# Description of the Chairman's Mark

# The Children's Health Insurance Reauthorization Act of 2007

Scheduled for Markup
by the
Senate Committee on Finance
On July 17, 2007

## Section 1. Short title; Amendments to Social Security Act; References; Table of Contents

*Current Law*

No provision

*Explanation of Provision*

This act may be cited as the "Children's Health Insurance Program (CHIP) Reauthorization Act of 2007." Unless otherwise noted, this act amends, or repeals provisions of the Social Security Act. When this act references: "CHIP" it is referring to the State Children's Health Insurance Program established under Title XXI; "MEDICAID" it is referring to the program for medical assistance established under Title XIX; "Secretary" it is referring to the Secretary of Health and Human Services.

# Title I — Financing of CHIP

## Section 101. Extension of CHIP

*Current Law*

Title XXI of the Social Security Act specifies the following national appropriation amounts in §2104(a) from FY1998 to FY2007 for SCHIP:

$4,295,000,000 in FY1998;
$4,275,000,000 in FY1999;
$4,275,000,000 in FY2000;
$4,275,000,000 in FY2001;
$3,150,000,000 in FY2002;
$3,150,000,000 in FY2003;
$3,150,000,000 in FY2004;
$4,050,000,000 in FY2005;
$4,050,000,000 in FY2006; and
$5,000,000,000 in FY2007.

These amounts are allotted to states, including the District of Columbia, except for (1) 0.25% of the total annual amount is allotted to the territories and commonwealths (hereafter referred to simply as "the territories"), and (2) from FY1998 to FY2002, $60 million was set aside annually for special diabetes grants (Public Health Service Act §330B and §330C), which are now funded by direct appropriations. The territories are also allotted the following appropriation amounts in §2104(c)(4)(B):

$32,000,000 in FY1999;
$34,200,000 in FY2000;
$34,200,000 in FY2001;
$25,200,000 in FY2002;

$25,200,000 in FY2003;
$25,200,000 in FY2004;
$32,400,000 in FY2005;
$32,400,000 in FY2006; and
$40,000,000 in FY2007.

*Explanation of Provision*

The following national appropriation amounts are specified for CHIP in §2104(a):
$9,125,000,000 in FY 2008;
$10,675,000,000 in FY 2009;
$11,850,000,000 in FY 2010;
$13,750,000,000 in FY 2011; and
$3,500,000,000 in FY 2012.

## Section 102. Allotments for the 50 States and the District of Columbia

*Current Law*

The annual SCHIP appropriation available to states, including the District of Columbia, is the amount of the total appropriation remaining after amounts set aside for the territories and, for FY1998 to FY2002, the special diabetes grants. Each state's share, or percentage, of the available appropriation is determined by a formula using the state's "number of children," as adjusted for geographic variations in health costs and subject to certain floors and a ceiling.

Beginning with the FY2001 SCHIP allotment, the "number of children" is equal to (1) 50 percent of the number of children in the state who are low income (with "low income" defined as having family income below 200% of the federal poverty threshold), plus (2) 50 percent of the number of *uninsured* low-income children in the state. The source of data is the average of the number of such children, as reported and defined in the three most recent Annual Social and Economic (ASEC) Supplements (formerly known as the March supplements) to the Census Bureau's Current Population Survey (CPS) before the beginning of the calendar year in which the applicable fiscal year begins. For example, in determining the FY2007 allotments, the three most recent supplements available before January 1, 2006, were used. Thus, states' FY2007 allotments were based on the "number of children" using data that covered calendar years 2002, 2003 and 2004.

The adjustment for geographic variations in health costs is 85% of each state's variation from the national average in its average wages in the health services industry. The source of data is the average wages from mandatory reports filed quarterly by every employer on their unemployment insurance contributions and provided to the Department

of Labor's Bureau of Labor Statistics (BLS). A three-year average of these data is also required in the statute.

Each state's "number of children," as adjusted for geographic variation in health costs, is calculated as a percentage of the national total. This is the state's preliminary proportion of the available SCHIP appropriation, against which the floors and ceiling are compared.

Since the beginning of SCHIP, no state's share of the available appropriation could result in an allotment of less than $2 million. No state has ever been affected by this floor. Beginning with the FY2000 allotment, two additional floors also applied: (1) no state's share could be less than 90% of last year's share, and (2) no state's share could be less than 70% of its FY1999 share. (Each state's FY1999 share was identical to its FY1998 share, per P.L. 105-277.)

