The Children's Health Insurance Program Reauthorization Act
Compiled by the National Health Law Program, March 27, 2009

On February 5, President Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Pub. L. No. 111-3. The bill reauthorizes the Children's Health Insurance Program (CHIP) for another four and a half years, from April 1, 2009 to September 30, 2013. While the CHIP program, Title XXI of the Social Security Act, is at the heart of the legislation, Medicaid, Title XIX, is also affected. The purpose of the legislation is to "provide dependable and stable funding for children's health insurance" under CHIP and Medicaid. CHIPRA, § 2. The goal is to enroll "all six million uninsured children who are eligible, but not enrolled, for coverage today" under CHIP or Medicaid. *Id. Compare* CHIPRA, § 622 (stating an intent to enact legislation this year that improves access to affordable, meaningful health insurance coverage for employees of small businesses and individuals). The legislation is funded in large part by increases in excises taxes on tobacco products. *See* CHIPRA, Title VII, § 701.

Effective Dates

Most of the CHIPRA amendments become effective on April 1, 2009, regardless of whether regulations have been issued to implement the amendments. CHIPRA, § 3. However, if the Secretary of the Department of Health and Human Services (DHHS) determines that a state will need to enact legislation to bring the state's CHIP or Medicaid plan into compliance with "one or more of the additional requirements" imposed by CHIPRA, the state will be given some leeway. *Id.* at § 3(b). In these cases, a state's CHIP/Medicaid plan will not be regarded as out of compliance with CHIPRA until after the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of CHIPRA enactment. *Id.* For example, if State A must authorize a new CHIPRA requirement legislatively and State A holds its next regular legislative session from July to December 2009, then State A will not be considered out of compliance until January 1, 2010.

Effective upon its enactment, CHIPRA repealed a 1999 law that required the Secretary of DHHS or any other federal officer or employee to use the term "SCHIP" instead of "CHIP" and the phrase "State Children's Health Insurance Program" instead of "Children's Health Insurance Program." *See* CHIPRA, § 612 (repealing § 704 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999).

In this analysis, we use "SCHIP" to refer to provisions under the original legislation and "CHIP" when discussing the recently enacted CHIPRA.

CHIP Funding Provisions

Extension of CHIP Funding—Section 101.

Through CHIPRA, funding for the CHIP program increased by $32.8 billion for fiscal year (FY) 2009 through FY 2013. The overall spending is now $69 billion. The total amount of funding allocated to states is as follows:

$10,562,000,000 for FY 2009
$12,520,000,000 for FY 2010
$13,459,000,000 for FY 2011
$14,982,000,000 for FY 2012
$17,406,000,000 for FY 2013.

CHIPRA, § 101 (amending 42 U.S.C. § 1397dd(a)).

The CHIP allotment for FY 2009 is nearly double the amount allocated in FY 2008. For provision of CHIP services, states will continue to receive federal dollars at an enhanced matching rate, which is higher than the rate for Medicaid.

Allotments for States and Territories for FYs 2009 through 2013—Section 102.

In the original legislation that enacted the SCHIP program, the Balanced Budget Act of 1997 (BBA), a formula established state allotments based upon the number of uninsured people in the state, not actual amounts that states were spending to cover children who would otherwise be uninsured. This resulted in some states not using all of their allotment and other states experiencing shortfalls.

The CHIPRA funding formula changes this. CHIPRA makes state allotments based upon actual state spending for their CHIP programs in earlier years. The initial allotment for FY 2009 is 110 percent of the highest of the: (1) FY 2008 allotment, (2) FY 2008 spending, or (3) FY 2009 spending projections. For FY 2010, state allotments will include the FY 2009 amount, adjusted for health care inflation and child population growth.

For FY 2011, the state allotment will be "rebased," or updated, to take into account the state's actual spending from earlier years. For FY 2012, states will receive their FY 2011 allotment, adjusted for health care inflation and child population growth. The FY 2013 funding, divided into two semi-annual periods, will include the re-based allotment reflecting actual use of CHIP funds from all sources in FY 2012. CHIPRA, § 102 (amending 42 U.S.C. § 1397dd).

Child Enrollment Contingency Fund—Section 103.

CHIPRA establishes a child enrollment contingency fund, created to ensure stable funding for the CHIP program. The contingency fund provides states additional funding if they face a CHIP shortfall and their enrollment of children exceeds the target level for that fiscal year. When a state experiences a shortfall, the DHHS Secretary pays the state the product of the amount by which the average monthly caseload exceeds the target number of enrollees, and the projected per capita expenditures under CHIP multiplied by the FMAP for the state for the fiscal

year. Funding comes from separate appropriations, set at 20 percent of the national allotment. A state's use of the contingency fund is built into future allotments in rebased fiscal years. CHIPRA, § 103 (amending 42 U.S.C. § 1397dd).

Performance Bonus Payment to Offset Additional Enrollment Costs—Section 104.

CHIPRA includes new performance bonus provisions to encourage greater enrollment of Medicaid-eligible children. *See* CHIPRA, §104 (amending 42 U.S.C. § 1397ee(a)). States implementing these provisions will receive additional federal payment for the costs of increasing enrollment beyond the target level, which is based upon Medicaid enrollment in FY 2007. The amount of the bonus will vary between 15 percent and 62.5 percent of the projected per capita state Medicaid expenditures for the fiscal year. *Id.*

To obtain the performance bonus, states must implement at least five of the following eight simplification procedures in their Medicaid and CHIP programs for children:

(1) Twelve months of continuous eligibility;
(2) Liberalization of asset requirements, including either elimination of the asset test or administrative verification of assets;
(3) Elimination of in-person interview requirements;
(4) Use of a joint Medicaid CHIP application;
(5) Automatic or administrative renewal;
(6) Presumptive eligibility for children;
(7) Express lane eligibility; and
(8) Premium assistance subsidies.

The performance bonuses offer a significant incentive for states to take serious steps to increase Medicaid enrollment. These bonuses are especially important given the economic recession. Indeed, some states that recently imposed new eligibility restrictions are now reconsidering those efforts. Advocates need to push states to put these procedures in place if they have not done so already.

Two-Year Availability of CHIP Allotments—Section 105.

Under original SCHIP funding, states were allowed to spend their allotments over three years. States are now given two years to spend their allotments. *See* CHIPRA, §105 (amending 42 U.S.C. § 1397dd(e)).

Redistribution of Unused Allotments—Section 106.

Allotments that states fail to use are redistributed. In the original SCHIP legislation, the Secretary of DHHS was allowed to decide how to redistribute unused funds. CHIPRA introduces a process and timeline for the Secretary to use to redistribute funds to states facing a shortfall. CHIPRA, §106 (amending 42 U.S.C. § 1397dd(f)). Shortfall states are states that have projected expenditures in a fiscal year that exceed funding available from current and prior-year

allotments and the contingency fund. *Id.* The Secretary may also prorate redistribution amounts and provide retrospective adjustments. *Id.*

Option for Qualifying States to Receive Enhanced Portion of CHIP Matching Rate for Medicaid—Section 107.

"Qualifying" states, those states that undertook significant Medicaid expansions prior to the creation of SCHIP, are allowed to submit revised projections and can now use CHIP funds for Medicaid expansions they made before CHIP was created. CHIPRA, §107 (amending 42 U.S.C. § 1397ee(g)).

Focus on Low-Income Children and Pregnant Women

Option to Cover Low-Income Pregnant Women Under CHIP—Section 111.

The SCHIP regulations were revised in 2001 to allow states to provide pregnancy-related services for pregnant women through SCHIP by obtaining special "waiver" permission from the Secretary of DHHS. *See* 42 C.F.R. § 457.10 (redefining "child" to mean an individual from conception to age 19). CHIPRA now requires that states choosing to cover low-income pregnant women submit a state plan amendment instead. *See* CHIPRA, §111(a)(adding Section 2112 to the Social Security Act, to be codified as 42 U.S.C. § 1397ll(a)). States may elect to provide pregnancy-related coverage under CHIP as long as they meet the following mandates:

(1) Cover pregnant women in Medicaid to at least 185 percent of the Federal Poverty Level (FPL);
(2) Cover children in CHIP up to at least 200 percent of the FPL;
(3) Not apply pre-existing condition exclusions or waiting periods;
(4) Apply cost-sharing protections to the pregnant woman's family;
(5) Not impose a waiting list for children;
(6) Not provide coverage to higher-income women before lower-income women; and
(7) Apply requirements and assistance in same manner for pregnant women as it does for children.

CHIPRA includes some important innovations from the Medicaid program as part of this new optional state plan coverage. States may provide presumptive eligibility to pregnant women who appear to be eligible for CHIP while they await a final determination. *Id.* CHIPRA also introduces "newborn deeming." Children born to CHIP-covered, pregnant women may now be deemed eligible for the state's CHIP program or Medicaid, as appropriate, for one year. *Id.*

The provision also clarifies that states offering prenatal services under CHIP may cover postpartum services through the end of the month in which the 60-day postpartum period ends in the same manner in which it provides those services through Medicaid. *Id.* Additionally, the provision requires that states not impose cost sharing for pregnancy-related services or waiting periods. CHIPRA, §111(b).

Phase-Out Coverage of Childless Adults, Conditions for Covering Parents—Section 112.

Under the Deficit Reduction Act of 2005 (DRA), the Secretary of DHHS was prohibited from approving new waivers, experimental, pilot or demonstration projects that would use SCHIP funds to cover nonpregnant, childless adults. CHIPRA goes a step further by preventing the Secretary from renewing any waivers or demonstration projects that provide coverage of nonpregnant, childless adults. *See* CHIPRA, §112(a) (adding Section 2111 to the Social Security Act, to be codified as 42 U.S.C. § 1397kk(a)). CHIP funds for existing projects shall be terminated after December 31, 2009. *Id.* States with projects that expire before January 1, 2010 may seek to have the project reauthorized by submitting an extension request prior to September 30, 2009 in order to receive an enhanced match until December 31, 2009. *Id.* Beginning 2010, states may offer coverage to nonpregnant childless adults by applying before September 30, 2009 for a Medicaid waiver under Section 1115 of the Social Security Act. *Id.* Budget neutrality rules would apply, *id.*, and note that only the Section 1115 waiver authority may be used.

