



Georgetown University Health Policy Institute
Center for Children and Families

The Children's Health Insurance Program Reauthorization Act of 2009



Overview and Summary
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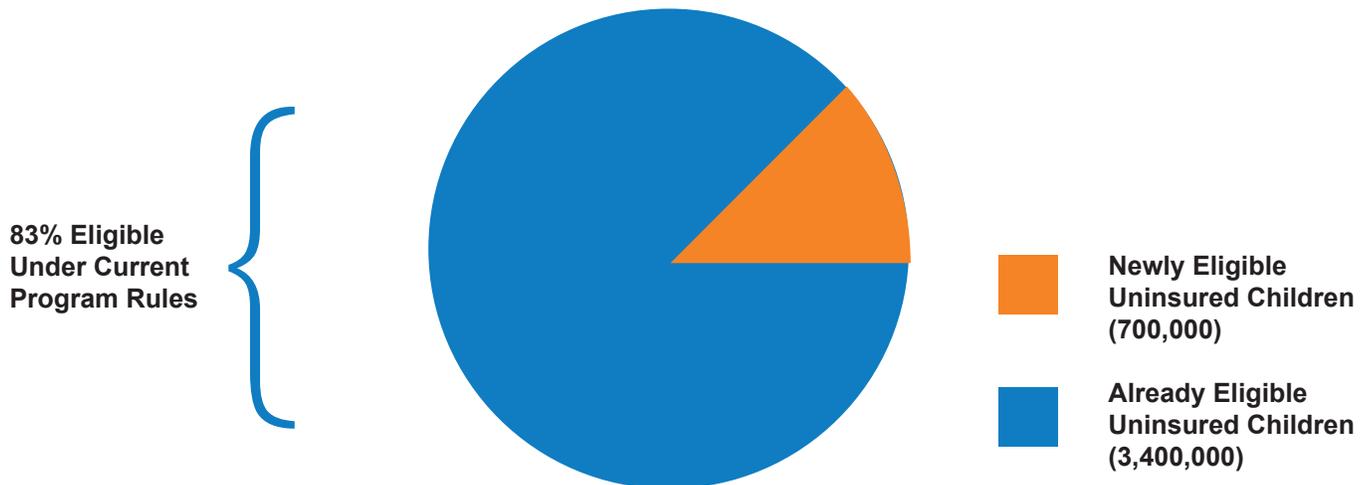
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I. INTRODUCTION

On February 4, 2009, President Obama signed into law the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The new law (Public Law No. 111-3) is designed to provide coverage to significant numbers of uninsured children and to improve the quality of care that all of America’s children receive. Most notably, it strengthens and extends the Children’s Health Insurance Program (CHIP)¹ over a four and a half year period (April 1, 2009 to September 30, 2013). Created in 1997, CHIP builds on its larger companion program, Medicaid, to offer coverage options to uninsured children in families without access to affordable employer-sponsored insurance. This report gives an overview of key elements of the new law, as well as a more detailed summary of each of its provisions.

CHIPRA is expected to result in substantial health coverage gains for millions of children, especially critical during the economic downturn when more and more families are losing jobs and health insurance. The law’s funding and policies are designed to put CHIP on more secure financial footing. It gives states the resources and tools they need to sustain and strengthen their CHIP programs and to enroll more of the uninsured children who already qualify for coverage through CHIP or Medicaid. Overall, under the new law, states are expected by 2013 to cover 4.1 million children who otherwise would be uninsured. The Congressional Budget Office (CBO) estimates that more than eight in ten of the children (83 percent) who will gain coverage under CHIPRA will be children who are eligible for CHIP or Medicaid under existing guidelines—the vast majority of whom are low-income (Figure 1).

By providing states with the funding and options they need to cover millions more of the nation’s children, the new CHIP law reaffirms that children’s coverage is a national priority. Now, the locus of action shifts to state capitols where policymakers and program administrators across the country must decide how to use the opportunities created by the new CHIP law to make progress in covering America’s children.



Source: Congressional Budget Office, February 11, 2009. Note: Projected average monthly new enrollment of otherwise uninsured children in Medicaid and CHIP for fiscal year 2013.

Figure 1: CHIPRA Will Cover Over 4 Million Children Who Otherwise Would Be Uninsured

¹ Note that the law changes the official name of the State Children’s Health Insurance Program (SCHIP) to the Children’s Health Insurance Program (CHIP), as designated throughout this report.

II. OVERVIEW OF KEY PROVISIONS

CHIPRA 2009 was designed to finance CHIP for the next 4.5 years while extending coverage to millions of additional uninsured children, most of whom are eligible under current rules but not enrolled. In addition, it improves benefits and data collection and launches a major new quality initiative for children's health care. The next section provides a detailed description of the law, but the key provisions are as follows. See Table 1 on the next page for implementation dates of key provisions.

- **Significant new CHIP funding through fiscal year 2013.** CHIPRA markedly increases CHIP allotments, modernizes the formula for dividing funds among the states, and establishes a mechanism for “re-basing” state allotments every two years to ensure that CHIP funds are targeted to states that are using them for covering children. The law provides funding over a period of four and a half years (April 1, 2009 to the end of fiscal year 2013) and is financed largely by a nearly \$0.62 increase in the tax on cigarettes. (Page 4 in the detailed summary.)
- **Initiatives to enroll the lowest-income uninsured children in coverage.** The law includes new tools, such as Express Lane eligibility, to encourage the enrollment of already-eligible uninsured children in coverage as well as an increase in federal funding for outreach. These new tools are accompanied by a performance bonus system that provides states with additional federal financial help when they significantly increase their enrollment of already-eligible uninsured children in Medicaid and adopt measures to streamline enrollment and renewal in both Medicaid and CHIP. The law applies current Medicaid citizenship documentation rules to CHIP, but also includes a new electronic option for documenting citizenship status in both Medicaid and CHIP to address concerns that red tape barriers to coverage were keeping low-income citizen children from enrolling in coverage for which they are eligible. (Page 10 in the detailed summary.)
- **State option to cover legal immigrant children and pregnant women.** CHIPRA provides states with the option to eliminate the five-year waiting period now imposed on lawfully residing immigrant children and pregnant women in Medicaid and CHIP. (Page 14 in the detailed summary.)
- **State option to cover pregnant women.** Although states have had some flexibility to cover pregnant women in CHIP through waivers or other means, CHIPRA establishes a new, explicit statutory option to cover pregnant women with CHIP funds. (Page 14 in the detailed summary.)
- **New rules on covering moderate-income children.** The original CHIP law gave states the flexibility to set the income eligibility level for children in their state, although in August 2007, a directive issued by the Centers for Medicare and Medicaid Services (CMS)² sharply limited that flexibility. On February 4, 2009, the President directed the Secretary of Health and Human Services (HHS) to rescind the CMS directive. The new CHIP law also retains state flexibility to set income eligibility levels, but reduces the matching rate that the federal government will provide for new expansions to children above 300 percent of the federal poverty level (FPL) from CHIP to Medicaid levels. (Page 14 in the detailed summary.)
- **Elimination of adult coverage.** The law eliminates the authority of the Secretary of HHS to grant CHIP waivers for family-based coverage and phases out existing CHIP waivers that allow states to cover parents and childless adults. (Page 15 in the detailed summary.)
- **New provisions for premium assistance.** CHIPRA includes provisions to reduce barriers states face when implementing premium assistance programs, as well as to ensure that premium assistance programs are cost-effective and provide children benefits that are equivalent to what they would receive if enrolled directly in a state's CHIP program. (Page 16 in the detailed summary.)
- **Improvements in the quality of care and benefits for children.** CHIPRA establishes a new initiative to improve the quality of care provided to all children, including those covered by private insurance. It includes the development and dissemination of new child-specific health quality measures, the creation of a new model electronic medical record for children, and demonstration projects on quality improvement and health information technology for children. (Page 18 in the detailed summary.) The law also strengthens dental coverage for children in CHIP, including requiring states to provide dental services in their CHIP plans. (Page 17 in the detailed summary.)