A ceiling has also applied beginning with the FY2000 allotment: No state's share can exceed 145% of its FY1999 share.

Once the floors and ceiling are applied to affected states to produce their adjusted proportion, the other states' shares are adjusted proportionally to use exactly 100% of the available appropriation. Each state's adjusted proportion multiplied by the appropriation available to states for a fiscal year results in each state's federal SCHIP allotment for that fiscal year.

*Explanation of Provision*

The annual CHIP funds available to states, including the District of Columbia — that is, the available national allotment — is the amount of the total appropriation remaining after amounts allotted to the territories.

For FY2008, a state's allotment is calculated as 110% of the greatest of the following four amounts: (1) the state's FY2007 federal CHIP spending multiplied by the annual adjustment; (2) the state's FY2007 federal CHIP allotment multiplied by the annual adjustment; (3) for states that were determined in FY2007 to have exhausted their own federal CHIP allotments (and therefore designated a shortfall state for FY2007), the state's FY2007 projected spending as of November 2006 (or as of May 2006, for a state whose May 2006 projection was $95 million to $96 million higher than its November 2006 projection) multiplied by the annual adjustment; and (4) the state's FY2008 federal CHIP projected spending as of August 2007 and certified by the state to the Secretary not later than September 30, 2007.

The annual adjustment for health care cost growth and child population growth is the product of (1) 1 plus the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for the fiscal year over the prior fiscal year, and (2) 1.01 plus the percentage increase in the child population (under age 19) in each

state as of July 1 of the fiscal year over the prior fiscal year's, based on the most timely and accurate published estimates from the Census Bureau.

For FY2009 to FY2012, a state's allotment is calculated as 110% of its projected spending for that year, as submitted to CMS no later than August 31 of the preceding fiscal year.

For FY2008, if the state allotments as calculated exceed the available national allotment, the allotments are reduced proportionally. For FY2009 to FY2012, if the state allotments as calculated exceed the available national allotment, then the available national allotment is distributed to each state according to its percentage calculated as the sum of the following four factors:

- Each state's projected federal CHIP expenditures for that fiscal year (as certified by the state to the Secretary no later than the August 31 of the preceding fiscal year), calculated as a percentage of the national total, multiplied by 75%;
- Each state's number of low-income children (based on the most timely and accurate published estimates from the Census Bureau), calculated as a percentage of the national total, multiplied by 12½%;
- Each state's projected federal CHIP expenditures for the preceding fiscal year (as certified by the state to the Secretary in November of the fiscal year), calculated as a percentage of the national total, multiplied by 7½%; and
- Each state's actual federal CHIP expenditures for the second preceding fiscal year, as determined by the Secretary, calculated as a percentage of the national total, multiplied by 5%.

If a state's projected CHIP expenditures for FY2009 to FY2012 are at least 10% more than the last year's allotment (excluding any reduction in states' allotments due to insufficient available national allotment) then, unless the state received approval in the prior year of a state plan amendment or waiver to expand CHIP coverage or the state received a payment from the CHIP Contingency Fund, the state must submit to the Secretary by August 31 before the fiscal year information relating to the factors that contributed to the need for the increase in the state's allotment, as well as any other information that the Secretary may require for the state to demonstrate the need for the increase in the state's allotment. The Secretary shall notify the state in writing within 60 days after receipt of the information that (1) the projected expenditures are approved or disapproved (and if disapproved, the reasons for disapproval); or (2) specified additional information is needed. If the Secretary disapproved the projected expenditures or determined additional information is needed, the Secretary shall provide the state with a reasonable opportunity to submit additional information to demonstrate the need for the increase in the State's allotment for the fiscal year. If a determination has not determined by September 30 whether the state has demonstrated the need for the increase in its allotment, the Secretary shall provide the state with a provisional allotment for the fiscal year equal to 110% of last year's allotment (excluding any reduction in states' allotments

due to insufficient available national allotment). Once the Secretary makes a determination, the Secretary may adjust the state's allotment (and the allotments of other states) accordingly, but not later than November 30 of the fiscal year.