Under the previous law, some states obtained permission from the Secretary of DHHS to use CHIP funds to cover parents of children eligible for Medicaid and SCHIP whose incomes are too high to qualify for Medicaid. Eight states presently receive CHIP funds to cover such parents: Arizona, Arkansas, Idaho, Minnesota, Nevada, New Jersey, New Mexico and Wisconsin.

Enactment of CHIPRA prohibits the Secretary from approving or renewing such coverage for parents. *Id.* States that were covering this group with CHIP funds can continue to receive CHIP funds and enhanced FMAP through the end of FY 2011, and those with expiring waivers can submit requests for extensions through the end of FY 2011. *Id.* Beginning October 1, 2011, funding for parental coverage will be provided through state block grants. *Id.* For states seeking to implement this coverage, funding allotments will be based upon 110 percent of the state's projected expenditures under the existing coverage. *Id.* States may receive enhanced FMAP if they meet the following conditions: (1) the state was awarded and implemented a child outreach grant and submitted a specific plan for outreach; (2) the state ranks among the lowest third of states in terms of uninsured rates for low-income children; and (3) the state qualified for a performance bonus discussed above. *Id.* If these conditions are not satisfied, the state will receive federal funds at the Medicaid matching rate. *Id.*

The provision also requires the Government Accountability Office (GAO) to conduct a study to determine whether coverage of parents, caretaker relatives, and legal guardians of CHIP-eligible children increases the enrollment of or quality of care for children, and whether such parents, caretakers and guardians are more likely to enroll their children in Medicaid or CHIP. *See* CHIPRA, §112(b).

Like the DRA, this CHIPRA provision is an effort to respond to the GAO's report entitled *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns.* The report expressed legal and policy concerns about states using SCHIP funds for purposes unrelated to expanding health care coverage to low-income children. The GAO determined that such efforts were inconsistent with the goals and fiscal integrity of SCHIP. The

GAO study was clearly needed. While it is critical that CHIP funds be used to further the goals of the program, it is also important to extend insurance coverage to their uninsured caretakers. Not only do these individuals have ongoing health care needs, but studies have shown that when parents are insured, their children have better access to and increased utilization of health care services.

Elimination of Counting Medicaid Presumptive Eligibility Costs Against CHIP Allotment—Section 113.

The original SCHIP legislation funded Medicaid child presumptive eligibility from Title XXI CHIP funds. CHIPRA no longer requires that state CHIP allotments be used to fund presumptive eligibility for children. *See* CHIPRA, §113(b)(2) (amending 42 U.S.C. § 1397ee(a)(1)). This presents a cost-saving for states, especially those experiencing CHIP shortfalls. This is especially important for states with separate CHIP programs, which are not entitlement programs; these states may seek to institute enrollment caps and waiting lists or cut back benefits if their state allotments are insufficient.

The original BBA also required that for a newborn to remain eligible for Medicaid for a period of one year, the child must be a member of the woman's household, and the woman must remain eligible for such assistance (as if she were still pregnant). CHIPRA eliminates these two mandates. Thus, a newborn need not remain in the household, nor must the woman remain eligible for Medicaid, potentially enabling more infants to remain eligible for Medicaid. CHIPRA, §113(b)(1) (amending 42 U.S.C. § 1397ee(a)(1)).

Limits on CHIP Funds for States Proposing Coverage that Exceeds 300 Percent of FPL—Section 114.

Currently, states such as New York and New Jersey receive enhanced FMAP rates for SCHIP coverage of children with family incomes over 300 percent of the FPL. Under CHIPRA, future states providing such coverage will receive FMAP at the federal Medicaid rate rather than at the enhanced CHIP rate. *See* CHIPRA, §114(a) (amending 42 U.S.C. § 1397ee(c)). However, New York and New Jersey are exempted from this modification and will continue to receive CHIP funds at the enhanced rate. *Id.*

Outreach and Enrollment

Grants and Enhanced Funding for Outreach and Enrollment—Section 201.

Grants—Section 201(a).

Section 201(a) authorizes $100 million to fund a campaign to identify and enroll uninsured children in Medicaid and CHIP during fiscal years 2009 through 2013. *See* CHIPRA, § 201 (adding § 2113 to the Social Security Act, to be codified as 42 U.S.C. § 1397mm(a)).

The legislation includes $10 million (10 percent) set aside for a national enrollment campaign. Among other things, the Secretary of DHHS can work with the Secretaries of Education and Agriculture to link the eligibility and enrollment systems for the child assistance programs that each Secretary administers; conduct public health awareness campaigns; increase enrollment hotlines; and develop special outreach materials for Native Americans or individuals with limited English proficiency. *Id.* (adding § 2113(h) to the Social Security Act, to be codified as 42 U.S.C. § 1397mm(h)).

The legislation also includes $10 million (10 percent) set aside for targeting outreach and enrollment efforts to Native American children. *Id.* (adding § 2113(b)(2) to the Social Security Act, to be codified as 42 U.S.C. § 1397mm(b)(2)).

The Secretary of DHHS is to award the remaining $80 million as grants to "eligible entities" that will target outreach and enrollment efforts to geographic areas with high rates of unenrolled children, including children in rural areas, racial and ethnic minorities and health disparity populations, and those who experience cultural and linguistic barriers to enrollment. CHIPRA, § 201(a). "Eligible entities" under this provision are: (1) states with state CHIP plans; (2) local governments; (3) Indian tribes or tribal organizations; (4) federal health safety net organizations, such as federally qualified health centers, disproportionate share hospitals, WIC programs, or Head Start or school lunch programs; (5) public or nonprofit organizations, including organizations that use "community health workers" or community-based doula programs; (6) faith-based organizations; and (7) elementary or secondary schools. The phrase "community health worker" is defined as an:

> individual who promotes health or nutrition within the community in which the individual resides--(A) by serving as a liaison between communities and health care agencies; (B) by providing guidance and social assistance to community residents; (C) by enhancing community residents' ability to effectively communicate with health care providers; (D) by providing culturally and linguistically appropriate health or nutrition education; (E) by advocating for individual and community health or nutrition needs; and (F) by providing referral and follow up services.

Id. (adding § 2113(f) to the Social Security Act, to be codified as 42 U.S.C. § 1397mm(f)). States that receive grants will have to adhere to maintenance of effort requirement to maintain the state share of funds expended for outreach and enrollment activities under the state CHIP plan at or above the state share expended in the fiscal year preceding the first fiscal year of the grant award. However, participating eligible entities, including states, are not required to provide any matching funds as a condition for receiving a grant. *Id.* (adding § 2113(e) to the Social Security Act, to be codified as 42 U.S.C. § 1397mm(e)).

Grants will be awarded using an application process. The application will include information showing that the eligible entity includes members who have "access to, and credibility with" target populations and can address enrollment barriers, such as "lack of awareness of eligibility, stigma concerns and punitive fears associated with receipt of benefits."

Id. (adding § 2113(c) to the Social Security Act, to be codified as 42 U.S.C. § 1397mm(c)). The application will also include performance measures for evaluating the effectiveness of the grant. Enrollment data and information collected from grantees will be publicly available, and the Secretary will submit an annual report to Congress based on the reported information. *Id.* (adding § 2113(d) to the Social Security Act, to be codified as 42 U.S.C. § 1397mm(d)).

Enhanced Administrative Funding for Language Access—Section 201(b).

CHIPRA authorizes enhanced federal administrative matching payments for the provision of language access services in CHIP and Medicaid programs. State CHIPs may now receive enhanced federal matching for translation or interpretation services "in connection with the enrollment of, retention of, and use of services under this title by, individuals for whom English is not their primary language." CHIPRA, § 201(b) (to be codified as 42 U.S.C. § 1397mm(b)). The enhanced rate will be the higher of 75 percent or the sum of the state's current federal CHIP administrative matching rate plus five percentage points.

State Medicaid programs may receive increased federal administrative payments for language access services provided to children, but not adults with disabilities or the elderly. State Medicaid programs may now receive a federal matching rate that is equal to 75 percent of sums expended and attributable to "translation or interpretation services in connection with the enrollment of, retention of, and use of services under this title by, children of families for whom English is not the primary language." CHIPRA, § 201(b) (amending 42 U.S.C. § 1396b(a)(2)).

Advocates should be aware that federal civil rights laws have been interpreted to require CHIP and Medicaid providers to provide language assistance services to limited-English proficient beneficiaries; however, these laws do not include payment mechanisms to assist the states. Thus, payment through CHIP and Medicaid can be critical to low-income children obtaining access to needed care. Currently, only 12 states and the District of Columbia provide for reimbursement. The enhanced administrative funding for language access in CHIPRA may cause more states to decide to do so. For more information about federal reimbursement for language services, *see Language Services Action Kit: Interpreter Services in Health Care Settings for People with Limited English Proficiency* (revised February 2004) http://www.healthlaw.org/library/attachment.65918 & *Medicaid and SCHIP Reimbursement Models for Language Services—2007 Update* http://www.healthlaw.org/library/item.142454].

Increased Outreach and Enrollment of Indians—Section 202.

Under original SCHIP law, states must include a description of their outreach and enrollment processes, including for Native American children. *See, e.g.*, 42 U.S.C. § 1397bb(b). Non-benefit payments under CHIP, including those attributable to outreach and administration, are generally capped at 10 percent of the total amount of CHIP expenditures.

