



National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

SCHIP Reauthorization

NASMD Summary

2-09-2009

SCHIP Reauthorization Legislation Summary of Key Provisions

Title I: Financing

- Extends SCHIP through FFY13 and increases federal funding for the program above the current levels. Appropriates the following amounts:
 - \$10.562 Billion for FFY09;
 - \$12.52 Billion for FFY10;
 - \$13.459 Billion for FFY11;
 - \$14.982 Billion for FFY12; and
 - \$17.406 Billion for FFY13.
- Establishes a child enrollment contingency fund to cover state SCHIP expenditures beyond the amount allotted in the statute for 2009-2013.
- Provides performance bonus payments to states for enrollment costs resulting from specified enrollment and retention efforts.
- Reduces the time-frame for states to spend their allotments from 3 years to 2 years for FY2009 and beyond.
- Explains that shortfall states must spend their redistributed funds by the end of the fiscal year in which the funds are redistributed.
- Provides states with the option to cover low income pregnant women.
- Requires the state to have a Medicaid option of at least 185% FPL for pregnant women and an option of at least 200% FPL for children under 19 for the state to use this option.
- Children born to women receiving benefits under the low income pregnant women option would be automatically enrolled in SCHIP for the first year of his/her life.
- Phases out coverage for non-pregnant childless adults. States can extend existing waivers for this coverage only through December 31, 2009.
- Prevents payment of enhanced FMAP, and instead requires payment of the regular FMAP, for services to children whose family income is above 300% of FPL.

Title II: Outreach & Enrollment

- Provides \$100 million over FY09-FY13 to fund grants to enhance outreach and enrollment for children aimed at increasing participation of children in Medicaid and SCHIP.
- Excludes expenditures for outreach activities to Native American from the 10% limit on administrative costs under SCHIP.
- Allows states to determine eligibility by using findings from an Express Lane agency (agencies that determine TANF, IV-D, SNAP, Head Start, School Lunch, Child Care Block Grant, Homeless Assistance, and Housing programs).
- Allows states to submit names and social security numbers of applicants to SSA in lieu of the paper documentation requirements for proving citizenship and identity.
- Allows states to elect to provide medical assistance, notwithstanding the five year bar, to children and pregnant women who are lawfully residing in the U.S. and who are otherwise eligible for Medicaid.

Title III: Reducing Barriers to Providing Premium Assistance

- Gives states the option to provide a premium assistance subsidy for qualified employer-sponsored coverage to targeted low-income children.
- Establishes special enrollment periods in group health plans to allow for the enrollment of individuals outside an open enrollment period if an individual loses Medicaid or CHIP coverage or if the individual is eligible for Medicaid or CHIP and the Medicaid or CHIP programs purchases the group coverage on behalf of the enrollee.

Title IV: Strengthening Quality of Care & Health Outcomes of Children

- By January 2010, the Secretary must identify and publish a recommended core set of child health quality measures for use under Medicaid and CHIP.
- The Secretary must identify existing quality of care measures for children that are in use under public and privately sponsored health care arrangements or part of reporting systems that measure both the presence and duration of health insurance coverage over time.
- The Secretary will award up to 10 grants (from FY09-FY13) to states and child health providers to conduct demonstration projects to improve the quality of child health care under Medicaid & CHIP.
- CHIP managed care providers will be required to meet the same standards that are in effect for Medicaid managed care providers.

Title V: Improving Access to Benefits

- Requires that the CHIP benefit package include coverage of dental services necessary to prevent disease and promote oral health and treat emergency conditions.
- Provides States the option to provide a supplemental dental benefit to low income children enrolled in group health programs that do not cover dental services.
- Establishes a grace period for individuals to make premium payments before their coverage may be terminated.
- Establishes a Medicaid and CHIP payment and access commission to review policies affecting children's access to covered items and services.

Title VI: Program Integrity and Other Miscellaneous Provisions

- Applies a minimum of 90% to expenditures related to administration of payment error rate measurement (PERM) requirements applicable to SCHIP.
- Waives the 10% cap on SCHIP administrative costs for all expenditures related to the administration of PERM requirements.
- Prevents CMS from calculating or publishing any national or state-specific SCHIP error rate based on PERM until 6 months after a new PERM final rule is published.
- Harmonizing MEQC and PERM.
- Requires that the final rule implementing the PERM requirements to include: (1) clearly defined criteria for errors for both states and providers; (2) a clearly defined process for appealing error determinations by review contractors or specified agency and personnel; and (3) clearly defined responsibilities and deadlines for states in implementing any corrective action plans.