² Centers for Medicare and Medicaid Services, Dear State Health Official, SHO #07-001, August 17, 2007. See <http://ccf.georgetown.edu/index/cmsdirective> for background information on the directive.

Table 1: Implementation Date of Key CHIPRA Provisions¹

February 4, 2009 (CHIPRA signed into law)	States can receive only the Medicaid (rather than the CHIP) matching rate for new expansions to children above 300% FPL. <ul style="list-style-type: none"> • HHS no longer can grant CHIP waivers for coverage of parents. • New rules for qualifying states go into effect. • Some improvements to existing citizenship documentation requirements are in effect, including states must allow eligible individuals to receive benefits while proving citizenship. (New option is effective January 1, 2010; see below.)
February 2009	States expected to submit to HHS projected CHIP spending for fiscal year 2009, which will be a key factor in determining state allotments in future years.
March 31, 2009	HHS will finalize fiscal year 2009 CHIP allotments.
April 1, 2009	The effective date of most provisions in the law, including new CHIP financing structure and state options to: <ul style="list-style-type: none"> • Eliminate the 5-year waiting period for lawfully resident immigrant children and pregnant women in Medicaid and CHIP. • Cover pregnant women in CHIP without a waiver. • Use Express Lane eligibility in Medicaid and CHIP. • Provide supplemental dental coverage to privately-insured children. • Employ new premium assistance options in Medicaid and CHIP.
August 4, 2009	HHS must issue new PERM regulations by this date.
August 31, 2009	States seeking an adjustment to their fiscal year 2010 allotment for an expansion must submit the request by this date.
October 1, 2009	New mandate to provide dental coverage in CHIP goes into effect.
January 1, 2010	Citizenship documentation extended to CHIP; states can begin to use the new electronic option for verifying citizenship status. <ul style="list-style-type: none"> • Existing childless adult waivers terminated; states may be able to receive some funding through Medicaid to continue coverage for already-enrolled adults. • HHS must release core set of child health quality measures for Medicaid and CHIP.
January 1, 2011	HHS must establish Pediatric Quality Measures Program for children's coverage.
March 1, 2011	First set of recommendations to Congress by the Medicaid and CHIP Access Commission.
August 31, 2011	States seeking an adjustment to their fiscal year 2010 allotment for an expansion must submit the request by this date.
September 30, 2011	Existing parent waivers are terminated; states can receive some funding outside of CHIP to continue parent waivers.

[1] This chart is not meant to be exhaustive and only provides information on key implementation dates. In addition, dates for certain provisions, such as outreach funding, are not included because the law does not stipulate the dates and further federal guidance is needed.

III. DETAILED SUMMARY

This summary provides a description of the major child and family health provisions in CHIPRA, which are effective April 1, 2009 through September 30, 2013 (unless otherwise noted). It is based on CCF's analysis of the provisions in the law. Some of these provisions raise questions of interpretation that will need to be resolved through federal guidance. As that guidance is issued, CCF will provide updated information.

The full text of CHIPRA is available at <http://ccf.georgetown.edu/index/schipreauthorization>.

A. FINANCING/FUNDING FOR CHILDREN'S COVERAGE

CHIPRA provides substantial new resources to states to provide coverage to uninsured children. Most notably, it extends and increases funding for CHIP through fiscal year 2013 and makes major changes in the formula used to determine how much CHIP funding each state will receive. It also includes provisions that are expected to increase Medicaid funding for children, such as a new performance bonus system to help states that succeed in significantly increasing enrollment of Medicaid-eligible children. Taken together, CBO has estimated that these and other provisions in CHIPRA will cause federal spending on CHIP, Medicaid, and other related programs to increase by \$32.8 billion in the period from fiscal year 2009 and fiscal year 2013. This spending increase is financed primarily by a nearly \$0.62 increase in the federal cigarette tax.

- **National CHIP Funding Levels.** Since CHIP's inception, the federal government has set aside a specified amount of federal funding each year for the CHIP program. The funds in these "national allotments" are then distributed according to a formula among the states and territories. Under prior law, CHIP funding was slated to expire March 31, 2009. With CHIPRA, Congress extended funding for the program through 2013, and set national allotments for fiscal years 2009 through 2013. The new national allotment levels, shown in Table 2, are designed to provide the funding states need to continue operating their existing CHIP programs, but also to increase enrollment among already-eligible children, expand coverage, and/or improve the scope and quality of care provided to children. Over the four and a half year period covered by the law, the national allotments will total \$68.9 billion.³

While the national funding base represents a significant increase, in the event that there is not enough CHIP funding to give each state the allotment it is otherwise slated to receive, the law calls for proportionately reducing the size of each state's allotment to fit within the national cap.

<i>Year</i>	<i>Allotment (In Billions)</i>
2009	\$10.562
2010	\$12.520
2011	\$13.459
2012	\$14.982
2013	\$17.406
Total (2009-2013)	\$68.929

³ The \$68.9 billion available to states in total CHIP allotments differs from CBO's estimate that CHIPRA will cost \$32.8 billion because the figures are designed to serve very different purposes. The \$68.9 figure reflects the total amount of CHIP funding (or, more technically, "budget authority") set aside for states in national allotments over the next four and a half years. In contrast, the CBO figure is designed to estimate the additional federal spending on CHIP, Medicaid, and other programs above "baseline" levels (i.e., spending that would have occurred even in the absence of CHIPRA) that will result from adopting CHIPRA. For example, CBO's baseline already assumed a little more than \$25 billion on CHIP spending over the same period, reducing the marginal cost of passing CHIPRA. At the same time, CBO's estimate takes into account that CHIPRA is expected to increase Medicaid spending on children, not just CHIP spending. As a result of these and other issues, there is only a minimal relationship between the size of the national allotments and CBO's estimate of the fiscal impact of the bill on federal spending.

- **State-Specific Allotments.** The national CHIP allotments are divided among states and territories according to a new statutory formula. The original formula was based primarily on a state's share of uninsured and uninsured low-income children and did not take into account actual state spending. As a result, some states ended up not using their full allotments even as others faced the prospect of running out of CHIP funds. In contrast, the new formula created by CHIPRA distributes the available CHIP funds among states based largely on their actual use of and need for such funds. The following describes the allotment formula for each fiscal year. (See Table 3 on the next page for a summary.)

- **Fiscal Year 2009.** Each state's allotment level for fiscal year 2009 will be set at 110 percent of the highest of:
 1. A state's fiscal year 2008 spending, adjusted for health care inflation and child population growth;^{4,5}
 2. A state's fiscal year 2008 allotment, adjusted for health care inflation and child population growth; or
 3. A state's projected spending of federal CHIP funds in fiscal year 2009, as reflected in February 2009 projections.⁶

These options plus the 10 percent add-on is designed to assure every state can receive additional federal funds to reach a greater share of already-eligible children, improve benefits, or expand coverage. (See table 4, page 8, for state-specific allotments.)