CHIPRA encourages states to take steps to improve outreach and enrollment of Indian children residing on or near reservations. CHIPRA, §202(a) (amending 42 U.S.C. § 1397bb(b)). State activities can include outstationing of eligibility workers and entering into agreements with

the Indian Health Service and tribal organizations to provide outreach and enrollment services. *Id.* Expenditures associated with these outreach and enrollment efforts are excluded from the 10 percent cap on administrative costs. *Id.*

State Option to Rely on Findings From an Express Lane Agency to Conduct Simplified Eligibility Determinations—Section 203.

State Medicaid agencies determine eligibility of applicants by assessing a number of factors, including income, citizenship, residency and personal characteristics (e.g. whether the applicant is a child under age 19 or an individual with a disability). State Medicaid agencies will approach other agencies, such as the Internal Revenue Service or the Social Security Administration, to verify the information provided by an applicant. States can make limited use of information obtained by other entities; for example, the agency administering the Temporary Assistance for Needy Families (TANF) program may obtain Medicaid eligibility information using a joint application form. State CHIP programs can only enroll low-income, uninsured children who do not qualify for Medicaid.

CHIPRA provides states with a new "Express Lane" option for streamlining Medicaid/CHIP eligibility determinations and/or redeterminations. *See* CHIPRA, § 203. "Child" is defined to mean an individual under age 19, or, at state option, up to age 21. The Express Lane option became effective upon enactment of CHIPRA, *id.* at § 203(f), and applies to eligibility determinations made on or before September 30, 2013, *id.* at § 203(a).

Specifically, the option allows the state Medicaid agency to rely on a finding made within a reasonable period (as determined by the state) from an "Express Lane agency" when it determines whether a child satisfies one or more eligibility requirements for Medicaid, notwithstanding any differences in income disregards, budgeting units or methodologies. CHIPRA, § 203(a) (adding 42 U.S.C. § 1396a(e)(13) (Medicaid), *see also* 42 U.S.C. § 1397gg(e)(1)(B) (CHIP) (conforming amendment), § 1396a(a)(25)(I)(i) (conforming amendment).

An "Express Lane" agency is a public agency that the state Medicaid or CHIP agency decides is capable of making determinations of one or more eligibility requirements. They can include the Medicaid, CHIP, TANF, WIC, school lunch program or public housing programs. However, the term does not include agencies that determine eligibility for a Title XX Social Services Block Grant program or private, for-profit organizations. At state option, a finding from an Express Lane agency can include gross income or adjusted gross income shown by state income tax records or returns.

States using the Express Lane option must meet the following conditions: First, if the Express Lane finding results in the child being ineligible for Medicaid/CHIP, the state must determine eligibility using its regular procedures. Second, if the Express Lane agency finds that the child qualifies for Medicaid/CHIP subject to payment of a premium, the state must notify the family that the child may qualify for lower premium payments under the state's regular policies and explain how to request such an evaluation. Third, the state must satisfy verification

requirements for citizenship status. *Id.* Fourth, the state must continue to satisfy "screen and enroll" policies, which require children who apply for CHIP to be enrolled in Medicaid if they qualify. *Id.*

States using Express Lane agencies are given options for satisfying the screen and enroll requirement. Under one option, the state can establish a threshold of the federal poverty level that exceeds the highest income threshold applicable under Medicaid for the child by a minimum of 30 percentage points, or, at state option, a higher percentage that reflects the value (as determined by the state) of differences between the income methodologies used by the Express Lane agency and Medicaid. A child with income at or below the threshold will be deemed to satisfy the Medicaid income eligibility criteria while a child with income above the screening threshold is considered eligible for CHIP. If the child is enrolled in CHIP under this option, the state must notify the caregiver that the child may be eligible for Medicaid if the regular eligibility process is applied, how to obtain a regular Medicaid determination, and a description of the differences between Medicaid and CHIP. CHIPRA, § 203(a).

Under the other option, the state enrolls the child in CHIP for a temporary period if the child appears eligible for CHIP based on the finding of an Express Lane agency. During the temporary enrollment period, the state will determine the child's eligibility for CHIP or Medicaid. In making the determination, the state must use procedures that, to the maximum extent, reduce the burden imposed on families and may not, for example, require verification of information already provided to the Express Lane agency unless there is reason to believe that information was erroneous. *Id.*

The Express Lane option allows the state agency to initiate and determine a child's eligibility without an application, but the child can only be automatically enrolled in Medicaid/CHIP if the child or caregiver affirmatively consents through written, oral, or electronic affirmation or by a signature on an Express Lane agency application. When automatic enrollment is used, the state agency must inform the caregiver of covered services and how to use them. In general, state Medicaid/CHIP agencies will not need to obtain an applicant's signature under penalty of perjury for those elements of eligibility that are based on the determination of the Express Lane agency or another public agency; rather, any signature requirement can be satisfied through an electronic signature, *see* 44 U.S.C. § 3504 note. CHIPRA, § 203(c) (adding 42 U.S.C. § 1396a(a)(dd)).

States must assign codes to affected children as directed by the Secretary of HHS and must annually provide the Secretary with a statistically valid sample of the children enrolled through Express Lane. Error rates will be determined. If the error rate exceeds three percent for either of the first two fiscal years during which the state is exercising the option, the state must demonstrate satisfactory corrective actions. If the error rate exceeds three percent for any fiscal year, there will be a reduction in federal funding; however, that reduction will be calculated based only on the children included in the sample size that exceeds the three percent error rate.

The Secretary is to conduct a comprehensive, independent evaluation of the option. The evaluation will address, among other things, the extent of erroneous enrollment; whether the

option improves the ability of the state to enroll uninsured, low-income children into Medicaid or CHIP; the extent to which the option produces administrative costs or savings; and recommendations for improving enrollment processes. A report is to be submitted to Congress no later than September 30, 2012.

A final amendment establishes a general authorization for information disclosure. *See* CHIPRA, § 203(d)(adding 42 U.S.C. § 1397gg(e)(1)(F)). Notwithstanding any other provision of law, a federal or state agency or private entity in possession of data directly relevant to eligibility determinations is authorized to convey such data or information to the state agency. This information includes eligibility files maintained by Express Lane agencies; wage or other income and eligibility verification information; vital records information about births in any state; National New Hire Database information; and information about other third party insurance coverage. However, the information can be conveyed only if the individual described in information (or such individual's caregiver) has either consented in advance to disclosure or has not objected to disclosure after being notified. The information can be used solely for the purposes of identification and enrollment of individuals who are eligible or potentially eligible for Medicaid/CHIP. Private entities that improperly disclose information are subject to a civil money penalty in an amount equal to $10,000 for each unauthorized publication or disclosure, and, if the publication or disclosure is willful, a fine of not more than $10,000 and/or imprisonment for up to one year for each unauthorized disclosure. CHIPRA, § 203(d).

Verification of Declaration of Citizenship or Nationality—Section 211.

Alternative State Process for Verification of Declaration of Citizenship or Nationality for Purposes of Eligibility for Medicaid—Section 211(a).

The previous law on citizenship documentation is found in 42 U.S.C. § 1396b(i)(22) and (x). Together, those provisions dictate that a state will not receive federal matching funds for services provided to any Medicaid recipient, with certain exceptions, who has not proven his or her citizenship by providing one or more of the documents set out in § 1396b(x)(3) or in the federal regulations treating this subject found at 42 C.F.R. § 435.407. The list of documents found in the statute, and the procedures for presenting them set out in the regulations, have created an onerous process that many citizens have been unable to navigate. Even when a person is successful, however, the cost of acquiring the necessary documents has represented a *de facto* application fee for Medicaid, one that can run almost as high as $100.

Effective January 1, 2010, CHIPRA gives states a new option for allowing applicants, and perhaps a few remaining current recipients, to verify their citizenship without acquiring any particular documents. *See* CHIPRA, 211(a)(adding 42 U.S.C. § 1396a(a)(46)(B)). This option allows a state either to follow the DRA citizenship documentation requirements or to follow a new procedure that is set out in a new § 1396a(ee). *Id.*

Under § 1396a(ee), a state may allow a person to provide his or her name and Social Security number (SSN) and send those to the Social Security Administration (SSA) to see if they match what that agency has on file for the person. *Id.* (adding 42. U.S.C. § 1396a(ee)(1)).

If the state gets a positive response from SSA, the person has met the citizenship documentation requirement. Note that because of the way the new law is structured, if and for so long as the state agency does not hear anything from SSA (i.e., it is not notified that the person's name and SSN do not match), the person will continue to receive Medicaid, if otherwise eligible. *Id.* (adding 42. U.S.C. § 1396a(ee)(4)). If the SSA notifies the state agency that a person's name and SSN do not match, then the agency must make a "reasonable effort to identify and address" the inconsistency by contacting the individual and by following such other procedures as the Secretary or the state have created. *Id.* (adding 42 U.S.C. § 1396a(ee)(1)(B)(i)). States will receive a 90 percent federal match for the costs involved in setting up the matching system with the SSA and will thereafter receive a 75 percent federal match for the operating costs of the system. *Id.* (adding 42 U.S.C. § 1396a(ee)(3)(F)).

This provision offers an important opportunity to advocate for your state to adopt a thorough procedure for attempting to resolve purported inconsistencies reported to it by the SSA, because the statute sets forth no outer time limit for that procedure to run its course, and the person will receive Medicaid benefits and the state will receive federal match for any benefits provided during that time.

If the state is unable to resolve the inconsistency, it must notify the person of this fact and give the person 90 days from receipt of the notice either to work with the SSA to resolve the problem, or to submit the documentation of citizenship required by the DRA statute and regulations. *Id.* (adding 42 U.S.C. § 1396a (ee)(1)(B)(ii). If at the end of this 90-day period, the person has neither resolved the problem with the SSA nor provided the documentation required under DRA, then the state agency must send the person a termination notice within 30 days. This notice and review procedure is subject to the same appeal procedures, including aid paid pending appeal, as is any other termination notice. *Id.*

Clarification of Requirements Relating to Presentation of Satisfactory Documentary Evidence of Citizenship or Nationality—Section 211(b).