For FY2008 allotment factors based on CHIP expenditures, the Secretary of Health and Human Services (HHS) shall use the most recent FY2007 expenditure data available to the Secretary before the start of FY2008. The Secretary may adjust the FY2008 allotments based on the actual expenditure data reported to CMS no later than November 30, 2007; the Secretary may not make adjustments after December 31, 2007.

For purposes of determining a state's allotment, the state's projected expenditures shall include payments projected using §2105(g) (discussed in Section 110) and for certain CHIP-enrolled parents and childless adults (discussed in Section 105).

## Section 103. One-Time Appropriation for FY2012

*Current Law*

No provision.

*Explanation of Provision*

In FY 2012, a one-time appropriation of $12,500,000,000 shall be made to the Secretary of Health and Human Services to add to the funds already provided under section 2104(a) for that year only. Such funds shall be distributed by the Secretary in a manner consistent with and under the same terms and conditions of section 102 of this Act.

## Section 104. Improving funding for the territories under CHIP and Medicaid

*Current Law*

The territories were to receive 0.25 percent of the total appropriations provided in §2104(a). Later legislation added specific appropriations for the territories in FY1999 to FY2007:

$32,000,000 in FY 1999;
$34,200,000 in FY 2000;
$34,200,000 in FY 2001;
$25,200,000 in FY 2002;
$25,200,000 in FY 2003;
$25,200,000 in FY 2004;
$32,400,000 in FY 2005;
$32,400,000 in FY 2006; and
$40,000,000 in FY 2007.

For FY1999, the $32 million represented approximately 0.75 percent of the total appropriations in §2104(a). For FY2000 to FY2007, the additional appropriation equaled 0.8 percent of the total appropriations in §2104(a). Combined with the 0.25 percent available through the original enacting legislation, the territories were allotted 1.05% of the total appropriations in §2104(a) from FY2000 to FY2007.

The amounts set aside for the territories were distributed according to the following percentages provided in statute: Puerto Rico, 91.6 percent; Guam, 3.5 percent; the Virgin Islands, 2.6 percent; American Samoa, 1.2 percent; and the Northern Mariana Islands, 1.1 percent.

Medicaid (and SCHIP) programs in the territories are subject to spending caps specified in statute. The federal Medicaid matching rate, which determines the share if Medicaid expenditures paid for by the federal government, is statutorily set at 50 percent of the territories. Therefore, the federal government pays 50% of the cost of Medicaid items and services in the territories up to the spending caps. For the 50 states and DC, certain administrative functions have a higher federal match. For example, startup expenses for specified computer systems are matched at 90%, and there is a 100% match for the implementation and operation of immigration status verification systems.

*Explanation of Provision*

From the national CHIP appropriation, the allotments to the territories are calculated as follows. For FY2008, each territory's allotment is its highest annual federal CHIP spending between FY1998 and FY2007, plus the annual adjustment for health care cost growth and national child population growth. FY2007 spending will be determined by the Secretary based on the most timely and accurate published estimates of the Census Bureau. For FY2009 through FY2012, each territory's allotment is the prior year's allotment, plus the annual adjustment for health care cost growth and national child population growth.

For FY2008 and each fiscal year thereafter, federal matching payments for specified data reporting systems (i.e., the design, development, and operations of claims processing systems and citizenship documentation data systems in each of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa would continue to be subject to the 50% match rate, but such expenditures would be matched with federal funds without regard to the specified spending caps.

The provision would require the Government Accountability Office (GAO) to submit a report to the appropriate committees of Congress not later than September 30, 2009, with regard to the territories' eligible Medicaid and CHIP populations, their historical and projected spending and the ability of capped funding streams to address such needs, the extent to which the federal poverty level is used for determining Medicaid and CHIP eligibility in the territories, and the extent to which the territories participate in data collection and reporting with regard to Medicaid and CHIP and

specifically the extent to which they participate in the Current Population Survey versus the American Community Survey, which are federal surveys that estimate the number of low-income children in the states. The report is also to provide recommendations for improving Medicaid and CHIP funding to the territories.

## Section 105. Incentive bonuses for states

*Current Law*

No provision.