- **Fiscal Year 2010.** In general, a state's fiscal year 2010 allotment will equal its fiscal year 2009 allotment, adjusted for health care inflation and child population growth. If the state relies on the "child enrollment contingency fund" (see page 6) in fiscal year 2009, this spending also will be built into its fiscal year 2010 allotment. For example, a state with an allotment of \$100 million in fiscal year 2009 that also uses \$10 million from the child enrollment contingency fund will receive an allotment of \$110 million, adjusted for health care inflation and child population growth, in fiscal year 2010. In addition, as described on page 6, CHIPRA allows states with approved plans to expand eligibility or benefits to request an adjustment in their 2010 allotments to account for the added costs.
- **Fiscal Year 2011.** To ensure that limited CHIP funds are directed to states that will use them, in fiscal year 2011 (and again in fiscal year 2013), a state's allotment will be updated ("re-based") to reflect its actual use of CHIP funds. For example, when allotments are set for fiscal year 2011, a state that used only \$80 million of a \$100 million allotment in fiscal year 2010 will receive an allotment in fiscal year 2011 of only \$80 million adjusted for health care inflation and child population growth. When updating or "re-basing" allotments in fiscal year 2011 (and again in fiscal year 2013), the CHIP law calls for taking into account all of a state's spending on CHIP—including spending out of a state's allotments from earlier years, redistributed funds from other states, and the child enrollment contingency fund—and updating it for health care inflation and child population growth.
- **Future Fiscal Years.** In 2012, each state will receive an allotment equal to its fiscal year 2011 allotment plus funding provided by the child enrollment contingency fund (if any), adjusted for health care inflation and child population growth. (The adjustment for approved eligibility or benefit expansions can also be applied in 2012.) Fiscal year 2013 is slated to be another re-basing year in which states will be eligible to receive an amount equal to their CHIP spending from all sources in 2012, adjusted for health care inflation and child population growth.

⁴ The health care inflation adjustment for a given fiscal year's allotment is based on the projected increase in the national per capita amount of health care expenditures in the preceding calendar year, as measured by the National Health Expenditures Survey. For example, the inflation adjustment for fiscal year 2010 is based on the increase in projected national per capita expenditures on health care between calendar year 2008 and 2009.

⁵ The adjustment for child population growth for a given year's allotment is based on the percentage increase, if any, in a state's child population from July 1st of the preceding fiscal year to July 1st of the specified fiscal year, according to Census Bureau data. For example, the adjustment used to determine fiscal year 2010 allotments will be based on a state's projected child population growth between July 1, 2009 and July 1, 2010.

⁶ As noted, these spending needs will be based on states' February 2009 projections and certified by the Secretary of HHS by March 31, 2009. CHIPRA also includes a provision specifically allowing a group of "qualifying" states (see page 7) to submit revised projections after February 2009 to reflect any additional need for CHIP funding based on changes in CHIPRA that allow these states to receive CHIP funding for certain Medicaid-eligible children.

Table 3: State Allotment Formula (FY 2009 – FY 2013)

	Fiscal Year 2009	Fiscal Year 2010	Fiscal Year 2011	Fiscal Year 2012	Fiscal Year 2013
Overview	Initial allotment.	Prior year's allotment, adjusted.	Re-basing year.	Prior year's allotment, adjusted.	Re-basing year.
Base Allotment¹	110% of the highest of: • FY 2008 allotment; • FY 2008 spending; • FY 2009 spending projections ²	FY 2009 allotment plus contingency fund payments in FY 2009.	Allotment "rebased" to reflect state's actual use of CHIP funds from all sources in FY 2010 ⁶	FY 2011 allotment plus contingency fund payments in FY 2010.	Allotment "rebased" to reflect state's actual use of CHIP funds, from all sources in FY 2012. ⁶
Base Adjustment	A standard adjustment for health care inflation and child population growth is made each year. ³				
Special Adjustment	Qualifying" states can submit revised projections. ⁴	Allotment increase available for states with approved plans to expand eligibility or benefits. ⁵		Allotment increase available for states with approved plans to expand eligibility or benefits. ⁵	

[1] States have 2 years to spend their allotments.

[2] Based on a state's projected spending submitted to HHS in February 2009 and certified by HHS by March 31, 2009.

[3] For FY 2009, the health care inflation and child population growth adjustments are not applied to state's using FY 2009 spending projections, as it is assumed that states will have built that into their projections.

[4] Qualifying states can now use CHIP funds for pre-CHIP Medicaid expansions; revised projections can be submitted after February 2009.

[5] Adjustments for expansions (in FY 2010 and FY 2012) are allowed for plans that become effective during or after FY 2010; request for adjustments must be submitted to HHS by August 31st before the start of the fiscal year.

[6] Sources can include spending out of a state's allotment from earlier years, redistributed funds from other states, and the contingency fund.

- **Adjustments for States with Expansions.** CHIPRA allows states with approved plans to expand eligibility or benefits to receive an increase in their allotments, but states can request the adjustments only for fiscal years 2010 and 2012. Requests for adjustments must be submitted to HHS by August 31st before the start of the fiscal year.
- **Child Enrollment Contingency Fund.** To promote more stable funding and reduce the need for Congress to act to fill CHIP funding shortfalls in the future, CHIPRA establishes the child enrollment contingency fund. It is financed through separate appropriations set at 20 percent of the national allotment (although the funding does not come out of the national allotment). The contingency fund can grow no larger than an amount equal to 20 percent of the national allotment, and any funds in excess of this amount will be applied to the performance bonuses described below. The contingency fund provides states with additional money if they face a CHIP funding shortfall⁷ and their enrollment of children exceeds a target level. Specifically, a state with a shortfall will receive a per capita⁸ federal payment for each child it enrolls above the target level.⁹

As noted, a state's use of child enrollment contingency funds is built into its future allotments. If the funding available through the contingency fund is not adequate to cover the additional funds needed by the states, the amounts will be reduced proportionally.

⁷ For purposes of the child enrollment contingency fund, a state is considered to be in shortfall if it does not have enough federal matching funds—excluding redistributed funds—to finance its CHIP program.

⁸ The size of a state's per capita federal payment is set at average per capita spending for children in CHIP in fiscal year 2008, adjusted over time for health care inflation and changes in a state's CHIP matching rate.

⁹ In fiscal year 2009, the target enrollment level for the child enrollment contingency fund is based on a state's average monthly enrollment of children in CHIP in fiscal year 2008, increased by the state's child population growth plus one percentage point. In future years, the target enrollment level is based on a state's target enrollment level in the previous fiscal year, adjusted by the state's child population growth plus one percentage point.

- **Redistribution of Unused CHIP Funds.** To help ensure that CHIP funds are sent to the states that need them for children's coverage, the law reduces the period during which a state can use an annual CHIP-allotment from three to two years, beginning with the fiscal year 2009 allotments. Unlike in the past when it largely was left to the discretion of the Secretary of HHS to decide how to redistribute unused CHIP funds, the law outlines a process and timeline for redistributing funds to states facing a CHIP funding shortfall. For purposes of redistribution, a shortfall state is defined as having projected expenditures in a fiscal year that will exceed funding available from current and prior-year allotments in addition to any contingency fund payments.