Section 211(b) of CHIPRA makes several changes to the current system of citizenship documentation that is set forth in § 1396b(x). The changes made by this Section of CHIPRA apply retroactively as if they were included in the DRA, which was enacted in February 2006. *See* CHIPRA, § 211(d)(1)(B).

Perhaps the most important change is one that mirrors the "reasonable opportunity" provision discussed above with regard to the new option available to states under § 1396a(ee). Current practice is that applicants for Medicaid do not get Medicaid benefits until they have successfully submitted the required documentation to the state agency. Thus, the applicant bears the risk not only of delay, but of getting a document that the agency decides is unacceptable for some reason. CHIPRA changes this situation by amending § 1396b(x) to require states to give an otherwise eligible person Medicaid while he or she is attempting to document citizenship, for at least the same "reasonable opportunity" period as is offered to qualified immigrants under 42 USC § 1320b-7(d)(4) to provide proof of qualifying immigration status. *See* CHIPRA, § 211(b)(2)(amending 42 U.S.C. § 1396b(x)(4)). For advocates in states that do not choose the §

1396a(ee) option, this is a very important provision, as applicants will be able to meet their medical needs while undertaking the citizenship documentation paper chase. They will now get a notice of termination, rather than a notice of denial, if they are unable to acquire the proper papers. *Id.* Accordingly, if a timely notice of appeal is filed, the person will have up to an additional 90 days to acquire the documentation while receiving Medicaid or CHIP benefits. *Id.*

Another change to the current system involves infants of undocumented immigrant mothers who are born in U.S. hospitals and whose births are covered by emergency Medicaid. Pursuant to CMS policy under the Bush administration, such infants were not deemed eligible for Medicaid for a year upon their births, despite the provision in § 1396a(e)(4) that seemed to make them eligible. Further, such children were required to document their citizenship in the manner set forth in § 1396b(x), despite the fact that the state agency, having paid for the birth under emergency Medicaid, had irrefutable proof of citizenship by virtue of birth in the country. CHIPRA § 211(b) fixes both of these problems. It amends § 1396b(x) to provide that a child born in the United States to an "alien mother" covered by emergency Medicaid is deemed eligible for Medicaid for the first year of life and is deemed to have documented his or her citizenship. *See* CHIPRA, § 211(b)(3)(amending 42 U.S.C. § 1396b(x)(2)(D) and (5)). It also amends § 1396a(e)(4) to require that such children be assigned a "separate identification number" upon birth so that they will not get lost in the Medicaid system. *Id.*

In addition to the changes above, § 1396b(x)(3) is amended to require the Secretary to accept federally recognized Indian tribe documents showing membership in the tribe as proof of citizenship. It also provides special rules for those tribes whose territory spans international borders. CHIPRA, § 211(b)(1)(amending 42 U.S.C. § 1396b(x)(3)).

Finally, because the amendments discussed above are retroactive in effect, CHIPRA provides that states may deem eligible for Medicaid, as of the date of denial, any person who was denied medical assistance between July 1, 2006 and October 1, 2009 solely because of a failure to document citizenship under § 1396b (x) as it was then in effect, if the person would have been eligible for Medicaid under § 1396b(x) as amended by CHIPRA. It is not clear from the amendment whether a state adopting this option would have to deem everyone in that category eligible or whether it could develop criteria, possibly based on hardship, for example, for making individual determinations. This provision offers an excellent opportunity for advocacy in your state to help people who may have incurred large medical bills because of an inability to document their citizenship under the unduly harsh rules that were in effect prior to CHIPRA. Advocacy on this issue may be especially important if you live in a state with a large Indian population, and/or if your state decides to develop criteria to apply this provision only in hardship situations.

The time limits set out above should allow advocates to acquire needed medical care for almost everyone who is financially eligible for Medicaid if your state adopts the new option. Depending on how frequently your state sends names and SSNs to the SSA (at a minimum, monthly), and how quickly your state resolves fair hearing requests, it could well be the case that nine months or more might pass between the time a person applies for Medicaid and a final determination is made regarding their citizenship. *See id.* (adding 42 U.S.C. § 1396a (ee)(2)(B)

(30 days to send the name and SSN to the SSA for confirmation, 10 days or more to hear back from the SSA that the name and SSN do not match, 30 days for the state agency to try to resolve the problem, 90 days for the person to try to resolve the problem if the state agency fails to do so, 30 days for the notice of termination if the person has not verified after 90 days, and up to 90 days for the state agency to decide the appeal, during which the person can get continued benefits if his or her appeal was timely filed.) States will get federal match for any benefits provided during this period, even if the person is ultimately unable to document citizenship. If a state experiences an error rate of more than three percent in matching names and SSNs and does not take certain enumerated steps to address that problem, then it may be subject to recoupment of federal match for that percentage of cases. *Id.* (adding 42 U.S.C. § 1396a(ee)(3)). The above timelines and procedure do not apply, however, if a person is unable to provide the state agency with a SSN. In that case, the state agency must provide the person with a "reasonable opportunity" to acquire the documentation required under the DRA and must provide the person with Medicaid benefits during that period. The reasonable opportunity period offered pursuant to this provision must be at least as much time as qualified immigrants are already currently being given under 42 U.S.C. § 1320b-7(d)(4) to provide proof of qualifying immigration status. The state will receive federal match for any benefits provided during the period. *Id.* (adding 42 U.S.C. § 1396a(ee)(2)(c)).

Application of Documentation System to CHIP—Section 211(c).

While the changes discussed above represent a major improvement over the previous law, for the first time, the requirement to verify citizenship has been extended to the CHIP program. This is accomplished by § 211(c) of CHIPRA, which adds a new paragraph (9)(A) to 42 U.S.C. § 1397ee(c) that requires states to comply with the requirements of § 1396a(a)(46)(B) in operating their CHIP programs. *See* CHIPRA, § 211(c)(amending 42 U.S.C. § 1397ee(c)). This means a state can, if not persuaded otherwise, apply the more onerous provisions of § 1396b(x) rather than the more sensible system authorized by § 1396a(ee). Advocates should be prepared to push hard to have their states adopt the latter system, as it is much less likely to result in eligible citizens being denied benefits.

States will be reimbursed 90 percent of their costs for setting up the citizenship documentation system for CHIP and 75 percent of their ongoing costs for operating the system. *Id.* (amending 42 U.S.C. § 1397ee(c)(9)(B)). In addition, the costs of operating the system will not count against the cap on administrative expenses that otherwise apply to CHIP. *Id.* (amending 42 U.S.C. § 1397ee(c)(2)(C)(ii).

In CHIPRA, Congress clarifies that no federal funding is allowed for individuals who are not legal residents. *See* CHIPRA, § 605.

Reducing Administrative Barriers to Enrollment—Section 212.

CHIPRA § 212 amends § 1397bb to require states to address enrollment barriers for eligible people in their CHIP and Medicaid programs. A state must now develop and describe in its CHIP state plan the "procedures used to reduce administrative barriers to the enrollment of

children and pregnant women who are eligible for" Medicaid or CHIP. *See* CHIPRA, § 212 (amending 42 U.S.C. § 1397bb(b)(4)(A)). The state must also update its procedures as often as it deems appropriate in response to the most recent data that it has regarding barriers to enrollment. *Id.* However, a state will be deemed to be in compliance with the requirements of § 1397bb(b)(4)(A) if it uses a common application, auxiliary forms and verification process for Medicaid and CHIP, and does not require the application to be filed in person or require a face-to-face interview. *Id.* (amending 42 U.S.C. § 1397bb(b)(4)(B). While the state may be deemed to have adequate procedures if it takes these steps, this should not affect the ongoing reporting and updating of procedures, as required by this provision.

Model Interstate Coordinated Enrollment and Coverage—Section 213.

CHIPRA requires the DHHS Secretary, within 18 months of enactment of CHIPRA, to develop a model process for coordinating the "enrollment, retention and coverage" under Medicaid and CHIP of children who frequently change their state of residency (or location) due to migration, natural disasters, public health emergencies, educational needs or other reasons. CHIPRA, § 213. The Secretary is instructed to develop this plan in consultation with state Medicaid and CHIP directors and "organizations representing program beneficiaries." *Id.* If you live in a state that is a migrant labor base or stream state, or in a state with frequent nature-related dislocations, this is a good opportunity to help design mechanisms for interstate continuation of benefits. After developing the plan, the Secretary is required to report to Congress and to inform Congress of any additional authority needed to further improve the interstate coordination of benefits. *Id.*

Permitting Coverage without a Five-Year Delay of Certain Children and Pregnant Women—Section 214.

Under earlier law, most immigrant children and pregnant women who are lawfully present in this country do not qualify for Medicaid or CHIP benefits for the first five years of their lawful presence here. Section 214 of CHIPRA amends the Medicaid Act to allow states the option to provide Medicaid to otherwise qualified members of either or both of these populations without the five-year waiting period. To qualify, a person must be "lawfully residing" in the United States, and that term includes battered individuals. CHIPRA, § 214 (amending 42 U.S.C. § 1396(v)(4)(A). However, "lawfully residing" is not a term of art used in immigration law, so it may eventually need to be defined by the Secretary. In the meantime, advocates should urge their state agencies to apply the term to anyone who is "lawfully present" in this country, as the latter term is regularly used in immigration law.

For purposes of this amendment, a "child" is defined as anyone under 21 years of age, and a "pregnant woman" is someone who is pregnant or is within the 60-day postpartum period. CHIPRA, § 214 (amending 42 U.S.C. § 1396b(v)(4)(A)(i) and (ii)).