*Explanation of Provision*

Incentive Pool

A CHIP Incentive Bonuses Pool is established in the U.S. Treasury. The Incentive Pool receives deposits from an initial appropriation in FY2008 of $3 billion, along with transfers from six different potential sources, with the currently available but not immediately required funds invested in interest-bearing U.S. securities that provide additional income into the Incentive Pool. The six sources for deposits are as follows:

- On December 1, 2007, the amount by which states' FY2006 and FY2007 allotments not expended by September 30, 2007, exceed 50% of the federal share of the FY2008 allotment, as determined by the Secretary by not later than October 1, 2007 ;
- On each December 1 from 2008 to 2012, any of the annual CHIP appropriation not used by the states;
- On October 1 of fiscal years 2009 to 2012, the amount by which the unspent funds from the prior year's allotment exceeds the applicable percentage of that allotment. The applicable percentage is 20% for FY2009, and 10% for FY2010, FY2011, and FY2012;
- Any original allotment amounts not expended by the end of their second year of availability;
- On October 1, 2009, any amounts set aside for transition off of CHIP coverage for childless adults that are not expended by September 30, 2009; and
- On October 1 of FY2009 through FY2012, any amounts in the CHIP Contingency Fund in excess of the fund's aggregate cap, as well as any Contingency Fund payments provided to a state that are unspent at the end of the fiscal year following the one in which the funds were provided.

Funds from the Incentive Pool are payable in FY2008 to FY2012 to states that have increased their Medicaid and CHIP enrollment among low-income children above a defined baseline, with associated payments as follows (reduced proportionally if necessary). (For purposes of Incentive Pool policies, a "child" enrolled in Medicaid

means an individual under age 19 — or age 20 or 21, if a state has so elected under its Medicaid plan; and "low-income children" means children in families with incomes at 200% of federal poverty or below.) Beginning in FY2009, a state may receive a payment from the Incentive Pool if its average monthly enrollment of low-income children in CHIP and Medicaid for the coverage period (which is defined as the last two quarters of the preceding fiscal year and the first two quarters of the fiscal year, except that for FY2009 it is based only on the first two quarters of FY2009) exceeds the baseline monthly average.

For FY2009, the baseline monthly average is each state's average monthly enrollment in the first two quarters of FY2007 enrollment (as determined over a 6-month period on the basis of the most recent information reported through the Medicaid Statistical Information System (MSIS) multiplied by the sum of 1.02 and the percentage increase in the population of low-income children in the state from FY2007 to FY2009, as determined by the Secretary based on the most recent published estimates from the Census Bureau before the beginning of FY2009. For FY2010 onward, the baseline monthly average is the prior year's baseline monthly average multiplied by the sum of 1.01 and the percentage increase in the population of low-income children in the state over the preceding fiscal year, as determined by the Secretary based on the most recent published estimates from the Census Bureau before the beginning of the fiscal year.

A state eligible for a bonus shall receive in the last quarter of the fiscal year the following amount, depending on the "excess" of the state's enrollment above the baseline monthly average: (i) If such excess with respect to the number of individuals who are enrolled in the State plan under title XIX does not exceed 2 percent, the product of $75 and the number of such individuals included in such excess; (ii) if such excess with respect to the number of individuals who are enrolled in the State plan under title XIX exceeds 2 percent, but does not exceed 5 percent, the product of $300 and the number of such individuals included in such excess; and (iii) if such excess with respect to the number of individuals who are enrolled in the State plan under title XIX exceeds 5 percent, the product of $625 and the number of such individuals included in such excess. For FY2010 onward, these dollar amounts are to be increased by the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for the calendar year beginning on January 1 of the coverage period over that of the preceding coverage period.

Payments from the Incentive Pool shall be used for any purpose that the State determines is likely to reduce the percentage of low-income children in the State without health insurance.

Redistribution of FY2005 Allotments

An appropriation of $5,000,000 is provided to the Secretary for FY2008 for improving the timeliness of MSIS and to provide guidance to states with respect to any new reporting requirements related to such improvements. Amounts appropriated are available until expended. The resulting improvements are to be designed and

implemented so that beginning no later than October 1, 2008, Medicaid and CHIP enrollment data are collected and analyzed by the Secretary within six months of submission.

FY2005 original CHIP allotments unspent at the end of FY2007 are to be redistributed on a proportional basis to states that were projected at any point in FY2007 to exhaust their federal CHIP allotments.