SCHIP Reauthorization of 2009 Detailed Summary

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Section 3: Effective Date

- Stipulates that, unless otherwise specified, the act and the amendments within shall take effect on April 1, 2009.
- Provides exception for State Plans (Medicaid and/or CHIP) that the Secretary determines will require State legislation due to changes or additions in this Act. In this situation, states have until the first day of the first full quarter following the end of the first State Legislative Session to conform.
- Coordinates FFY09 appropriations and allotments made prior to April 1, 2009, with appropriations and allotments made after April 1, 2009.
 - Amounts appropriated but not allotted before 4/1/09 are rescinded; and
 - Any amounts allotted to states under this Act will be reduced by funds already allotted during FFY09, prior to the Act's enactment.

TITLE I – FINANCING

Section 101: Extension of CHIP

- Extends CHIP until the end of FFY13.
- Appropriates the following funding:
 - \$10.562 Billion for FFY09;
 - \$12.52 Billion for FFY10;
 - \$13.459 Billion for FFY11;
 - \$14.982 Billion for FFY12; and
 - \$5.7 Billion for FFY13, divided into two 6-month periods at \$2.85 Billion each. (note: Section 108 appropriates an additional \$11.706 Billion for FFY13 for a total of \$17.406 Billion).

Section 102: Allotments for States and Territories

- Allocates FFY09 funds to each of the 50 states and the District of Columbia, based upon the greatest of either:
 - 110% of actual 2008 federal payments multiplied by an allotment increase formula – $1.10 \times (2008 \text{ federal payments}) \times (\text{allotment increase})$; or
 - 110% of the original 2008 allotment multiplied by the allotment increase formula – $1.10 \times (2008 \text{ original allotment}) \times (\text{allotment increase formula})$; or
 - 110% of the state projection of total Federal payments for FFY09, based upon prior the authorization.
- Allocates FFY09 funds to the territories based upon the Federal payments during the year with the highest spending between 1999-2008, multiplied by the average allotment increase for the entire United States – $(\text{Highest Annual Federal Payments from 1999-2008}) \times (\text{Average National Allotment Increase})$.
- Allows certain qualifying states¹ under section 2105(g) of the Social Security Act to revise their state projection of total Federal payments to account for changes made by this act (the addition of paragraph 4 to 2105(g) occurs in section 107).

¹ According to the Congressional Research Service, in 2008 these states were: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island,

- Defines the allotments and allotment increase formulas (growth factors) for 2010-12, based on the prior year's original allotment + any additional money redistributed during the prior year multiplied by a formula based upon increase in National per-capita health expenditures and the state's child population growth.
- Defines the allotments and growth factors for 2013 based upon the prior year's original allotment + any additional money redistribute, multiplied by the growth factor for 2013. Breaks the payments and allotments for 2013 into two prorated 6 month periods.
- Affirms that in any year where the aggregate allotments exceed the amount appropriated, each state will receive a reduced allotment based on its proportional share of the total appropriation. (i.e.: if the total appropriation is only 90% of the actual allotments, each state will receive 90% of its calculated allotment).
- Allows States to request an increased allotment to expand eligibility or benefits to children from 2010-2013.

Section 103: Child Enrollment Contingency Fund

- Establishes a "Contingency" fund and makes an initial appropriation of 20 percent of the total FY09 appropriation for 2009 (approximately \$2.11 Billion) to the fund.
- For FY10-13, appropriates the amount necessary to make payments to eligible states, but not to exceed 20% of the total annual appropriation for CHIP. Additionally, restricts the total payments from the fund to 20% of the overall CHIP appropriation (from section 101. i.e., in 2010, the total payments and appropriation may not be more than 20% of \$12.52 Billion).
- Reserves any money above the 20% limit to pay for performance bonuses to States (as defined in Section 104).
- Reserves the money in this contingency fund to increase allotments to states that exceed their allotment *due to a higher-than-expected child enrollment*.
- The additional allotment will be based on a formula of the average per capita CHIP payments multiplied by the number of extra children enrolled (above the annual projections). The allotments will be prorated if states are eligible for more funds than are available.
- Requires states to spend the money by the end of the fiscal year or period in which they are allotted.
- Asserts that the funds will not be used to pay territories unless there is a satisfactory way to collect reliable data for projecting the enrollment of children in each territory, as defined by the Secretary.

Section 104: Performance Bonus Payment for Enrollment and Retention Efforts

- Creates an incentive for states to enact policies that promote enrollment and retention of eligible children. Makes an initial appropriation of \$3.225 Billion, and allows the fund to be increased by transfers from unallocated CHIP money, unspent allocations to states, excess child enrollment contingency fund, and unexpended transitional coverage block grant funds.