If a state elects to provide benefits to qualified immigrants under this amendment, the costs of any benefits received are not considered a debt of the immigrant's sponsor, and the sponsor's income will not be deemed to the immigrant. *Id.* (amending 42 U.S.C. §

1396b(v)(4)(A) and (B)). A state electing to cover immigrant children and/or pregnant women must have a procedure for ascertaining upon redetermination that the person continues to "lawfully reside" in the United States, but the state agency is required to make this determination using documents provided upon initial application, unless that is not possible. *Id.* (amending 42 U.S.C. § 1396b(v)(4)(C)). Note that in most cases the documentation provided upon application will reveal a qualifying immigration status that is not subject to change in a way that would render the person ineligible for benefits, at least while the person remains in this country.

Finally, CHIPRA allows a state the option of covering these same groups of "lawfully residing" immigrants under its CHIP program. However, a state cannot choose this option unless it has also chosen to cover the same category or categories of "lawfully residing" immigrants under Medicaid. *Id.* (amending 42 U.S.C. § 1397gg(e)(1)(E).

Reducing Barriers to Providing Premium Assistance

State Option for Providing Premium Assistance—Section 301.

CHIPRA offers states additional options under CHIP for providing premium assistance subsidies for qualified employer-sponsored coverage to CHIP-eligible, low-income children who voluntarily elect to receive such a subsidy. Under this provision, qualified employer-sponsored coverage means a group health plan offered through an employer that provides creditable coverage for which the employer contribution is at least 40 percent and is offered to all individuals in a nondiscriminatory manner. It does not, under this provision, include coverage consisting of a health flexible spending arrangement or high deductible health plan. CHIPRA, § 301(a)(1)(amending 42 U.S.C. § 1397ee(c)). The term premium assistance subsidy means the amount equal to the difference between the employee contribution required for enrollment only of the employee and the employee contribution required for enrollment of the employee and the child in such coverage, less any applicable cost-sharing. *Id.* Participation by employers and families is voluntary, and states must create a process for allowing parents of low-income children receiving the subsidy to disenroll from the employer-sponsored coverage and enroll in the CHIP program, effective on the first day of any month in which the child is eligible for CHIP and in a manner that ensures continuity of care. *Id.*

The state can provide the subsidy as a reimbursement to the employee or directly to the employee's employer. Expenditures shall be considered child health assistance under CHIP. The state will be treated as a secondary payor. Advocates should be aware of the fact that this provision does not affect premium assistance waiver programs; these programs, established by states under Medicaid or CHIP waiver authority, offer Medicaid and CHIP-eligible individuals premium assistance for employer-sponsored coverage rather than traditional fee-for-service or managed care program benefits. *Id.*

For premium assistance subsidies in the CHIP program, the state must provide supplemental coverage of federally mandated services that are not covered or only partially covered; for example, if the employer-sponsored plan did not cover radiological services, then the state would have to provide supplemental coverage of that mandated benefit. The state must

also provide cost-sharing protections. *Id.* However, if the group health plan or insurance offered through an employer is certified as actuarially equivalent to the benefits coverage in a benchmark benefit package, *see* 42 U.S.C. § 1397(b) and (c), then the state may provide a premium assistance subsidy without having to offer supplemental coverage for benefits or cost-sharing protections. *Id.* CHIPRA also requires that any waiting period under the state child health plan apply to the same extent to the premium assistance subsidy. *Id.* This provision allows states to provide the subsidy to parents in the same manner in which the state offers it to the child.

In addition, CHIPRA permits states to establish employer-family premium assistance purchasing pools for employers with less than 250 employees that have at least one employee who is either a pregnant woman eligible for CHIP or a member of a family with a child enrolled in CHIP. *Id.* The coverage must offer a choice of no less than two private health plans that offer benchmark or benchmark-equivalent benefits packages. *Id.; see also* 42 U.S.C. § 1397(b) and (c).

Note that for premium assistance subsidies offered to children receiving child health assistance under Medicaid, the provisions of Section 1906A, to be codified as 42 U.S.C. § 1396e-1, shall apply and supersede any other provisions inconsistent with the Section. *Id.*

If a state does elect to provide premium assistance subsidies, it must include information about the availability of the subsidy on application and enrollment forms, and provide information describing the subsidy's availability and means of election as part of the application and enrollment process. The state must also establish procedures to ensure that parents are fully informed of the choices of receiving child health assistance through the CHIP program or through receipt of the subsidy. *Id.*

Section 301 of CHIPRA also enables states to offer premium assistance subsidies to children under the age of 19 who are entitled to Medicaid benefits. *See* CHIPRA, § 301(b) (adding §1906A to the Social Security Act, to be codified at 42 U.S.C. § 1396e-1). As with premium assistance subsidy programs under CHIP, the subsidy must be offered only for qualified employer-sponsored coverage. *Id.* Here too, qualified employer-sponsored coverage means a group health plan offered through an employer that provides creditable coverage for which the employer contribution is at least 40 percent and is offered to all individuals in a nondiscriminatory manner; it does not include coverage consisting of a health flexible spending arrangement or high deductible health plan. *Id.* Coverage provided under qualified employer-sponsored coverage shall be treated as third party liability under 42 U.S.C. § 1396a(a)(25). *Id.* The term premium assistance subsidy in the Medicaid context means the amount of the employee contribution for enrollment in the qualified employer-sponsored coverage by the individual under age 19 or by the individual's family. *Id.*

Participation by employers and families is voluntary, and the state shall create a process allowing parents of individuals under the age of 19 receiving the subsidy be allowed to disenroll. *Id.* The state must pay all enrollee premiums and all deductibles, coinsurance and other cost-sharing obligations for items and services otherwise covered by Medicaid. *Id.*

CHIPRA mandates that no later than January 1, 2010, the GAO will study cost and coverage issues relating to any premium assistance program for which federal funding is made under Medicaid or CHIP. *See* CHIPRA, § 301(c).

While premium assistance subsidies have the potential of saving states a great deal of money and enabling families to possess the same health plan and group of providers, it is uncertain how comprehensive the coverage will be for children entitled to CHIP and Medicaid benefits. Moreover, for Medicaid-eligible children, how EPSDT benefits will be provided or ensured remains unclear.

Outreach, Education and Enrollment Assistance—Section 302.

CHIPRA requires a state to include in its state child health plan how it will provide outreach, education, and enrollment assistance for families who are likely to be eligible for the premium subsidies discussed above to inform them of the availability of subsidies and to assist them in enrolling their children, and also for employers likely to provide coverage eligible for such subsidies, including the specific, significant resources the state intends to apply to educate employers about the availability of the subsidies. *See* CHIPRA, § 302 (amending 42 U.S.C. § 1397bb(c)). While outreach expenditures related to premium assistance subsidies will not be subject to the 10 percent limit on nonbenefit expenditures, they will be limited to an 11.25 percent cap. *Id.*

Special Enrollment Period Under Group Health Plans in Case of Termination of Medicaid or CHIP Coverage or Eligibility for Assistance in Purchase of Employment-Based Coverage—Section 311.

This provision amends the federal Internal Revenue Code, the Public Health Service Act, and the Employee Retirement Income Security Act (ERISA) by allowing eligibility in or termination of Medicaid or CHIP benefits to serve as a "qualifying event" for purposes of enrolling in an employer-sponsored insurance plan. The employee must request coverage under the group health plan or health insurance coverage no later than 60 days from the eligibility determination or date of termination. CHIPRA, § 311.

Additionally, each employer that maintains a group health plan shall provide to each employee a written notice informing the employee of potential opportunities for premium assistance. The employer may also provide the model notice to the employee in connection with an open season or election process. The plan administrator is required to disclose to the state information about the benefits available under the group health plan in sufficient detail to allow the state to determine the cost-effectiveness of providing medical or child health assistance through premium. *Id.*

CHIPRA requires that within one year of the legislation's enactment, the Secretary of DHHS in consultation with the State Medicaid Directors and the State CHIP Directors, develop national and state-specific model notices to enable employers to comply with the requirements described above. *Id.* Within 60 days of enactment, the Secretary of DHHS with the Secretary

of Labor is required to establish a Medicaid, CHIP and Employer-Sponsored Coverage Coordination Working Group to develop a model coverage coordination disclosure form, and to identify impediments to the effective coordination of coverage available to families that include employees of employers that maintain group health plans and members who are eligible for Medicaid and CHIP benefits. *Id.* The model form is a form for plan administrators of group health plans, described above. It shall include, at a minimum, the following information:

(1) A determination of whether the employee is eligible for coverage under the group health plan;
(2) The name and contract information of the plan administrator of the group health plan;
(3) The benefits offered under the plan;
(4) The premiums and cost-sharing required under the plan; and
(5) Any other information relevant to coverage under the plan.

Id. The Working Group should consist of no more than 30 members, and shall include representatives of DHHS, Department of Labor, State CHIP Directors, State Medicaid Directors, employers, plan administrators and sponsors, health insurers, and children and other Medicaid and CHIP beneficiaries. Within 18 months of CHIPRA enactment, the Working Group must submit the model form to the Secretary of DHHS and the Secretary of Labor. *Id.*

Strengthening Quality of Care and Health Outcomes

Child Health Quality Improvement Activities for Children Enrolled in Medicaid or CHIP—Section 401.

Under previous law, DHHS was pursuing a number of quality improvement activities. CHIPRA adds a new, multi-pronged initiative to improve health quality measures for children enrolled in Medicaid or CHIP. *See* CHIPRA, § 401 (adding section 1139A to the Social Security Act, to be codified as 42 U.S.C. § 1320b-9).

For each of fiscal years 2009 through 2013, $45 million is appropriated for the purpose of carrying out these activities, *id.* at § 401(i), with some of the funding earmarked for certain activities described below.