After addressing shortfall states, any remaining unspent allotments are used to finance performance bonuses (discussed on page 10). If the amount of total funds available for redistribution is less than what is needed by shortfall states, each state will receive a proportional share of available funding.

- **Treatment of States with Significant Medicaid Expansions Pre-CHIP ("Qualifying States").** The states that significantly expanded Medicaid coverage for children prior to the enactment of CHIP in 1997 are given more flexibility under the law to use CHIP funds for these Medicaid expansions. It allows these states to use funds from their fiscal year 2009 through 2013 CHIP allotments to draw down the difference between the Medicaid match rate and the enhanced matching rate for children in Medicaid with family income above 133 percent of the federal poverty level (FPL). (Previously, states were limited to using no more than 20 percent of any allotment for children in Medicaid with family income above 150 percent of the FPL.)

The new rules apply to expenditures made after February 4, 2009. As previously mentioned, qualifying states may submit new projections of their expected use of CHIP funds for purposes of establishing the size of their fiscal year 2009 allotments.

- **Treatment of the Territories.** The U.S. territories also receive a share of the national allotment each year. In fiscal year 2009, the amount that they receive will be determined by taking the highest annual federal payment that each received in any fiscal year between fiscal year 1999 and 2008, and adjusting it for fiscal year 2009 by child population growth and health care inflation. In future years, the allotments for territories will continue to be adjusted by these same two factors.
- **Financing Presumptive Eligibility.** The law fixes a technical problem with financing for Medicaid's existing presumptive eligibility option. It eliminates a requirement that states count Medicaid child presumptive eligibility costs against a state's CHIP allotment.
- **State option to decide whether to use CHIP or Medicaid funds to cover eligible children.** CHIPRA clarifies that states can decide whether they want to use Medicaid or CHIP funds for children covered under a Medicaid expansion for which a state could receive CHIP funds. While this has been the practice in the past, the clarification addresses recent CMS decisions suggesting states must use CHIP funds in such circumstances, including when they are seeking to move some children from CHIP to Medicaid coverage to address a pending shortfall in CHIP funding.

TABLE 4: PROJECTED FY2009 STATE CHIP ALLOTMENTS, IN MILLIONS

State	Projected Federal CHIP Spending for All of FY2009	Projected Allotments Under CHIPRA 2009 ¹
Alabama	\$126.9	\$139.5
Alaska	\$20.3	\$22.3
Arizona	\$122.9	\$171.2
Arkansas	\$94.2	\$133.5
California	\$1,297.3	\$1,481.2
Colorado	\$82.8	\$97.5
Connecticut	\$29.0	\$45.6
Delaware	\$10.9	\$15.0
District of Columbia	\$10.0	\$14.2
Florida	\$319.4	\$358.4
Georgia	\$267.5	\$294.2
Hawaii	\$13.9	\$20.8
Idaho	\$41.2	\$45.3
Illinois	\$262.1	\$344.4
Indiana	\$98.3	\$120.4
Iowa	\$62.2	\$68.4
Kansas	\$53.2	\$58.5
Kentucky	\$108.7	\$119.6
Louisiana	\$188.8	\$207.7
Maine	\$33.1	\$39.3
Maryland	\$165.8	\$184.2
Massachusetts	\$302.4	\$332.6
Michigan	\$86.5	\$203.4
Minnesota	\$45.6	\$84.1
Mississippi	\$167.0	\$183.7
Missouri	\$117.6	\$129.3
Montana	\$29.5	\$32.4
Nebraska	\$38.0	\$41.8
Nevada	\$29.6	\$61.4
New Hampshire	\$14.5	\$15.9
New Jersey	\$452.5	\$497.8
New Mexico	\$178.4	\$196.2
New York	\$355.6	\$391.2
North Carolina	\$223.4	\$245.7
North Dakota	\$15.5	\$17.1
Ohio	\$267.0	\$293.7
Oklahoma	\$131.1	\$144.2
Oregon	\$75.8	\$83.4
Pennsylvania	\$284.1	\$312.5
Rhode Island	\$58.8	\$69.5
South Carolina	\$141.8	\$156.0
South Dakota	\$15.4	\$18.4

Tennessee	\$125.8	\$138.4
Texas	\$859.7	\$945.6
Utah	\$59.5	\$65.4
Vermont	\$4.8	\$6.7
Virginia	\$159.7	\$175.6
Washington	\$40.6	\$94.0
West Virginia	\$36.9	\$43.3
Wisconsin	\$71.7	\$88.5
Wyoming	\$10.2	\$11.2
STATE TOTAL ²	\$7,807.5	\$9,060.2

Source: C. Peterson, "Projections of FY2009 Federal SCHIP Allotments Under CHIPRA 2009," Congressional Research Service (January 15, 2009); and C. Peterson, "What Happens to SCHIP After March 31, 2009?," Congressional Research Service (December 19, 2009).

[1] The estimates reported are based on CRS's analysis, including projections provided by the states in November 2008. Allotments under CHIPRA 2009 could be based on updated projections submitted in February 2009. As a result, for those states whose allotments are based on projected need, the actual allotments may differ from those presented here.

[2] Total allotments shown include state allotments only; allotments for territories are not shown.

B. Reaching Eligible But Unenrolled Children

With six million uninsured children¹⁰ in the country already eligible for Medicaid or CHIP, CHIPRA includes a number of policies aimed at reaching these children. Specifically the law provides states with a combination of new funding incentives and increased flexibility to eliminate enrollment roadblocks, as described below.

- **Performance Bonuses.** CHIPRA includes new performance bonuses to encourage states to enroll more of the uninsured children who are already eligible for Medicaid for the period 2009-2013. States that implement specified enrollment and renewal procedures (see below) and increase enrollment of these children above a target level receive a federal payment for each extra child enrolled to help defray the added cost of successful efforts. The size of the payment can vary from 15 to 62.5 percent of the average cost to a state of covering a child, depending upon the extent to which a state's enrollment exceeds target levels. The target level is based on fiscal year 2007 enrollment in Medicaid, adjusted over time by annual growth in a state's child population plus an additional percentage (4 percentage points through 2009; 3.5 percentage points for 2010, 2011, and 2012; 3 percentage points for 2013, 2014, and 2015; and 2 percentage points in future years).
- **Performance Bonus Simplification Conditions.** To qualify for the performance bonus payments described above, a state must implement, throughout the fiscal year, at least five of eight measures for simplifying enrollment and renewal procedures in CHIP and Medicaid for children. These measures may not be the only steps a state will want to take to assure that it reaches enrollment targets, but the adoption of five of these measures is a pre-condition to qualifying for the bonus payments. Further guidance is needed from CMS on how some of the performance measures will be defined, but the law outlines the measures as:
 1. Adopt 12-month continuous eligibility for all children;
 2. Eliminate the asset test for children. A state can also meet this requirement by allowing applicants to self-certify their assets or resources or by verifying assets by other means that do not require the family to provide unnecessary documentation;
 3. Eliminate in-person interview requirements at application and renewal;
 4. Use joint applications and supplemental forms and the same application and renewal verification process for the two programs;
 5. Allow for administrative or paperless verification at renewal through the use of pre-populated forms or ex parte determinations (when a state uses information available to it through other databases to verify ongoing eligibility);
 6. Exercise the option to use presumptive eligibility when evaluating children's eligibility for coverage;
 7. Exercise the new option in the law to use Express Lane (described on page 11); and
 8. Exercise the new options in the law in regard to premium assistance (described on page 16).
- **Outreach Funding.** CHIPRA includes a number of provisions increasing outreach funding and activities to enroll eligible but uninsured children in coverage, with a particular focus on those who may be the hardest to reach. The law allocates \$100 million for fiscal years 2009 through 2013 to support Medicaid and CHIP outreach and enrollment activities. It provides guidelines on how the funding will be allocated but also gives the Secretary of HHS wide discretion on implementation. The initiative includes:
 - **National Enrollment Campaign:** \$10 million (out of the \$100 million) will be dedicated to a national campaign to improve the enrollment of children in CHIP and Medicaid. The Secretary of HHS will develop and implement the campaign, however, the law provides examples of what the campaign may include: partnerships with the Secretaries of Education and Agriculture (which administer other public programs that serve low-income children) in order to link eligibility and enrollment systems for these programs and to conduct joint public awareness initiatives; public health awareness campaigns; increased financial and technical support for enrollment hotlines; and the development of outreach materials for targeted populations.
 - **Outreach and Enrollment Grants:** HHS will award \$90 million (out of the \$100 million) to state and local governments and other eligible organizations—which include federally-qualified health centers, disproportionate share hospitals, federal public programs that serve children (such as WIC or school lunch), faith-based organizations, community-based groups, or schools—to conduct outreach campaigns. The law does not provide information on the