Tennessee, Vermont, Washington, and Wisconsin. See <http://www.floridakidcare.org/council/mm-1-14-08/RS22739.pdf>

- Defines two tiers of payments based upon the number of children enrolled in Medicaid above a baseline number. Defines the baseline for each year from 2009-2015 with a formula consisting of: children enrolled in Medicaid during prior year(s), estimated increase in children in the state, and a congressional defined adjustment (ranging from 3-4%). Does not allow state's to qualify for this bonus based on Medicaid expansions.
- Sets eligibility for receiving payments. Requires states to meet five of the following eight conditions to receive any payments:
 - Establish 12 month continuous eligibility for children under 19 (in Medicaid);
 - Liberalize asset requirements by either removing asset/resource tests or reducing documentation requirements for parents;
 - Eliminating in-person interview requirements for enrollment;
 - Establishing a joint application for Medicaid and CHIP;
 - Automatically renew a child's eligibility for Medicaid;
 - Implement Presumptive Eligibility for Children;
 - Implement the Express-Lane eligibility (defined in Section 203); and
 - Providing premium assistance subsidies.

Section 105: Two-Year Initial Availability of CHIP Allotments

- Reduces the time-frame for states to spend their allotments from 3 years to 2 years for FY2009 and beyond.
- Asserts that shortfall states (under section 2104(f)) must spend redistributed funds by the end of the fiscal year in which the funds are redistributed.

Section 106: Redistribution of Unused Allotments

- Defines shortfall states as states that will spend more than available carryover funding, contingency funding, and annual allotment funding in the fiscal year.
- Prorates redistributed funding if the amount of funds available for redistribution is less than the estimated shortfalls.
- Extends the period for states to spend redistributions from unused FY06 funds until September 30, 2009.

Section 107: Option for Qualifying States to Receive Enhanced FMAP for Certain Children

- Allows certain qualifying states² under section 2105(g) of the Social Security Act to use funds from their CHIP allotment at the enhanced FMAP rate for Medicaid services to children under age 19 in families that qualify for Medicaid and have income above 133% of FPL.

Section 108: One-Time Appropriation

- Appropriates \$11.706 Billion for October-March of FY13, to remain available until expended.

² Ibid

Section 109: Improving Funding to Territories

- Excludes administrative funding under section 1903(a)(3) of the Social Security Act when determining the capped amount of funding for Territories beginning in FY09.

Section 111: State Option to Cover Low Income Pregnant Women

- Allows a state to amend its CHIP plan to provide pregnancy-related assistance to targeted low-income pregnant women.
- Requires a state to have a Medicaid option of at least 185% FPL for pregnant women (and not reduce it from the level in place as of July 1, 2008) and an option of at least 200% FPL for children under 19 for the state to use this option.
- Requires the state to have a higher income level for CHIP than Medicaid, and to cover lower income pregnant women before covering higher income pregnant women.
- Imposes the CHIP cost-sharing protections, including a total cost-sharing limit of 5% of the total family income for this population.
- Requires that the state not have a waiting list for children in CHIP.
- If the state elects to provide coverage to pregnant women and meets all the preceding requirements, it may elect to provide presumptive eligibility for pregnant women as described in 1920 for under the CHIP plan.
- Defines targeted low-income pregnant woman as:
 - A woman who is either pregnant, or who was less than 60-days from of the end of her pregnancy at the beginning of the current month;
 - Who's income exceeds the Medicaid option for pregnant women (of at least 185% FPL) but is below the CHIP eligibility level; and
 - Who satisfies other requirements of children applying for CHIP.
- Children born to woman receiving this option would be automatically enrolled in CHIP for the first year of his/her life.

Section 112: Phase-out of Nonpregnant Childless Adults & Conditions for Coverage of Parents

- Prevents the approval of any new waivers to use CHIP funds for coverage to childless, non-pregnant adults.
- Allows states to extend existing waivers until December 31, 2009. Prevents any funding for non-pregnant, childless adults after December 31, 2009.
- Provides option for states to apply for an 1115 Medicaid waiver to cover childless adults terminated from a CHIP waiver. Cost neutrality under this waiver would be determined by comparing 2010 costs to 2009 expenditures under the CHIP waiver with an index for increased health care costs. Subsequent cost-neutrality will be determined on prior FY expenditures indexed for increase in health care costs.
- Prevents the approval of any new waivers to use CHIP funds for coverage to parents of CHIP children.
- Allows states to extend existing waivers for parents until 2011 and continue to receive enhanced FMAP.
- Transitions the funding for parental coverage to a block grant for FY12 and FY13. Defines set-aside as 110% of the projected FMAP for the year, as certified by the state, and does not permit Federal spending above the block grant level.

