan options under sections 1906A and 2105(c)(10) of the Act in order to qualify for a bonus payment?**

Premium assistance is one of the qualifying program features for the CHIPRA performance bonus, but, under the law, only premium assistance programs operating under the authority of section 1906A and section 2105(c)(10) of the Act may qualify. However, a State may already be providing premium assistance to children who meet the requirements for participation under section 1906A and section 2105(c)(10) of the Act if the State currently has approved a premium assistance program for Medicaid and CHIP under section 1906, section 2105(c)(3), and/or a section 1115 demonstration. To implement a section 1906A or a section 2105(c)(10) premium assistance program, the State must submit a State plan amendment to exercise this option. CMS has provided a model template for this amendment in CHIPRA letter # 10-002, which was issued February 4, 2010.

[http://www.insurekidsnow.gov/professionals/federal/chipra\\_premium.pdf](http://www.insurekidsnow.gov/professionals/federal/chipra_premium.pdf)

Changes in the scope of premium assistance may be required for converting a premium assistance program under section 1906 of the Act to a program under section 1906A of the Act as well as for converting a program under section 2105(c)(3) to a program under section 2105(c)(10) of the Act. Premium assistance provided under sections 1906A and section 2105(c)(10) must be offered on a voluntary basis to all eligible children who can obtain qualified employer-sponsored coverage. Qualified employer-sponsored coverage is defined in both section 1906A(b) and section 2105(c)(10)(B) of the Act, and this definition includes an employer contribution of at least 40 percent of the cost of the premium.

In general, under these premium assistance options, States will need to consider establishing processes to confirm the individual’s voluntary election to receive a premium assistance subsidy and to permit the parent of an individual under age 19 to disenroll the individual from the qualified employer-sponsored coverage for any month. Premium assistance programs operating under section 1906A of the Act must ensure that Medicaid claims

payments systems pay all enrollee premiums, deductibles, coinsurance, and other cost-sharing obligations for items and services covered under the State plan for the individual under age 19 and the individual's parent.

States that currently provide premium assistance to Medicaid- or CHIP-eligible children who have access to qualified employer sponsored coverage may move those children from an existing demonstration into the State plan, as long as the States do not apply more restrictive criteria for employer participation. States with existing premium assistance programs where the employer coverage being offered does not qualify under the definition of "qualified employer sponsored coverage" may leave existing demonstrations in place for these individuals.

**12. If CMS determines that a State does not qualify for a bonus payment, will the State be able to request a review of that determination?**

Yes. If CMS determines that a State does not qualify for a bonus payment, CMS will outline in the State's CMS bonus payment determination letter a procedure for the State to request reconsideration of the decision and/or reevaluation of the State's enrollment data. All reconsiderations will be evaluated on a case-by-case basis, depending on the issues presented.