## Section 106. Phase-out of coverage for nonpregnant childless adults under CHIP, conditions for coverage of parents

*Current Law*

Section 1115 of the Social Security Act gives the Secretary of HHS broad authority to modify virtually all aspects of the Medicaid and SCHIP programs. Under Section 1115, the Secretary may waive requirements in Section 1902 (usually, freedom of choice of provider, comparability, and statewideness). For SCHIP, no specific sections or requirements are cited as "waive-able." SCHIP statute simply states that Section 1115, pertaining to research and demonstration projects, applies to SCHIP. States may obtain waivers that allow them to provide services to individuals not traditionally eligible for SCHIP, or limit benefit packages for certain groups as long as the Secretary determines that these programs further the goals of SCHIP.

Approved SCHIP Section 1115 waivers are deemed to be part of a state's SCHIP state plan for purposes of federal reimbursement. Costs associated with waiver programs are subject to each state's enhanced-FMAP. Under SCHIP Section 1115 waivers, states must meet an "allotment neutrality test" where combined federal expenditures for the state's regular SCHIP program and for the state's SCHIP demonstration program are capped at the state's individual SCHIP allotment. This policy limits federal spending to the capped allotment levels.

Under current law, including 1115 waiver authority, states cover pregnant women, parents of Medicaid and SCHIP eligible children and childless adults in their SCHIP programs.

The Deficit Reduction Act of 2005 prohibited the approval of new demonstration programs that allow federal SCHIP funds to be used to provide coverage to nonpregnant childless adults, but allowed for the continuation and renewal of such existing Medicaid or SCHIP waiver projects affecting federal SCHIP funds that were approved under the Section 1115 waiver authority before February 8, 2006.

*Explanation of Provision*

Childless Adults

The provision would prohibit the approval or renewal of Section 1115 demonstration waivers that allow federal CHIP funds to be used to provide coverage to nonpregnant childless adults (hereafter referred to as applicable existing waivers) on or after the date of enactment of this Act. Beginning on or after October 1, 2008, rules regarding the period to which an applicable existing waiver would apply, individuals eligible for coverage under such waivers, and the amount of federal payment available for such coverage would be subject to the following requirements: (1) no federal CHIP funds would be available for coverage of nonpregnant childless adults under an applicable existing waiver after September 30, 2008, (2) State-requested extensions of applicable existing waivers that would otherwise expire before October 1, 2008, would be granted by the Secretary but only through September 30, 2008, and (3) coverage to a nonpregnant childless adult under applicable existing waivers provided during FY2008 will be reimbursed at the CHIP enhanced FMAP rate.

States with applicable existing waivers (that are otherwise terminated under this provision) would be permitted to extend coverage, through FY2009, to individual nonpregnant childless adults who received coverage under the applicable existing waiver at any time during FY2008 (regardless of whether the individual lost coverage at any time during FY2008 and was later provided benefit coverage under the waiver in that fiscal year) subject to the following restrictions: (1) for each such State, the Secretary would be required to set aside an amount as part of a separate allotment equal to the federal share of the State's projected FY2008 expenditures (as certified by the state and submitted to the Secretary by August 31, 2008) for providing coverage under the waiver to such individuals in FY2008 increased by the annual adjustment for per capita health care growth (described in Section 102 of this bill), (2) the Secretary may adjust the set aside amount based on State-reported FY2008 expenditure data (reported on CMS Form 64 or CMS Form 21 not later than November 30, 2008), but in no case shall the Secretary adjust such amount after December 31, 2008, and (3) the Secretary would pay an amount equal to the federal Medicaid matching rate for expenditures related to such coverage (provided during FY2009) up to the set-aside spending cap.

States with existing CHIP waivers to extend coverage to nonpregnant childless adults (that are otherwise terminated under this provision) would be permitted to submit a request to CMS (not later than June 30, 2009) for a Medicaid nonpregnant childless adult waiver. For such states, the Secretary would be required to make a decision to deny or approve such application within 90 days of the date of submission. For such states, if no CMS decision to approve or deny such request has been made as of September 30, 2009, the provision would allow such application to be deemed approved.

States with applicable existing waivers that request a Medicaid nonpregnant childless adult waiver under this provision would be required to meet the following "budget neutrality" requirements. For fiscal year 2010, allowable waiver expenditures for such populations would not be permitted to exceed the total amount payments made to the State (as specified above) for FY2009, increased by the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for fiscal year 2010 over fiscal year 2009). In the case of any succeeding fiscal year, allowable

waiver expenditures for such populations would not be permitted to exceed each such State's set aside amount (described above) for the preceding fiscal year, increased by the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for such fiscal year over the prior fiscal year.