- Places conditions on states in order to receive enhanced FMAP for 2012. States must do one of the following, or else receive standard FMAP for parents in the block-grant:
 - Receive a CHIP outreach grant (as defined in section 2113);
 - Implement 1 or more of the enhanced enrollment and retention provisions (see section 104) for the fiscal year;
 - Submit a specific outreach plan for the fiscal year;
 - Rank in the lowest 1/3 of states for percentage of low-income children without health insurance; or
 - Qualify for a performance bonus (see section 104) for the fiscal year).
- Places conditions on states to receive an adjusted FMAP for 2013 – Adjusted FMAP is defined as the regular FMAP + ½ the difference between enhanced FMAP and regular FMAP (i.e., if FMAP was 60% and enhanced FMAP was 75%, then the adjusted FMAP would be 67.5%). States must do one of the following, or else receive standard FMAP for parents in the block grant:
 - Rank in the lowest 1/3 of states for percentage of low-income children without health insurance; or
 - Qualify for a performance bonus (see section 104) for the fiscal year).
- Prevents any additional payments to states for parents once the block grant is exhausted. Additionally prevents any block grant payments for parents who are from families with incomes greater than allowed under the existing waiver at the time of the Act’s passage. States are not prohibited from applying for 1115 waivers under title XIX to cover these parents.
- Requires a report on the impact of providing parental coverage on the coverage and quality of care of children.

Section 113: Elimination of Presumptive Eligibility Costs Impacting CHIP Allotment

- Removes the requirement to pay for a child’s presumptive eligibility under 1920A out of the CHIP block grant.

Section 114: Limitation on Matching Rates for Coverage above 300% FPL

- Prevents payment of enhanced FMAP, and instead requires payment of the regular FMAP, for services to children whose family income is above 300% of FPL.
- Allows states with existing approved waivers or state plan amendments, or state legislation to pursue such a waiver or spa, that cover children above 300% FPL to continue to receive enhanced FMAP for those children.

Section 115: State Authority Under Medicaid

- Allows states to choose whether children are covered under Medicaid or under CHIP.

TITLE II: OUTREACH AND ENROLLMENT

Section 201: Grants and Enhanced Administrative Funding for Outreach

- Allocates \$100 million over FY09-FY13 to fund grants to enhance outreach and enrollment for children. The grants are intended to increase participation of children in Medicaid and CHIP.

- \$10 million is reserved for a national enrollment campaign;
- \$10 million is reserved for awards that specifically target increasing enrollment of Native Americans with disabilities.
- The remaining funds prioritize outreach to geographic areas with high rates of eligible but unenrolled children or high rates of racial and ethnic minorities.
- States are required to continue any spending on outreach that was in place prior to the receipt of the award in order to be eligible.
- Provides states with enhanced match for translation or interpretive services under Medicaid and CHIP. For CHIP, this enhanced FMAP is either 75% of total costs, or the Enhanced FMAP plus 5% -- whichever is higher. For Medicaid, this enhanced FMAP is 75%.

Section 202: Increased Outreach and Enrollment of Indians

- Directs the Secretary of Health and Human Services to encourage and facilitate greater communication and collaboration on outreach and enrollment activities between States and organizations that serve Native Americans, including Indian Health Service, Indian Tribes, and Tribal Organizations.
- Excludes expenditures for outreach activities to Native Americans from the 10% limit on administrative costs under CHIP.

Section 203: State Option to Utilize Express Lane Eligibility

- Allows states (including the District of Columbia but not including the territories) to determine eligibility by using findings from an “Express Lane agency” (EL agency). If the EL agency finds a child ineligible, the state must review the case and do its own full eligibility determination. Additionally, if the EL agency determines that the family owes a premium, the state must inform the child/family that they may qualify for a lower premium and can request a redetermination from the staff.
- EL Agency is defined as a **public agency** that has fiscal or legal responsibility for the accuracy of eligibility determinations for the state or that is subject to an interagency agreement that limits the use and disclosure of the information used to determine eligibility. This specifically includes any agency that determines eligibility for TANF, IV-D, Medicaid, CHIP, SNAP, Head Start, School Lunch, Child Care Block Grant, Homeless Assistance, Housing programs, but explicitly excludes agencies that determine eligibility for social services block grants or private non-profit organizations.
- Defines two options for states to establish the EL process:
 - **A screening threshold:** The state would set a “threshold” of at least 30% (or more – at the state’s option) above the highest eligibility category for Medicaid. If a child falls underneath the threshold, they are determined eligible for Medicaid. If the child is above the threshold, but below the CHIP threshold, they are enrolled in CHIP but the Medicaid agency must send a notice informing the family of the process to request a Medicaid determination and of the difference between CHIP benefits and cost-sharing/premiums and Medicaid. States have the option of adopting this for Medicaid, CHIP or both.