¹⁰ Kaiser Family Foundation, "Health Insurance Coverage in America: 2007," (October 2008).

parameters of the grants (such as the timing, the number to be awarded, and the award amounts). However, entities will apply for the grants through an application process, to be determined the Secretary of HHS, and priority will be given to campaigns in geographic areas with high rates of: eligible but unenrolled children (including children who reside in rural areas) and “racial and ethnic minorities and health disparity populations.”

In addition, \$10 million of the \$90 million will be dedicated to grants targeting Native American children that will be awarded to Indian Health Service providers and organizations serving Native Americans in urban areas.

These outreach funds do not require a state match. However, in order to encourage new outreach efforts and not supplant state funding, a state receiving a grant must maintain the funding level it spent for outreach and enrollment activities in the previous fiscal year. The Secretary must submit an annual report on the outreach activities conducted through the grants and publish enrollment data reported by the grantees.

- **Native American Children Outreach.** In addition to the grants targeting Native American children described above, the law requires the Secretary of HHS to encourage states to increase efforts to enroll Native American children in Medicaid and CHIP and to facilitate cooperation and/or agreements between states and the Indian Health Service, Indian tribes, tribal organizations and urban Indian organizations. To assist states in these efforts, the law excludes the costs for such outreach to potentially Medicaid- or CHIP-eligible Native American children from the 10 percent cap on non-benefit expenditures under CHIP.

In addition, the law makes explicit that CHIP outreach funds can be used for activities conducted by community health workers.

- **Translation and Interpreter Services.** CHIPRA also provides an enhanced matching rate in CHIP and Medicaid for translation and interpretation services for children for whom English is not the primary language. For CHIP, the enhanced matching rate will equal the highest of 75 percent or the state’s current enhanced match rate plus 5 percentage points. For Medicaid, the matching rate will equal 75 percent. The enhanced match is available to states providing translation and interpretation services when an individual enrolls in coverage, renews coverage, and utilizes coverage.
- **Express Lane Option.** Currently, a high number of uninsured Medicaid- and CHIP-eligible children are enrolled in other public programs. The new law provides states with new tools and flexibility for reaching and enrolling these children. While CMS guidance will be needed as states begin to implement the Express Lane provisions, in general, the new option:
 - **Gives states the opportunity to use relevant findings from other public programs**, like school lunch, food stamps, and WIC, when determining children’s eligibility for CHIP and Medicaid at enrollment or renewal. For example, if the school lunch program has determined that a child is at 100% of the FPL the state can use that determination, without re-computing income or requiring the family to resubmit or re-verify the information, to determine that the child is income-eligible for Medicaid. A state must still follow Medicaid and CHIP rules when verifying someone’s citizenship status. When verifying an element of Medicaid or CHIP eligibility provided through another public program or agency, the state does not have to obtain the applicant’s signature under penalty of perjury for that specific component of eligibility.

If a finding from another public program results in a child being found ineligible for Medicaid or CHIP, the state is required to make a regular determination.

- **Outlines enrollment procedures states can take to meet “screen and enroll” rules under Express Lane.** While states can rely on income determinations from other programs, they will still need to assess whether a child’s income makes them eligible for CHIP or Medicaid. One option is for states to establish an income eligibility “screening threshold”¹¹ in which a child under that level can be deemed Medicaid-eligible and a child above can be deemed CHIP-eligible, with the state receiving the corresponding matching rate.¹² Another option is for states to temporarily enroll a child in CHIP based on the other program’s finding pending an eligibility determination; however, the state must simplify the process for families by not seeking information that is already available to the state. The state will receive the CHIP matching rate for these children during the temporary enrollment period.

¹¹ The screening threshold would be set as a percentage of the FPL that exceeds the highest income eligibility threshold under Medicaid by a minimum of 30 percentage points (or, at state option, by a higher number that reflects the differences in income methodologies used by the other public program versus Medicaid).

¹² For a child deemed CHIP-eligible under this process, the state must notify the family that the child might be Medicaid-eligible if he or she was evaluated using the state’s regular determination process, and must allow the family to seek a new determination as a result.

- **Allows states to automatically enroll a child in Medicaid and CHIP.** Children can be enrolled without an application if information required to make an eligibility determination can be obtained from other data sources. A family's affirmative consent will be required. Affirmative consent can be obtained in writing, by telephone, orally, through electronic signature, signature on another program's application, or by other means allowed by the Secretary of HHS. A state must also provide the family with information on the program, including cost sharing requirements.
- **Increases states' ability to access other public program databases** by authorizing relevant federal, state, or private entities to share information with a Medicaid and CHIP agency, with some restrictions on use of the data. In addition, for those states implementing Express Lane, the law allows the Medicaid and CHIP agency to receive data from the National Directory of New Hires, or other relevant sources.
- **Assures that program integrity standards take the new option into account**, by establishing new error rate procedures for monitoring eligibility determinations under Express Lane. In addition, the law requires the Secretary of HHS to conduct an evaluation of the program by the end of fiscal year 2012.
- **Citizenship Documentation Requirement.** The Deficit Reduction Act of 2005 (DRA) added a new requirement for children, parents, and pregnant women who declare that they are citizens or nationals. Under the DRA, they must meet new, tightly prescribed and paperwork-intensive rules to document their citizenship. (The rules mostly affect children, parents, and pregnant women; nearly all seniors and people with disabilities are exempt.) Non-citizen applicants have always had to provide documentation of their immigration status.

Reports by the Government Accountability Office (GAO), the Congressional Research Service, and numerous states have shown that tens of thousands of eligible U.S. citizen children have been removed from, or denied entry into, Medicaid as a result of the citizenship documentation requirement.