CHIPRA directs the Secretary of DHHS to develop an initial core set of child health quality measures for use by state Medicaid and CHIP programs and their contractors. These measures will include:

(1) The duration of children's health insurance coverage over a 12-month period;
(2) The availability and effectiveness of preventive services and treatments, including services to promote healthy births, detect the presence or risk of conditions that could adversely affect growth and development, and treatments to correct or ameliorate physical and mental conditions;
(3) The availability of care in a range care settings; and

(4) The types of measures that can be used to estimate the overall national quality of health care for children, and to perform comparative analyses of pediatric health care quality and racial, ethnic, and socioeconomic disparities in care.

Id.

By February 2010, the DHHS Secretary, in consultation with states, must develop a standardized format for reporting the measures, along with procedures that will encourage states to use the core set of child quality measures. The term "core set" is referring to a group of "valid, reliable, and evidence-based" quality measures that, taken together, provide information regarding the quality of health coverage and health care for children through the developmental age span, and allow purchasers, families, and health care providers to understand the quality of care in relation to the preventive and treatment needs of children. *Id.*

The Secretary of DHHS is also to disseminate information to states regarding best practices among states with respect to measuring and reporting on the quality of child health care and to facilitate the adoption of the best practices. These best practice approaches are to give particular attention to techniques that ensure the timeliness and accuracy of provider reporting, improve efficiency in data collection and using health information technology, and encourage successful quality improvement strategies. The Secretary will report to Congress on the status of the core measurement efforts, along with any recommendations for legislative changes, no later than January 1, 2011 and every three years thereafter. *Id.*

The Secretary of DHHS is also charged to improve pediatric quality measures. *Id.* By January 1, 2011, the Secretary is to establish a pediatric quality measures program to improve and strengthen the initial core child health care quality measures, advance the development of new quality measures, and "increase the portfolio of evidence-based, consensus" pediatric quality measures. *Id.* At a minimum, the measures developed under this program must be evidence-based; designed to identify and eliminate racial and ethnic disparities in child health and the provision of child health care; designed in standard formats that permit comparison; and periodically updated. The Secretary is to consult with a range of entities including states, pediatric care providers, national organizations representing children and purchasers of children's health care, national organizations and individuals with expertise in pediatric health quality measurement, and voluntary standards-setting organizations. The Secretary will also award grants and contracts for the development, testing, and validation of new evidence-based measures for children's health care services, and for the dissemination of such measures to public and private purchasers of health care for children. Beginning no later than January 1, 2013, and annually thereafter, the Secretary will publish recommended changes to the core quality measures that will reflect the findings of the pediatric quality measures program. *Id.*

States also have important responsibilities in the new quality initiative. Each state must annually report to the Secretary on the state-specific child health quality measures being used, including information collected through external quality reviews of managed care organizations, *see* 42 U.S.C. § 1396u-4, and benchmark plans, *see* 42 U.S.C. §§ 1396u-7, 1397cc. The

Secretary will analyze this information and issue annual reports beginning no later than September 30, 2010. *Id.*

CHIPRA appropriates $20 million to allow the Secretary to award up to 10 states and child health providers demonstration projects to evaluate promising practices for improving the quality of children's health care and the use of health information technology. These grants will occur during fiscal years 2009 through 2013, and may include evaluation of provider-based models or the use of model electronic health records. *See id.*

Childhood obesity receives targeted attention in the quality improvement effort. The Secretary of DHHS is appropriated $25 million over five years to develop a comprehensive and systematic model for reducing childhood obesity through grants to eligible entities. These entities include cities and counties, educational agencies, local health departments, health care providers, and community-based organizations. Priority will be given to entities that have established track records, comprehensive strategies and plans for continuing the project after federal funding ends. Grantees must use the funding to carry out community-based activities aimed at reducing childhood obesity through, for example, educational curricula and interventions for children and caregivers, after-school recreational activities, and community education that stress exercise and diet. The Secretary will report to Congress on implementation of the demonstration project within three years after its implementation. *Id.*

Congress intends for the Secretary and the states to pursue use of electronic heath record formats for children enrolled in Medicaid or CHIP. No later than January 1, 2010, the Secretary must establish a program to encourage the development and dissemination of a model electronic health record format that is accessible and useful to parents and caregivers, and that is compatible with other standards developed for electronic health records. Congress appropriates $5 million for this effort. *Id.*

The Institute of Medicine is to study pediatric health and health care quality measures and report to Congress no later than July 1, 2010. In conducting such study, the Institute of Medicine must identify child heath quality information captured by the major population-based reporting systems sponsored by the federal government and make recommendations for improvement. One million dollars is appropriated for this report. *Id.*

States will receive increased federal payments, set at their federal Medicaid matching rate for services, for expenditures attributable to development or modification of systems needed for efficient collection and reporting on child health measures. *Id.* (adding 42 U.S.C. § 1396b(a)(3)(A)(iii)).

Finally, CHIPRA includes an important beneficiary protection. Notably, child health advocates sometimes encounter situations where prescribed items or services are denied or terminated by the state on the grounds that they do not reflect “evidence-based medicine.” CHIPRA makes it clear that states and Medicaid/CHIP participating health plans cannot use the quality improvement efforts enacted by CHIPRA to support this argument. Importantly, Congress has provided that nothing in this new law is to be construed as supporting the

restriction of coverage under Medicaid or CHIP to only those services that are evidence based. *See* CHIPRA, § 401(b). Congress also included a rule of construction stating, "Notwithstanding any other provision in this Section, no evidence based quality measure developed, published, or used as a basis of measurement or reporting under this Section may be used to establish an irrebuttable presumption regarding either the medical necessity of care or the maximum permissible coverage for any individual child who is eligible for and receiving medical assistance" under Medicaid or CHIP. *Id.*

Improved Availability of Information Regarding Enrollment—Section 402.

Original SCHIP legislation requires states to report annually on the status of their SCHIP programs. Among other things, these reports assess the number of children served and their characteristics (e.g. family income, prior insurance coverage), the quality of coverage provided, and actions taken to coordinate CHIP coverage with other public and private insurance. *See* 42 U.S.C. § 1397hh(a).

CHIPRA improves these reporting requirements. The annual report must now also include:

> (1) Eligibility criteria, enrollment, and retention data (including data regarding continuity of coverage or duration of benefits);
> (2) Data regarding the extent to which the state uses eligibility processing measures such as 12-month continuous eligibility, self-declaration of income, or presumptive eligibility;
> (3) Data regarding denials of eligibility and redeterminations of eligibility;
> (4) Data regarding access to primary and specialty services, networks of care, coordinated care, using quality and satisfaction measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey;
> (5) If the state provides child health assistance in the form of premium assistance for the purchase of coverage under a group health plan, data regarding the state's administration of such assistance, and the characteristics of the children provided such assistance; and
> (6) A description of any state activities that are designed to reduce the number of uncovered children in the State.

CHIPRA, § 402 (adding 42 U.S.C. § 1397hh(e)). By February 2010, the DHHS Secretary must specify a standard reporting form for this information. States will be given up to three reporting periods to transition to using this form. *Id.* at § 402(b).

CHIPRA also authorizes $5 million to the Secretary for FY 2009 to improve CMS' Medicaid Statistical Information System (MSIS) so as to provide more timely data on enrollment and eligibility of children under Medicaid and CHIP and to provide guidance to states on reporting requirements related to such improvements. The improvements must be implemented so that, beginning no later than October 1, 2009, MSIS data regarding the enrollment of low-income children in Medicaid and CHIP will be collected and analyzed by the Secretary within six months of submission. *See* CHIPRA, § 402(c).

CHIPRA Section 402(d) requires the GAO to conduct a study of children's access to primary and specialty services under Medicaid and CHIP, including the extent to which providers are willing to treat children; geographic availability of primary and specialty services; and the extent to which care coordination is provided. The GAO is to submit the report to Congress within two years, and include recommendations for legislative and administrative changes to address barriers that may be found to exist.

Application of Certain Managed Care Quality Safeguard to CHIP—Section 403.

The new law extends important Medicaid managed care beneficiary protections to CHIP, specifically the requirements for: enrollment and disenrollment processes, *see* 42 U.S.C. § 1396u-2(a)(4); provision of information to enrollees and potential enrollees, *id.* at § 1396u-2(a)(5); protections for enrollees, *id.* at § 1396u-2(b); quality assurance standards, *id.* at § 1396u-2(c); protections against fraud and abuse, *id.* at § 1396u-2(d); and sanctions against managed care plans for noncompliance, *id.* at § 1396u-2(e). *See* CHIPRA, § 403(a) (adding 42 U.S.C. § 1397bb(f)(3)). This amendment will apply to contract years for health plans beginning on or after July 1, 2009. *See* CHIPRA, § 403(b).

Improving Access to Benefits

Dental Benefits—Section 501.

Under the original SCHIP law, states are not required to offer dental benefits to CHIP-enrolled children. As in the Medicaid program for adults, dental benefits are optional, not mandatory.

CHIPRA requires that beginning October 1, 2009, all CHIP programs provide dental benefits to CHIP-eligible children that include coverage of "services necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions." *See* CHIPRA, § 501(a)(amending 42 U.S.C. § 1397cc). States may elect to meet this requirement through coverage equivalent to benchmark dental benefits offered by the most frequently selected federal employee benefits package in either of the two previous years, the most frequently selected state employee benefits in either of the two previous years, or the dental benefits plan that has the largest insured commercial, non-Medicaid enrollment offered in the state. *Id.*

Additionally, CHIPRA offers states the option to provide dental-only supplemental coverage to children who are enrolled in a group health plan or health insurance coverage offered through an employer who would otherwise qualify as targeted low-income children under the state child health plan. *See* CHIPRA, §501(b) (amending 42 U.S.C. § 1397jj(b)). This is significant because, prior to enactment of CHIPRA, states generally have not been allowed to use CHIP funds to cover children with other health insurance. The state may determine at which family income level to limit the dental-only supplemental benefits, but the level cannot exceed the maximum CHIP program income level. *Id.* Note that the state may not offer the dental-only supplement unless the following conditions are satisfied:

(1) The state has the highest income eligibility standard allowed as of January 1, 2009;
(2) The state does not impose an enrollment camp or waiting list in its CHIP program;
(3) The state provides benefits to all children in the state who apply for and meet the eligibility standards; and
(4) The state child health plan does not provide more favorable dental coverage or cost-sharing protection for dental coverage than that provided to targeted low-income children eligible for the full range of benefits under the state's CHIP program.