- **Temporary CHIP enrollment pending screen and enroll:** the EL agency screens for CHIP eligibility and if it appears that the child is eligible, they are automatically enrolled into CHIP. The state then must promptly perform a full determination of Medicaid and CHIP eligibility, using procedures that reduce the burden on the family. During this period, CHIP matching funds are available for medical services provided.
- Allows a state to automatically determine eligibility, without a formal application, based on information provided by the EL agency. Requires consent from the child/family to enroll in Medicaid/CHIP.
- Requires the state to track and report on eligibility errors through the EL process. If the error rate is above 3% for the first 2 years of the EL process, the state must demonstrate corrective action to reduce errors. If the error rate exceeds 3% during any year, the state will not receive matching funds for the children included in the sample who exceed the 3% threshold. This error rate may not be applied broadly to the entire population determined eligible through the EL process or through the regular eligibility determination process.
- Authorizes the EL agencies to transmit information to the State Medicaid/CHIP agencies for the purposes of determining eligibility, copayment/premium amounts and benefit packages.

Section 211: Verification of Declaration of Citizenship

- Establishes an effective date of 1/1/2010 for the following provisions:
- Allows the States to submit names and social security numbers of applicants to the Social Security Administration to check for validity, in lieu of providing paper documentation. If the state receives information from SSA that suggests inconsistencies, the state must follow up with the individual to resolve any inconsistencies. If no resolution is found, the state must close the case. Individuals are given the option to submit other types of documentation.
- Requires the state to provide reports on eligibility and payment errors due to this citizenship screening. If the report determines that more than 3% of the determinations result in improper payments, the state must submit a corrective-action plan. The state must also repay the amount equal to the total amount of payments made to people determined eligible under this option multiplied by the percent of individuals (above the 3% threshold) who were improperly determined eligible.
- Provides 90% federal match for the development of an information system to perform the eligibility transmittal to SSA. Provides 75% match for ongoing maintenance.
- Includes documents from recognized Native American Tribes as acceptable documentation.
- Requires states to provide a reasonable opportunity for individuals to submit evidence of citizenship or legal immigration status.
- Declares a child born in the United States under Medicaid to be eligible without further documentation. Requires states to issue a unique Medicaid identification number for that child.
- Requires states to apply eligibility verification requirements to the CHIP program. Provides enhanced payments of 90% for development and 75% for administration of an information system to verify eligibility with SSA.

- Excludes expenditures related to development and administration of citizenship verification from the 10% administrative limit under CHIP.
- Retroactively restores eligibility for any person who was denied Medicaid under the previous citizenship documentation rules but who would be eligible under the rules as amended by this Act.
- Declares that any individual who is a member of a federally-recognized Indian tribe who has a document issued by that tribe is eligible for Medicaid, retroactively effective on 7/1/2006.

Section 212: Reducing Administrative Barriers to Enrollment

- Requires the CHIP plan to include a description of procedures used to reduce administrative barriers for children and pregnant women that are eligible for Medicaid or CHIP.
- Waives this requirement if a state uses a joint CHIP/Medicaid application, and does not require an in-person application or in-person interview.

Section 213: Model of Interstate Coordinated enrollment and Coverage

- Requires CMS/HHS to coordinate with Medicaid Directors, CHIP directors, and organizations that represent beneficiaries in order to develop a model program for coordinating enrollment, retention and coverage across state lines. The program is intended to serve children who must frequently change State of residency, or who are temporarily located outside of their State of residency.
- Requires a report to congress after the development of this program.

Section 214: Permitting States to Ensure Coverage Without a 5-Year Delay of Certain Children & Pregnant Women Under the Medicaid Program & CHIP

- Allows states to elect (in a Medicaid state plan amendment) to provide medical assistance, notwithstanding the five year bar, to children and pregnant women who are lawfully residing in the United States and who are otherwise eligible for Medicaid.
- Requires a state to verify, during redeterminations, that the individual continues to lawfully reside in the United States using the documentation presented to the State by the individual on initial enrollment. If the State cannot successfully verify that the individual is lawfully residing in the United States in this manner, it shall require that the individual provide the State with further documentation or other evidence to verify that the individual is lawfully residing in the United States.
- Protects the individual's sponsors from debts on basis of assistance.
- Requires a state to apply these requirements to Medicaid and CHIP if they choose to adopt this option.

TITLE III: REDUCING BARRIERS TO PROVIDING PREMIUM ASSISTANCE

Section 301: Additional State Option for Providing Premium Assistance

- Allows a state to subsidize an employee and purchase employer coverage to cover children with access to qualified employer coverage.