CHIPRA gives states a new way to comply with the citizenship documentation requirement while also extending the requirement to CHIP. The new option, effective January 1, 2010:

- Allows states to document citizenship by submitting the names and Social Security Numbers (SSNs) of individuals declaring they are citizens or nationals to the Social Security Administration (SSA).
- If SSA finds that the name, the SSN, or that the applicant's declaration of citizenship or nationality is inconsistent with its records, the state must make a reasonable effort to address the discrepancy while providing coverage to the otherwise eligible individual.
- If the issue is not resolved by the state, individuals have 90 days to document their citizenship or fix the problem with SSA. If not resolved, they will be dis-enrolled within 30 days following the 90-day period.
- To assist states with implementing this option, the law allows states to enter into an agreement with SSA to submit the names and SSNs of enrollees electronically. States will receive an enhanced match for the development (90 percent match) and maintenance or operation (75 percent match) of such an electronic system. For CHIP purposes, the law excludes costs expended to comply with the citizenship verification requirements against the 10 percent cap on non-benefit expenditures.
- If a state does not implement the new option through an electronic system (described above), the law includes requirements for states if the average monthly percentage of invalid names and SSNs is greater than three percent. A name or SSN will only be considered "invalid" if: the name or SSN does not match SSA records; the state or applicant could not resolve the inconsistency; and the state made expenditures related to this individual. If the state still has a monthly average percentage that is greater than three percent, the state must develop and adopt a corrective plan and reimburse certain expenditures. However, the Secretary of HHS may waive all or part of the payment if the state is unable to reach the allowable error rate despite a good faith effort by the state. These provisions do not apply to a state implementing the new option through an electronic system.

CHIPRA also makes some important changes in the existing citizenship documentation requirement that are effective immediately:

- Individuals who meet other eligibility requirements must be provided benefits while they are proving their citizenship.
- Newborns who currently automatically receive Medicaid coverage based on their mother's eligibility at the time of birth no longer have to document their citizenship after that year of eligibility ends.
- Native American tribes will have new ways to meet citizenship documentation requirements.
- **State Reporting.** The law requires states to include in their annual reports data to help assess enrollment and retention efforts, including data on continuity of coverage, denials of eligibility at both the application and renewal stages, and children's access to care. It also requires states to provide more timely Medicaid and CHIP enrollment data to the Secretary of HHS and to include in their CHIP state plans a description of state activities to reduce administrative barriers to enrollment and renewals. The Secretary will provide (by February 4, 2010) a standardized format for states to report the new data and the states will be given up to three reporting periods to transition to the new requirements (state annual reports are due January 1st following the end of the fiscal year).

The law also allocates \$5 million in fiscal year 2009 to the Secretary of HHS to improve its Medicaid Statistical Information System (MSIS) to provide timely enrollment and eligibility data. By October 1, 2009, annual MSIS data must be collected and analyzed by the Secretary within six months of state submission.

- **Other Outreach and Enrollment Provisions.** The law includes some other provisions related to health insurance coverage and reaching eligible but uninsured children:
 - Reaffirms that an **electronic signature meets Medicaid or CHIP signature requirements.**
 - As discussed above in the Express Lane option, **increases the ability for all states to access other public program databases** by authorizing relevant federal, state, or private entities to share such information with a Medicaid and CHIP agency, with some restrictions on the use of the data.
 - Requires states to provide a **30-day premium payment grace period** under CHIP (for new coverage periods beginning on or after January 4, 2009) before terminating a child's coverage and to provide a notice to families within seven days of the possible termination and their right to appeal.
 - Establishes a task force, consisting of the Small Business Administration and the Secretaries of HHS, Labor, and Treasury, to conduct a **nationwide campaign of education and outreach for small businesses** regarding the availability of health coverage for children (including private, Medicaid, and CHIP).
 - Requires the Secretary of HHS to develop a **model process (and report to Congress) for the coordination of enrollment, retention, and coverage of children who frequently change their state residency** due to migration or emergency evacuations.

C. Eligibility Rules for Children and Pregnant Women

CHIPRA retains the flexibility states have to set the income levels for children under CHIP (although it establishes a change in the matching rate for coverage of the more moderate-income children) and provides states with new options for covering pregnant women and legal immigrant children. These new eligibility rules follow.

- **Income Rules.** Since CHIP was first enacted, federal law has accorded states the flexibility to set the income levels for the children they will cover, subject to available federal and state resources. A directive issued by CMS on August 17, 2007¹³, attempted to constrain that flexibility by requiring states to meet nearly impossible hurdles before they could cover children with gross incomes above 250 percent of the FPL. President Obama rescinded that directive on the same day he signed CHIPRA into law.

The new law includes a compromise provision that maintains the longstanding state flexibility to set income levels, but lowers the matching rate (to the Medicaid rate) for states that propose to cover children over 300 percent of the FPL. (Note that the 300 percent FPL level is based on net, not gross income, although states cannot use so-called “block of income” disregards to circumvent the new match rate limitation.)

Two states (New Jersey and New York) that already cover children above 300 percent of the federal poverty level can receive the enhanced CHIP matching rate for continuing this coverage.

- **Legal Immigrant Children and Pregnant Women.** CHIPRA gives states a new option to provide Medicaid and CHIP coverage to lawfully residing immigrant children and pregnant women during their first five years in the country, if otherwise eligible. Prior to CHIPRA, states were prohibited from providing federally-funded Medicaid and CHIP coverage to legal immigrant children and pregnant women during their first five years in the country, although they could provide coverage after the five years. About 18 states made the decision to provide this coverage anyway, using state funding to cover the costs. The new provision allows all states the option to receive federal funding to provide Medicaid and CHIP coverage to legal immigrant children and pregnant women, without requiring them to wait five years after entry.

For those enrolled under this provision, the law requires states to verify at renewal (using information obtained at application) that the individual continues to be lawfully residing in the country. If the state cannot use the information that it already has on hand from the initial application process to do so, it must require the person to provide documentation or other evidence of legal residency status.

- **Pregnant Women.** For the first time, the law gives states the option to cover pregnant women with CHIP funds by submitting a state plan amendment; no waiver will be required. States can use this option to cover pregnant women (through 60 days postpartum) up to but no higher than the state’s income eligibility level for children, subject to the following:
 1. The state must be covering children up to at least 200 percent of the FPL and cannot limit enrollment or impose a waiting list for children;
 2. It must cover pregnant women in Medicaid up to at least 185 percent of the FPL, and, to avoid supplantation of CHIP for Medicaid, the state cannot reduce its Medicaid eligibility level for pregnant women below the level in effect on July 1, 2008;
 3. The state cannot cover higher income pregnant women without covering lower income women and cannot impose pre-existing conditions or have waiting periods before a pregnant woman can be covered.

The coverage must generally conform to the CHIP cost sharing and benefit rules applicable to children, but in addition it must include prenatal, delivery, and postpartum care.

States may use the presumptive eligibility option to allow pregnant women who appear to be eligible to receive care pending a final eligibility determination. Similar to Medicaid law, the children born to women receiving pregnancy-related assistance through this option shall be deemed enrolled in CHIP until the child turns one. (No separate enrollment is necessary.) The law retains existing authority for states to cover pregnant women through the “unborn child” option.

- **Undocumented Immigrants.** The law includes language that restates current law that no federal funding will be allocated to immigrants who are not in the country legally.