Id. Additionally, the state may choose not to apply a waiting period for the dental-only supplemental coverage. *Id.*

This provision also requires states to develop and implement programs to deliver oral health educational materials, informing new parents about risk for and prevention of early childhood caries and the need for a dental visit within their newborn's first year of life. *See* CHIPRA, § 501(c). CHIPRA allows the provision of dental benefits for Medicaid and CHIP beneficiaries through federally qualified health centers. CHIPRA, § 501(d)(amending 42 U.S.C. § 1396a(a) and § 1397g(e)(1)).

This CHIPRA provision establishes new reporting mandates. It requires that in its annual reports to CMS, a state must now add information about the provision of dental services, including the number of children enrolled, the number who receive any preventive or restorative dental care, and the number of children who have received a protective sealant by age 8. In the state report, there should also be information on the number of children enrolled in managed care plans. *See* CHIPRA, § 501(d) (amending 42 U.S.C. § 1396a(a)(43)(D)(iii) (requiring EPSDT reporting) and § 1397hh). To improve access to dental services, the Secretary of DHHS shall include on the Insure Kids Now website (http://www.insurekidsnow.gov), a current and accurate list of dentists and providers within each state that provide dental services to children enrolled in the Medicaid or CHIP programs, and shall update the list quarterly. CHIPRA, § 501(f). The Secretary must also include a description of the dental services provided under each state Medicaid and CHIP plan. *Id.* All of this information shall be posted no later than six months after the date of CHIPRA enactment. *Id.* Finally, by August 4, 2010, the GAO must conduct a study examining access to dental services by children in underserved areas, children's access to oral health care under Medicaid and CHIP, and the feasibility and appropriateness of using qualified mid-level dental providers in coordination with dentals to improve access to oral health care and public health overall. CHIPRA, § 501(h).

America's low-income children have high rates of untreated tooth decay, which often lead to more serious medical problems, according to the GAO Report *Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay*. CHIPRA provisions to mandate dental coverage in CHIP programs and establish a wrap-around benefit for those with private insurance offer important first steps toward addressing oral health concerns. Efforts to offer dental benefits at FQHCs and to publish provider lists are critical in enabling families to find dentists and access services to which they

are entitled. Finally, enhancing reporting requirements will enable state and federal officials, providers, advocates and policymakers to better monitor utilization.

Mental Health Parity in CHIP Plans—Section 502.

This provision requires that if a state provides mental health or substance abuse services through CHIP, the financial requirements and treatment limitations for mental health or substance abuse services cannot be more restrictive than those for medical and surgical benefits. *See* CHIPRA, §502(a) (amending 42 U.S.C. § 1397cc(c)). States that provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to CHIP-eligible children are deemed to be in compliance with this mandate. *Id.* at §502(b).

While this provision does not mandate the coverage of mental health services in CHIP, it does ensure parity with medical and surgical benefits. It is unclear what impact this will have and whether in an economic recession, states covering mental health benefits will be incentivized to drop such coverage rather than ensure its parity. An additional measure is needed to mandate mental health benefits coverage in CHIP.

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

Under this provision, separate CHIP programs must reimburse FQHCs and Rural Health Clinics based on Medicaid's payment system. *See* CHIPRA, §503(b)(amending 42 U.S.C. § 1397gg(e)(1)).

Premium Grace Period—Section 504.

While previous SCHIP law limits the amount of premiums and cost-sharing in the CHIP program, it does not offer any grace periods for delays in premium payment. CHIPRA offers individuals enrolled in CHIP plans a 30-day grace period to make a premium payment before their coverage is terminated. *See* CHIPRA, §504(a) (amending 42 U.S.C. § 1397cc(e)(3)). Also, it provides that no later than seven days after the first day of the grace period, the state must send a notice that failure to pay the premium within the grace period will result in termination of CHIP benefits. *Id.*

A number of states already offer a grace period for payment of CHIP premiums. This provision ensures uniformity and consistency of the grace period across states, and is especially important in an economic recession, when families may need additional time to pay premiums to maintain their children's CHIP coverage.

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

This provision clarifies that states may provide CHIP coverage for services furnished through a school-based health center. *See* CHIPRA, §504(a) (amending 42 U.S.C. § 1397cc(c)).

School-based health centers are those health centers that are located at or near a school facility; are organized through school, community or health provider relationships; administered by a sponsoring facility; and provide primary health services to children and satisfy state requirements for operation of such a clinic. *Id.* Providing an additional venue for obtaining health care services and one that is convenient for children and youth will no doubt improve health care access and possibly also health of CHIP-enrolled children.

Medicaid and CHIP Payment and Access Commission—Section 506.

CHIPRA establishes a Medicaid and CHIP Payment and Access Commission (MACPAC). CHIPRA, §506(a) (adding §1900 of the Social Security Act, to be codified as 42 U.S.C. § 1395kkk). MACPAC shall: (1) review Medicaid and CHIP policies affecting children's access to covered items and services; (2) make recommendations concerning such access policies; (3) submit no later than March 1 of each year a report to Congress containing the reviews and recommendations; and (4) submit no later than June 1 of each year a report to Congress examining issues affecting Medicaid and CHIP, including implications of changes in health care delivery and in the market of health care services on such programs. CHIPRA, §506(b). MACPAC shall also review and assess specifically Medicaid and CHIP payment policies, the interaction of Medicaid and CHIP payment policies with health care delivery generally, and policies relating to transportation and language barriers. *Id.* MACPAC shall create an early-warning system to identify provider shortage areas or other problems affecting access to care and health care status of Medicaid and CHIP beneficiaries. *Id.*

Program Integrity and Data Collection

Payment Error Rate Measurement—Section 601.

DHHS must annually review Medicaid and CHIP to estimate the amount of improper payments. These are called the payment error rate measurement requirements (PERM). *See* 42 C.F.R. part 431 (Medicaid) and part 457 (CHIP). State Medicaid agencies also operate under the Medicaid Eligibility Quality Control (MEQC) system.

CHIPRA applies a federal matching rate of 90 percent to expenditures related to administration of the PERM requirements applicable to CHIP and excludes expenditures related to the administration of PERM requirements from the 10 percent cap on CHIP administrative costs. *See* CHIPRA, § 601(a)(amending 42 U.S.C. § 1397ee(c)).

CHIRA also requires the Secretary of DHHS to issue new PERM regulations by August 2009 (within six months of CHIPRA enactment). *See* CHIPRA, § 601(g). The new final PERM rule must include clearly defined criteria for errors for both states and providers, for appealing error determinations, and for implementing corrective action plans. Importantly, the payment error rate must not take into account payment errors resulting from verification of an applicant's self-declaration or self-certification of Medicaid or CHIP eligibility, if the state is following federal requirements for self-verification. *See* CHIPRA, § 601(c). The Secretary cannot calculate or publish any national or state-specific error rates based on the application of the

PERM requirements to CHIP until six months after the new final rule is in effect for all states. CHIPRA, § 601(b).

The Secretary is also charged with reviewing the MEQC and PERM requirements, and assuring coordinated implementation. CHIPRA, § 601(e).

Improving Data Collection—Section 602.

The previous CHIP statute required the Secretary of Commerce to take steps to assure that the Current Population Survey (CPS) produces helpful data estimates about uninsured children. *See* 42 U.S.C. § 1397ii(b). The CPS is the primary data source for deciding states' CHIP allotments.

Beginning in fiscal year 2009, CHIPRA appropriates $20 million annually to improve population-based data estimates. In addition to the previous requirements, the Secretary of Commerce must adjust the CPS to develop more accurate state-specific estimates of children enrolled in Medicaid or CHIP; adjust CPS to more accurately estimate child population growth; include health insurance survey information for the American Community Survey (ACS) related to children; and make recommendations to the Secretary of DHHS about whether the American Community Survey should be used in lieu of, or in combination with, the CPS. Thereafter, the Secretary of DHHS can decide whether to use ACS and/or CPS estimates. CHIPRA, § 602 (amending 42 U.S.C. § 1397ii(b)(2)).

Updated Federal Evaluation of CHIP—Section 603.

The Secretary of DHHS was to conduct independent evaluations of 10 states with approved CHIP plans and to submit a report to Congress by December 21, 2001. *See* 42 U.S.C. §§ 1397(a)-(c). CHIPRA updates the federal evaluation provisions by appropriating $10 million for fiscal year 2010, and requires the Secretary conduct a new independent evaluation of 10 states and report to Congress by December 31, 2011. *See* CHIPRA, § 603 (amending 42 U.S.C. § 1397hh(c)(5)).

Access to Records for Audits and Evaluations—Section 604.

The new law provides for the Secretary of DHHS, Office of Inspector General, and Comptroller General to be given access to records of the state and its contractors for auditing and evaluation purposes. Access extends to any books, accounts, records, correspondence, and other documents related to the expenditure of federal funds under CHIP and that are in the possession, custody, or control of states receiving federal CHIP funds, political subdivisions of the states, or any grantee or contractor of the states or political subdivisions. CHIPRA, § 604 (amending 42 U.S.C. § 1397hh(d)).

Miscellaneous Health Provisions

Deficit Reduction Act Technical Corrections—Section 611.

CHIPRA includes a number to "technical corrections" to the previously enacted Deficit Reduction Act (DRA) of 2005, Pub. L. No. 109-171, 120 Stat. 88. *See* CHIPRA, § 611.