- Defines “qualified employer coverage” as creditable coverage for which the employer pays at least 40% of the premium and offers to all employees. It does not include flexible health spending arrangements or a high deductible health plans.
- Defines the premium subsidy as the amount equal to the difference between what the employee would pay for his coverage and the amount that would be required for coverage of the child and the employee.
- Allows states to provide the payments directly to the employee or the employer. Employers have the option to opt out of the direct payment option by the state.
- Requires the State to wrap around benefits to assure that the benefits meet the CHIP benefit package, and to ensure the CHIP cost sharing protections are met. If the employer coverage is determined by an actuary to be equivalent to a benchmark or benchmark equivalent plan, then the state would not have to provide the benefit wrap around or cost sharing protections.
- Requires the State to impose any waiting periods in effect on to this program and to allow parents the ability to opt out effective on the first day of a month.
- Allows a state the option to subsidize the employee plan to include amount that would pay for the cost of the parent, if the state covers parents under CHIP.
- Allows the State to establish a premium assistance purchasing pool for employers with less than 250 employees, if the purchasing pool offers access to at least 2 private health plans that are benchmark or benchmark equivalent packages. States will be required to inform beneficiaries of the availability of premium assistance subsidies.
- Modifies the cost effectiveness for family coverage and adds a new test. Under this provision, the cost effectiveness would now compare the amount of expenditures under the state health plan, including administrative costs, to what the state would pay for the premium assistance for the targeted low income child or the family coverage (In the past only the costs related to the targeted low income child would be considered). The new test is an aggregate test comparing the amount of expenditures under the state health plan (including administrative costs) to what the state would pay for all targeted low income children or families.
- Allows a state to enroll a Medicaid beneficiary (under age 19) in a state subsidized employer program. In such instance a state would be obligated to pay all cost sharing requirements over and above the Medicaid allowed amount. Individuals would still be eligible for all Medicaid benefits including those offered outside the employer plan. Beneficiaries and employers are free to opt out of this. Third party liability rules would apply.

Section 302: Outreach, Education, & Enrollment Assistance

- Excludes outreach and education costs to inform beneficiaries and employers about premium assistance subsidies from the CHIP 10% admin cap. However, these costs would be limited to 1.25% of the allowable state CHIP administrative costs.

Section 311: Special Enrollment Period Under Group Health Plans

- Defines loss of CHIP or Medicaid as a qualifying event that allows individuals to enroll in qualified employer plans not later than 60 days after the termination of coverage. Also, establishes a qualifying event if a state opts to purchase group health

coverage on behalf of a CHIP of Medicaid eligible child. This section modifies provisions contained in the Internal Revenue Code, Employee Retirement Income Security Act, and Public Health Service Act.

TITLE IV: STRENGTHENING QUALITY OF CARE & HEALTH OUTCOMES

Section 401: Child Health Quality Improvement in Medicaid and CHIP

- Requires the Secretary to identify and publish a recommended core set of child health quality measures for use under Medicaid and CHIP by January 2010. The core standards must include:
 - The duration of the insurance coverage over a 12 month period;
 - The availability and effectiveness of a full range of preventive services, treatments, and for acute conditions as well as to correct any physical and mental conditions for children;
 - The availability of care in a range of ambulatory and inpatient health care settings; and
 - The type of measures that will provide an estimate of national quality of care for children.
- Requires that the Secretary, in consultation with the States, develop a standardized reporting format that encourages states to voluntarily report information regarding the quality of pediatric health care.
- Directs the Secretary to establish a set of pediatric quality measures not later than January 1, 2011, that improves the initial core measures, expands the existing measures, and increases the portfolio of evidence based pediatric quality measures available. Requires that the Secretary consult with the states, pediatricians, other primary and specialized pediatric health professions, dental professionals, and national organizations (including advocacy groups) to establish these measures.
- Establishes \$20 million to award grants and contracts to develop and test these measures. The states must report these measures annually to the Secretary for publication. From FY2009-FY2013 the Secretary will give up to 10 grants to states and child health providers to conduct demonstration projects to improve the quality of child healthcare under title XIX and XXI.
- Directs the Secretary to conduct a demonstration project to develop a model for reducing childhood obesity by awarding grants to cities, counties, FQHC's, universities, health care providers, and community based organizations but these cannot be awarded to states. The Secretary will give priority in awarding grants to entities that have demonstrated previous success, carry out programs that meet the goals for the Healthy People 2010 plan of the state, provide non-Federal contributions to the costs of funding activities, are located in communities that are medically underserved, and located in areas in which the poverty rate is at least 150 percent or higher of the average poverty rate in the state involved. The Secretary shall design this project within 1 year of the enactment of this legislation and the Secretary shall report to Congress within 3 years. There will be \$25 million for this demonstration for FY2009-FY2013.
- By January 2010, the Secretary shall establish a program to encourage the development and dissemination of a model electronic health record for children

enrolled in the State plan under title XIX or XXI. This must be capable of being compatible with other standards developed for electronic health records. There is \$5 million appropriated to carry this out for a fiscal year.