¹³ Centers for Medicare and Medicaid Services, Dear State Health Official, SHO #07-001, August 17, 2007. See <http://ccf.georgetown.edu/index/cmsdirective> for background information on the directive.

D. Coverage Of Parents and Adults

Over the years several states have been given authority through section 1115 waivers to cover parents and other adults with CHIP funds. The Deficit Reduction Act of 2005 stopped all new childless adult waivers (other than those covering pregnant women) and since 2007, the Secretary of HHS has not approved any new parent waivers or renewed any CHIP-funded adult coverage waivers that were about to expire. Currently, 11 states have such waivers.¹⁴ The new law ends these waivers, but provides some transition funding outside of CHIP.

- **Parents.** CHIPRA prohibits HHS from approving any new waivers to cover parents with CHIP funds. Coverage of parents in the eight states that currently have such waivers can continue without change through the end of fiscal year 2011 (states with waivers that expire before October 1, 2011 can apply to receive an extension through September 30, 2011). For 2012 and 2013, federal funding for these parent waivers is moved out of CHIP and financed through separate capped allotments (allotment amounts are based on 110 percent of a state's projected expenditures under its waiver). If a state achieves specified child coverage benchmarks,¹⁵ it can receive the enhanced matching rate under the separate capped allotments for parent coverage in fiscal year 2012 and a lower, modified enhanced matching rate in fiscal year 2013. (The modified rate is mid-way between the CHIP matching rate and the Medicaid matching rate.) If the benchmarks are not met, states are limited to receiving the regular Medicaid matching rate for these parents out of the separate allotment.

The law also requires the GAO to conduct a study and provide recommendations to Congress, by February 4, 2011, on whether coverage of parents under the waivers increases enrollment or quality of care for children.

- **Childless Adults.** CHIPRA restates the existing ban on new waivers that allow CHIP funds to be used for childless adults, and it ends federal financial participation through CHIP for the three existing childless adult waivers after December 31, 2009. States with waivers that expire before January 1, 2010, must request (by September 30, 2009) to receive an extension through the end of 2009. In 2010 and beyond, states can apply for a section 1115 Medicaid waiver to cover these "grandfathered" childless adults; HHS is permitted—but not required—to approve the waivers. Waiver budget neutrality standards would be tied to spending in the previous year.

¹⁴ "Parent and Adult Coverage Waivers in SCHIP," Center for Children and Families, February 13, 2009.

¹⁵ To receive the enhanced match rate in 2012, a state must 1) have been awarded an outreach grant, have submitted an outreach plan, or have implemented one of the measures that are preconditions to receiving a performance bonus (discussed on page 10); 2) rank among the top one-third of states in terms of having the lowest uninsurance rates among low-income children; or 3) qualified for the performance bonus (discussed on page 10). The standards are more stringent in 2013: a state must have qualified for the enhanced match rate in 2012 and meet the conditions in either (2) or (3) above.

E. Premium Assistance

Over the years, states have sought ways to better coordinate public and private coverage, including the implementation of premium assistance programs (when a state subsidizes employer coverage with public dollars). CHIPRA includes new rules and options for states implementing these programs.

- **New options for CHIP and Medicaid.** The law reduces barriers for states to provide subsidies for the purchase of employer-sponsored coverage (ESI) by allowing states to include the cost of covering parents in assessing the cost-effectiveness of providing premium subsidies to CHIP-eligible children¹⁶. States must also include administrative costs in the cost-effectiveness test when comparing the cost of subsidizing ESI versus direct coverage.

Coverage that can be subsidized must meet some conditions: 1) employers must contribute 40 percent of the cost; 2) the benefit package must meet an actuarial equivalency test to the CHIP coverage or children are eligible for supplemental benefits and cost-sharing protections; and 3) subsidies may not be used to purchase high deductible plans and/or benefits provided under flexible health spending accounts. Participation must be voluntary and children must be permitted to “opt-out” by moving back into direct coverage at the end of any month. Waiting periods are not required, but states that otherwise have waiting periods in their CHIP programs must apply those same waiting periods to their premium assistance programs.

- **Coordination between Public and Private Coverage.** The law amends federal Employee Retirement Income Security Act (ERISA) law to promote coordination between public and private coverage by establishing that both the loss or gain of Medicaid or CHIP coverage counts as a “qualifying event” for the purposes of being able to enroll in employer-sponsored coverage. These provisions are intended to do two things: 1) in the case of a family that loses its Medicaid or CHIP coverage because its employment situation improves and the family is over-income, the family can sign up for their employer-sponsored coverage without having to wait for the open enrollment period and experiencing a gap in coverage; and 2) in the case of a child that becomes eligible for Medicaid or CHIP and has access to ESI which the state wishes to subsidize through a premium assistance option, the family may sign up immediately and not have to wait for the open enrollment period. Employers must also share information about their benefits packages at state request to allow states to assess cost effectiveness and the need for supplemented services.

The law also encourages outreach on premium assistance by lifting the 10 percent cap on non-benefit expenditures under CHIP to 11.25 percent if the money is used for this purpose, authorizes the development of model notices about premium assistance for employers by the federal government, and establishes a working group to develop these notices and identify impediments to the effective coordination of public and private coverage. In addition, the law mandates the GAO to conduct a study on state premium assistance programs by January 2010.

- **New “Buy-in” Option.** CHIP gives states the option to establish a purchasing pool for employers with fewer than 250 employees and at least one employee who is CHIP-eligible or has a CHIP-eligible child and/or families wishing to purchase coverage. The purchasing pool must offer at least two CHIP benchmark or benchmark-equivalent products. States can provide CHIP-funded subsidies for premium costs for those eligible for CHIP.

¹⁶ The law also creates a new child-only Medicaid premium assistance option that is similar to the existing Medicaid premium assistance option.

F. Benefits and Access

CHIPRA makes substantial improvements to the benefits provided to children through CHIP, including a new requirement that CHIP plans include dental coverage, which is a high need for many low-income children.

- **Dental Coverage Requirement.** CHIPRA requires CHIP plans, starting October 1, 2009, to include coverage of dental services. A state has the option to meet this requirement by providing coverage that is equivalent to benchmark dental benefit standards available under the following dental benefit plans:
 1. A Federal Employees Health Benefits Plan that has been selected most frequently by employees seeking dependent coverage in either of the previous two plan years;
 2. A state employees benefit plan that has been selected most frequently by employees seeking dependent coverage in either of the previous two plan years; or
 3. A commercial dental benefit plan in the state that has the largest non-Medicaid enrollment of dependents.

The law also includes provisions for dental services through Federally-Qualified Health Centers (FQHCs) and dental education for parents of newborns. It requires the Secretary of HHS to provide information on dental services for children by publishing provider lists and covered dental services under Medicaid and CHIP through the Insure Kids Now web site and hotline. States are also required to provide information on dental coverage for children in their annual CHIP reports and the GAO must conduct a study, by August 4, 2010, on children's access to oral health care, including preventive and restorative services under Medicaid and CHIP.