EPSDT in Benchmark Plans—Section 611(a).

The Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is a mandatory service for most children under age 21. EPSDT covers comprehensive medical, vision, hearing, and dental screening, and guarantees coverage of all federally coverable services needed to correct or ameliorate an individual child's condition. *See* 42 U.S.C. §§ 1396a(a)(10), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

The DRA authorized states, through state Medicaid plan amendments, to require certain populations, including children, to obtain health insurance coverage through benchmark or benchmark-equivalent plans similar to those offered in CHIP. *See* DRA, § 6044 (adding 42 U.S.C. § 1396u-7). The wording of the DRA led to confusion about the extent to which states would be required to provide EPSDT. *See* Jane Perkins, National Health Law Program, *The Deficit Reduction Act of 2005 (DRA) Benefit Provisions and EPSDT* (Apr. 26, 2006), *available at* http://www.healthlaw.org (Child Health folder).

CHIPRA makes it very clear that Congress is committed to maintaining EPSDT for Medicaid-eligible children and youth. CHIPRA clarifies that states must "provide EPSDT services for all children in benchmark benefit packages under Medicaid." *See* CHIPRA, § 611(a). The clarification is accomplished through a number of amendments to 42 U.S.C. § 1396u-7, the benchmark provision:

(1) The provision is amended to list the specific Medicaid provisions that can be disregarded in state plans using benchmark coverage, rather than referring to all of Title XIX as specified in the original DRA. *See* CHIPRA, § 611(a) (amending § 1396u-7(a)(1)(A)(i) by striking "Notwithstanding any other provision of this title" and inserting "Notwithstanding [§ 1396a(a)(1)] (relating to statewideness), [§ 1396a(a)(10)(B)] (relating to comparability) and any other provision of this title which would be directly contrary to the authority under this section…").

(2) The provision is amended by striking a clause that required benchmark states to provide "wrap-around" EPSDT coverage to children under age 19. That clause is replaced with language that requires coverage of Medicaid-eligible individuals under age 21, and coverage that consists of EPSDT services provided in accordance with the EPSDT informing, screening, treatment, and reporting requirements. *See* CHIPRA, § 611(a) (amending 42 U.S.C. § 1396u-7(a)(1)(A)(ii) and citing 42 U.S.C. § 1396d(a)(4)(B), 1396a(a)(10), 1396a(a)(17),1396a(a)(43), 1396d(r)). "Wrap-around," the word used in the DRA to refer to EPSDT, is removed.

(3) The provision is amended to include a "rule of construction" specifying that nothing in the provision shall be construed as "affecting a child's entitlement to care and

> services described in subsections (a)(4)(B) and (r) of [§ 1396d] and provided in accordance with [§ 1396a(a)(43)] whether provided through benchmark coverage, benchmark equivalent coverage, or otherwise." CHIPRA, § 611(a)(3) (adding 42 U.S.C. § 1396u-7(a)(1)(E)).

The amendment is effective as if included in the DRA. *See* CHIPRA, § 612(d).

Foster Care—Section 611(b).

The DRA excluded some populations from mandatory enrollment in benchmark plans, including certain children in foster care. *See* DRA, § 6044 (adding 42 U.S.C. § 1396u-7(a)(2)(B)(viii)). CHIPRA corrects a DRA reference to these children by striking "aid or assistance is made available under part B of title IV to children in foster care and individuals" and inserting "child welfare services are made available under part B of title IV on the basis of being a child in foster care or." *See* CHIPRA, § 612(b). The amendment is effective as if included in the DRA. *See* CHIPRA, § 612(d).

Secretary-Approved Benchmark Coverage—Section 611(c).

As noted above, the DRA authorized states to require certain populations to obtain health insurance coverage through benchmark coverage. States have the option to use benchmark benefit packages, benchmark-equivalent coverage, or "Secretary-approved coverage." *See* 42 U.S.C. § 1396u-7(b). As authorized by the DRA, Secretary-approved coverage is essentially without standards. A handful of states have taken advantage of the benchmark option. The states worked with the Bush administration to implement "Secretary-approved coverage." As applied, it was not at all clear what criteria the Secretary used to approve the state plans.

CHIPRA takes a step to address the secrecy of the approval process: On the date a state plan amendment is approved, the DHHS Secretary must publish on the CMS website a list of the Medicaid provisions that the Secretary has determined do not apply in order to enable the state to carry out the plan amendment and the reason for each such determination. The listing must be published in the Federal Register within 30 days after the date of approval. *See* CHIPRA, § 612(c) (adding 42 U.S.C. 1396u-7(c)). The amendment is effective as if included in the DRA. CHIPRA, § 612(d).

Taken together, these technical corrections reflect clear Congressional intent that the Medicaid Act provisions apply to the greatest extent possible, that affected residents in a state understand exactly which provisions will not apply and why, and that use of the Secretary-approved coverage option be sharply curtailed.

Prohibiting Initiation of New Health Opportunity Account Demonstration Programs—Section 613.

The DRA authorized the Secretary of DHHS to approve Health Opportunity Account (HOA) demonstration programs in up to 10 states. The HOA programs would feature the use of

health savings accounts and deductibles or other cost sharing. After an initial five-year period, the state could make the program permanent, and other states would be able to implement HOA programs unless all of the initial demonstrations were unsuccessful. *See* 42 U.S.C. § 1396u-8. CHIPRA, § 613 prohibits the Secretary of DHHS from approving any new HOA demonstration programs. CHIPRA, § 613. The savings from elimination of new programs is estimated at $100 million.

Adjustment in Computation of Medicaid FMAP to Disregard an Extraordinary Employer Pension Contribution—Section 614.

Most state Medicaid services are reimbursed at the Federal Medical Assistance Percentage (FMAP), a rate that is calculated based on state per capita income. *See* 42 U.S.C. § 1396d. State per capita income is determined by looking at per capita personal income, and one component of that is employee pension and insurance funds.

CHIPRA amends the FMAP computation to disregard any "significantly disproportionate" employer pension or insurance fund contributions in computing state per capita income. *See* CHIPRA, § 614(a). A significantly disproportionate employer pension and insurance fund contribution is "any identifiable employer contribution towards pension or other employee insurance funds that is estimated to accrue to residents of such State for a calendar year (beginning with calendar year 2003) if the increase in the amount so estimated exceeds 25 percent of the total increase in personal income in that State for the year involved." *Id.* at § 614(b). No state will have its FMAP for a fiscal year reduced as a result of the application of this provision. CHIPRA, § 614(c). No later than May 15, 2009, the Secretary of DHHS must report to Congress on the problems presented by the earlier treatment of pension and insurance fund contributions, and on possible alternative methodologies to mitigate such problems. CHIPRA, § 614(d).

Clarification for Regional Medical Center—Section 615.

Over the years, state Medicaid programs have used provider taxes and intergovernmental transfers to boost their state funds and draw down additional federal Medicaid funding. *See* 42 U.S.C. § 1396b(w). CHIPRA prohibits the Secretary of DHHS from denying federal funding when the state share of funding has been transferred from certain out-of-state regional medical centers if the Secretary determines that the use of such funds is proper. *See* CHIPRA, § 615. "Regional medical center" is defined to mean a publicly owned center that provides level one trauma and burn care services; provides level three neonatal care services; is obligated to serve all patients, regardless of ability to pay; is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least three states; is a tertiary care provider for patients residing within a 125-mile radius; and that meets the criteria for a disproportionate share hospital (DSH) in at least one state other than the state in which the center is located. According to the Congressional Budget Office, this provision is referring to the Memphis Regional Medical Center. *See* Letter from Peter R. Orszag, Congressional Budget Office, to Hon. John D. Dingell, Chairman, U.S. House of Representatives Comm. On Energy and Commerce (Sept. 25, 2007), http://www.cbo.gov/ftpdocs/86xx/doc8655/hr976.pdf.

Extension of Medicaid DSH Allotments for Tennessee and Hawaii—Section 616.

Medicaid payments are adjusted for hospitals that serve a disproportionate share of low-income people with special needs. For most states, there is a capped allotment. *See* 42 U.S.C. § 1396r-4. Over the years, Congress has authorized Tennessee and Hawaii to receive allotments different from those authorized in the Medicaid Act. *See* 42 U.S.C. § 1396r-4(f)(6)) (as amended by Section 202 of the Medicare Improvements for Patients and Providers Act of 2008). Tennessee and Hawaii operate their Medicaid programs as Section 1115 demonstration projects that waived the requirement to make DSH payments. CHIPRA extends the allotments methods used for these two states through the first calendar quarter of FY 2012. *See* CHIPRA, § 616 (amending 42 U.S.C. § 1396r-4(f)(6)).

GAO Report on Medicaid Managed Care Payment Rates—Section 617.

CHIPRA requires the GAO to submit a report to the Congress analyzing the extent to which state payment rates for Medicaid managed care organizations are actuarially sound. The report is due no later than August 2010 (18 months after the enactment of CHIPRA). *See* CHIPRA, § 617.

Outreach Regarding Health Insurance Options Available to Children—Section 621.

Section 621 of CHIPRA establishes a task force to conduct a nationwide campaign to educate small-business owners and employees about the value of children's health coverage and the availability of health insurance coverage for children through private insurance options, Medicaid, and CHIP. The task force will be composed of the Administrator of the Small Business Administration (Administrator) and the Secretaries of DHHS, Labor and Treasury. In carrying out their responsibilities, the task force is authorized to partner with organizations ranging from chambers of commerce to health advocacy groups. Efforts to educate will include information about the hotline operated as part of the DHHS Insure Kids Now program. The Administrator must also ensure that links to information on the eligibility and enrollment requirements for each state's Medicaid and CHIP programs are prominently displayed on the website of the Small Business Administration. The Administrator must report to Congress on the status of the nationwide campaign every two years. CHIPRA, § 621(b).