- By July, 2010, the Institute of Medicine will study and report to Congress about the quality of child health care.
- Increases the matching rate for collecting and reporting on child health measures. Claims to develop and collect these measures will be paid at state's FMAP rate.

Section 402: Improved Availability of Public Information Regarding Enrollment of Children in CHIP and Medicaid

- Requires States to include the following additional information in their annual reports: eligibility criteria, enrollment and retention data; data regarding the extent to which the state uses process measures with respect to determining the eligibility of children under CHIP; denials and re-determinations of eligibility; information on access to care; information on premium assistance programs; activities to reduce the number of uninsured children.
- Directs the Secretary to provide a standardized format for this reporting and allows states up to 3 reporting periods to transition to the new format.
- Appropriates \$5 million for improving Medicaid Statistical Information System (MSIS).
- Directs GAO to conduct a study of children's access to services under Medicaid and CHIP which includes the extent to which providers are willing to treat children in these programs; geographic availability of services in the program, and the extent to which care coordination is provided for children under Medicaid and CHIP.

Section 403: Application of Certain Managed Care Quality Safeguards to CHIP

- Requires that CHIP programs need to have the same safeguards as Medicaid programs have with regard to managed care entities, enrollments brokers, and managed care organizations.

TITLE V: IMPROVING ACCESS TO BENEFITS

Section 501 Dental Benefits

- CHIP coverage must include dental services necessary to prevent disease and promote oral health. This must be equivalent to a dental benchmark plan. Dental benchmark plans are defined as: federal employee's children's dental coverage, state employee dependent dental coverage, or the coverage offered through the State's largest commercial dental plan(s).
- A state is permitted to provide dental-only coverage to children who would have met the definition of a targeted low income child, but for the fact they are enrolled in an employer sponsored health insurance or group health plan (without dental benefits). The state may limit this supplemental dental coverage to a specific poverty level as long as that level does not exceed the maximum income level otherwise established under CHIP.

- The state may not offer dental-only supplemental coverage unless it has the highest income standard permitted by CHIP as of January 1,2009; it has no waiting period and does not limit the number of people; and provides benefits to all children in the state who apply for and meet eligibility standards. The state may not provide better coverage or cost sharing protections for enrollees of this supplemental than it would for its targeted low income children under its CHIP plan. At the state's option it may not apply a waiting period for the benefit.
- Under Medicaid, the State will not prevent FQHCs from entering into contractual relationships with private dental providers in the provision of FQHC services.
- Under Medicaid and CHIP, the state must report the following information related to dental services in its annual report: The number of children by age grouping used for reporting on EPSDT; for children with each group, the type of information contained on question 12 (a)-(c) of the CMS-416; and for children in the age 8 grouping, the number that received a dental sealant. This information must also be collected for enrollees in managed care plans.
- Within 6 months of enactment the Secretary must work with the states to create a complete list of dentists and providers that provide dental services to children enrolled in Medicaid or CHIP on the Insure Kids Now website and must update this information quarterly.
- States must also report on their efforts to improve dental care in their reports on the quality of children's health.

Section 502 Mental Health Parity in CHIP Plans

- Modifies the coverage requirements of CHIP to require that if a CHIP benefit plan provides both medical and surgical benefits and mental health or substance use disorder benefits, the plan may not impose a lower lifetime or annual dollar limit, institute a lower coverage limit, or charge higher out-of-pocket costs on mental health benefits than exists for medical/surgical benefits,. To the extent that the CHIP plan provides EPSDT coverage, it is deemed to comply with this requirement.

Section 503 Application of Prospective Payment System for Services Provided By Federally Qualified Health Centers and Rural Health Clinics

- CHIP plans must apply the Medicaid PPS reimbursement system to FQHCs.
- Five million dollars in transition grants are available to assist stand alone CHIP programs and combination programs to come into compliance with this provision.

Section 504 Premium Grace Period

- CHIP programs must give enrollees 30 days from the beginning of a new coverage period to make premium payments before the individual's coverage will be terminated and the state must provide such an individual, not later than 7 days after the first day of such grace period notice that if he does not pay, he will lose eligibility and that he has a right to challenge the proposed termination.

Section 505 Clarification of Coverage of Services Provided Through School Based Health Centers

- Clarifies that nothing in this title shall be construed as limiting a state's ability to provide child health assistance for covered items and services furnished through school based centers and provides a definition of a school based health center.

Section 506 Medicaid & CHIP Payment and Access Commission

- Establishes a Medicaid & CHIP Payment and Access Commission (MACPAC) which will review policies of the Medicaid program and CHIP; make recommendations to Congress concerning access policies; and create an early warning system to identify shortages of providers.
- Defines the make-up of the commission as 17 people appointed by the Comptroller which will include: physicians, employers, third party payers, parents of enrollees in Medicaid or CHIP, and individuals with national expertise.
- Sets the members' terms at 3 years.