- **Supplemental Dental-Only Coverage.** In general, states cannot use CHIP funds to provide coverage or cost sharing help to children who have other insurance. The new law makes an exception with respect to dental coverage. The law allows states to provide dental-only supplemental coverage or cost-sharing protections for dental coverage to otherwise eligible children who have group health insurance or health insurance through an employer. A state can determine at what income level children are eligible for this benefit, but the income limit cannot exceed the state's CHIP income level. To participate, a state must also meet certain criteria related to its CHIP program, including not limiting (through an enrollment cap or waiting list) enrollment of children in its regular CHIP plan. The law also allows the state to waive any waiting period it has in place for children receiving this benefit option.
- **Mental Health Parity.** The law does not require mental health services in CHIP, but it does require that if a state provides mental health or substance abuse services through CHIP that the financial requirements and treatment limitations for those benefits not be more restrictive than those for medical and surgical benefits. CHIP plans that include Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services will satisfy this requirement.
- **Medicaid and CHIP Access Commission.** Establishes a Medicaid and CHIP Payment and Access Commission (MACPAC), similar to Medicare's MedPAC, to evaluate children's access to care in addition to payment policies in Medicaid and CHIP. The commission will make annual recommendations to Congress, the first set due by March 1, 2010.
- **CHIP Payment Rules.** Requires CHIP, effective October 1, 2009, to reimburse FQHCs and Rural Health Clinics based on Medicaid's payment system (and allocates \$5 million to states for the transition). The Secretary of HHS will report to Congress by October 1, 2011, on the impact of the new payment system on access to benefits, provider payment rates, and scope of benefits.
- **School-Based Health Centers.** The law clarifies that effective immediately states can provide covered benefits and services under CHIP through school-based health centers.
- **EPSDT Services in Medicaid.** CHIPRA makes a technical fix to the DRA of 2005 to clarify that EPSDT services must be provided as part of benchmark benefit packages for children under Medicaid.

G. Child Health Quality

To date, the federal government has led efforts to improve health care quality outcomes in Medicare for adults, but has not done the same for children's health quality. CHIPRA implements a major child health quality initiative that establishes a leadership role for the federal government in ensuring children receive quality and stable coverage through the following provisions.

- **Funding for Child Health Quality.** CHIPRA provides \$225 million over fiscal years 2009 through 2013 for child health quality improvements in accordance with the measures outlined below.
- **Core Child Health Quality Measures.** By January 1, 2010, the Secretary of HHS will develop, test, and disseminate a core set of child health measures that address the quality and stability of children's coverage for use by state Medicaid and CHIP programs and contracting managed care entities. The core set of child health quality measures must include, but are not limited to:
 - Duration of children's health insurance coverage over a 12-month period;
 - Availability and effectiveness of a full range of preventive services, treatments, and services for acute conditions, and treatments for physical and mental conditions;
 - Availability of care in ambulatory and inpatient health care settings; and
 - Types of measures that can be used to estimate the national quality of health for children.

In addition, the Secretary of HHS must provide assistance to states by:

- Developing (by February 4, 2011) a standardized reporting format for states that encourages their use of the core quality measures (states are required to report on child health quality measures, see below, but are not required under the law to use the core set of measures designed by HHS in doing so);
- Providing information on best practices for measuring and reporting on the quality of health care for children, and facilitate the adoption of such best practices; and
- Providing technical assistance to assist them in adopting and utilizing child health quality measures.

The law requires that HHS report to Congress, by January 1, 2011, and every three years after, on the status of its efforts to improve the quality of children's health in Medicaid and CHIP, and the status of states utilizing the core quality measures for reporting purposes.

- **Pediatric Quality Measures Program.** By January 1, 2011, the Secretary must establish an ongoing program that advances and improves pediatric quality measures for all children. The program will:
 - Monitor and improve upon the initial core measures for children in Medicaid and CHIP that reflect the testing and development described below. Beginning January 1, 2013, and every year after, requires the Secretary to publish recommended changes;
 - Expand upon and increase existing pediatric measures used by public and private health care purchasers, including those that are evidence-based; and
 - Award grants for developing and testing pediatric quality measures.
- **State Reporting.** The law requires states to submit a child health quality report to HHS each year and that HHS make the information reported publicly available (no later than September 30, 2011, and annually thereafter). Most states will receive enhanced administrative funding in Medicaid for collecting and reporting on child health measures. Instead of the regular 50 percent administrative match, states will receive the matching rate they receive for providing services under Medicaid.
- **Demonstration Grants.** CHIPRA includes \$20 million annually for a demonstration project. HHS will provide grants to up to 10 states and child health providers to use and test child health quality measures and to promote the use of health information technology for children. The law also includes a separate allocation of \$25 million (not part of the \$225 million) in demonstration funding to combat obesity.



- **Studies.** Under CHIPRA, the Institute of Medicine will conduct a study, by July 1, 2010, on pediatric health and health quality measures. The GAO, by February 4, 2011, will also issue a report on children's access to care under CHIP and Medicaid and recommendations for improving such access.
- **Model Electronic Health Record.** The law requires HHS, by January 1, 2010, to establish a program to encourage the development of a model electronic health record format for children in Medicaid and CHIP.
- **Managed Care Standards Applied to CHIP.** The law applies Medicaid managed care standards, such as beneficiary protections and quality assurance standards, to CHIP. The requirements will be effective for health plan contract years beginning on or after July 1, 2009. The law also requires that by August 4, 2010 that the GAO report to Congress on the extent to which state Medicaid payment rates for managed care organizations are actuarially sound.

H. Other Provisions

CHIPRA includes a number of other provisions including:

- **Payment Error Rate Measurement (PERM).** The new law requires issuance of new PERM regulations (i.e., the regulations which require states to report on errors in claim payments and eligibility determinations in Medicaid). Among other things, it includes a requirement that the new regulations ensure that payment error rates do not interfere with the use of self-verification if a state is following federally-approved procedures. The final PERM regulations must be published within six months of the law's enactment (August 4, 2009).
- **Data and Evaluation.** The law provides \$20 million each year to the Census Bureau to improve the state-specific estimates of uninsured children available under the Current Population Survey and to explore using the American Community Survey for such estimates. In addition, the law requires a new federal evaluation of CHIP by December 31, 2011. The law also requires that the Secretary of HHS, Inspector General, and GAO be given access to any state records or information related to CHIP for any evaluations or audits they undertake.
- **Health Opportunity Accounts.** The law prohibits the Secretary of HHS from approving any new Health Opportunity Account demonstrations, which were provided for in the DRA of 2005.
- **Intergovernmental Transfers by Regional Medical Centers.** The law allows certain regional medical centers in other states to fund the state share of Medicaid payments. The Secretary must determine that the use of such funds is proper and in the interest of the Medicaid program and the centers must meet specific criteria.
- **Medicaid FMAP Adjustment.** Prior to the new law, state Federal Medical Assistance Percentages (FMAP) are calculated using state and U.S. per capita income, which includes a computation of personal income derived from employer contributions for employee pensions and insurance funds. CHIPRA changes the computation by disregarding any "significantly disproportionate" employer pension or insurance fund contribution in computing state per capita income (but not U.S. per capita income). No state would have its FMAP reduced as a result. The law also requires that the Secretary submit a report to Congress, by May 15, 2009, on the treatment of pension and insurance fund contributions.
- **Disproportionate Share Allotments to Tennessee and Hawaii.** Tennessee and Hawaii receive specified allotments for making disproportionate share (DSH) of care payments to hospitals that serve low-income patients with special needs. (They do not have the standard allotment cap that other states operate under due to the fact that their state Medicaid programs operate under a Section 1115 waiver that waived the requirement to make DSH payments.) The new law extends the two states allotments through the first quarter of fiscal year 2012.

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