TITLE VI: PROGRAM INTEGRITY AND OTHER MISCELLANEOUS PROVISIONS

Section 601: Payment Error Rate Management (PERM)

- Provides a minimum of 90% FMAP, under section 2105(c), for activities relating to PERM of the CHIP program;
- Excludes expenditures towards PERM from cap on administrative funding under CHIP under Section 2105(c)(2)(C).
- CMS can not calculate or publish any national or State-specific CHIP error rate based on PERM until 6 months after a new PERM final rule is published. The new rule is to be based on the following requirements:
- Must include clearly defined criteria for errors for both States and providers;
- Must include a clearly defined process for appealing error determinations by review contractors or state/agency staff responsible for the evaluation of eligibility reviews and associated activities;
- Must include clearly defined responsibilities and deadlines for States in implementing any corrective action plans; and
- Cannot use account payment errors resulting from the State's verification of an applicant's self-declaration or self-certification of eligibility for medical assistance or child health assistance if the State's process for verifying an applicant's self-declaration or self-certification meets the CMS approved requirements for such process.
- After the new rule is in effect for all states, a state which was subject to the interim rule of 2007 may elect to adopt a payment error rate determined by the 2007 data or elect to be treated as if 2010 or 2011 were the first fy PERM requirements.
- Harmonizing MEQC and PERM - The secretary shall review MEQC and PERM and reduce redundancies; A state may elect to substitute PERM data from the new rule for data obtained by MEQC; and for meeting Medicaid eligibility reviews, a state may elect to substitute MEQC data for data for the PERM reviews, but only if the MEQC reviews are based on a broad representative sample.

- The secretary shall establish State specific sample sizes for CHIP beginning in 2009, minimizing administrative cost burden on States and maintaining State flexibility to manage the programs.
- The final rule implementing PERM must be published within 6 months of the Act's enactment.

Section 602: Improvements to Data Collection

- Increases appropriations for data collection & requires CMS and Commerce to adjust the Current Population Survey to collect information on children enrolled in Medicaid and other health insurance, and to collect more accurate information to calculate the child population growth factor. Also, requires the Commerce Secretary to assess the best way (using either CPS, American Community Survey, or a combination) to calculate the child population growth factor.

Section 603: Updated Federal Evaluation

- Requires the Secretary to conduct an independent evaluation of 10 state CHIP programs by December 31, 2011.

Section 604: Access to Records for IG and GAO Audits/Evaluations

- Requires any state or state grantee/subcontractor who keeps records that are related to the expenditure of Federal CHIP funds to provide copies to the Federal Government Accountability Office and the Federal Inspector General upon request.

Section 605: Funding for Illegal Aliens

- Reasserts that no federal funding under titles XI, XIX or XXI may be used to provide services to illegal aliens.

Section 613: Prohibition on Initiating New Health Opportunity Account

- Prevents the Secretary of HHS from approving any new Health Opportunity Account demonstration programs, under section 1938 of the Social Security Act.

Section 614: Employer Pension Disregard for FMAP Calculation

- Defines and disregards an "Extraordinary" employer pension or insurance fund contribution when calculating average state income for purposes of FMAP calculation.
- Prevents state FMAP from being negatively affected by this calculation.

Section 616: Extends Medicaid DSH Allotments for Tennessee and Hawaii

- Extends the Medicaid DSH allotments under Tennessee and Hawaii's statewide 1115 Managed Care waivers.

Section 617: GAO Report on Medicaid Managed Care Payments

- Requires a report from the GAO regarding whether the managed care rates paid by State Medicaid agencies are actuarially sound.

Section 621: Outreach Regarding Health Insurance Options for Children

- Establishes a taskforce to conduct a national education and outreach campaign regarding availability of health insurance coverage for children under private insurance, Medicaid and CHIP. Includes the Small Business Administration, Health and Human Services Administration, the Secretary of Labor, and the Secretary of the Treasury.

Section 622: Sense of the Senate

- Declares that the Senate intends to enact legislation to improve access to health insurance coverage for employees of small businesses and for self-employed individuals through health insurance pools and incentives for the purchase of private insurance.

TITLE VII: REVENUE PROVISIONS

Section 701: Increase in Tobacco Tax

- Increases tobacco taxes to fund the bill. Tax increases include, among other things: cigars, cigarettes, cigarette papers, cigarette tubes, & pipe tobacco.

Section 702: Administrative Improvements

- Provides definitions for tobacco related products.

Section 703: Treasury Study Concerning Tobacco Smuggling

- Directs the Secretary shall to conduct a study concerning the magnitude of tobacco smuggling in the U.S. and to make recommendations to reduce it.