Parents

The provision would also prohibit the approval of additional Section 1115 demonstration waivers that allow federal CHIP funds to be used to provide coverage to parent(s) of a targeted low-income child(ren) (hereafter referred to as applicable existing CHIP parent coverage waiver) on or after the date of enactment of this Act. Beginning on or after October 1, 2009, rules regarding the period to which an applicable existing CHIP parent coverage waiver extends coverage to eligible populations, and the amount of federal payment available for coverage to such populations under the waiver would be subject to the following requirements: (1) State-requested extensions of applicable existing CHIP-financed Section 1115 parent coverage waivers that would otherwise expire before October 1, 2009, would be granted by the Secretary but only through September 30, 2009, and (2) the CHIP enhanced FMAP rate would apply for such coverage to such eligible populations during FY2008 and FY2009.

States with existing CHIP waivers to extend coverage to parent(s) of targeted low-income child(ren) would be permitted to continue such assistance during each of fiscal years 2010, 2011, and 2012 subject to the following requirements: (1) for each such State and for each such fiscal year, the Secretary would be required to set aside an amount as part of a separate allotment equal to the federal share of 110% of the State's projected expenditures (as certified by the state and submitted to the Secretary by August 31 of the preceding fiscal year) for providing waiver coverage to such individuals enrolled in the waiver in the applicable fiscal year, and (2) the Secretary would pay the State from the set aside amount (specified above) for each such fiscal year an amount equal to the applicable percentage for expenditures in the quarter to provide coverage as specified under the waiver to parent(s) of targeted low-income child(ren).

In fiscal year 2010 only, costs associated with such parent coverage would be subject to each such state's CHIP enhanced FMAP for States that meet one of the outreach or coverage benchmarks (listed below) in FY2009, or each such state's Medicaid FMAP rate for all other states. The provision would prohibit federal matching payments for the payment of services beyond the set-aside spending cap.

For fiscal year 2011 or 2012, costs associated with such parent coverage would be subject to: (1) each such state's Reduced Enhanced Matching Assistance Percentage (REMAP) (i.e., a percentage which would be equal to the sum of (a) each such state's FMAP percentage and (b) the number of percentage points equal to one-half of the difference between each such state's FMAP rate and each such state's enhanced FMAP rate) if the state meets one of the coverage benchmarks (listed below) for FY2010 or FY2011 (as applicable), or (2) each such state's FMAP rate if the state failed to meet any of the coverage benchmarks (listed below) for the applicable fiscal year. The provision

would prohibit federal matching payments for the payment of services beyond the set-aside spending cap.

FY2010 outreach and coverage benchmarks include: (1) the state implemented a significant child outreach campaign including (a) the state was awarded an outreach and enrollment grant (under Section 201 of this bill) for fiscal year 2009, (b) the state implemented 1 or more process measures for that fiscal year, or (c) the state has submitted a specific plan for outreach for such fiscal year, (2) the state ranks in the lowest 1/3 of the States in terms of the State's percentage of low-income children without health insurance based on timely and accurate published estimates of the Bureau of the Census, or (3) the State qualified for a payment from the Incentive Fund for the most recent coverage period.

FY2011 and 2012 coverage benchmarks include: (1) the state ranks in the lowest 1/3 of the States in terms of the State's percentage of low-income children without health insurance based on timely and accurate published estimates of the Bureau of the Census, and (2) the State qualified for a payment from the Incentive Fund for the most recent coverage period.

A rule of construction clarifies that states are not prohibited from submitting applications for 1115 waivers to provide medical assistance to a parent of a targeted low-income child.

The General Accountability Office would be required to conduct a study to determine if the coverage of a parent, caretaker relative, or legal guardian of a targeted low-income child increases the enrollment of or quality of care for children, and if such parents, relatives, and legal guardians are more likely to enroll their children in CHIP or Medicaid. Results of the study (and report recommended changes) would be reported to appropriate committees of Congress 2 years after the date of enactment.

## Section 107. State option to cover low-income pregnant women under CHIP through a State plan amendment

*Current Law*

Under SCHIP, states can cover pregnant women ages 19 and older in one of two ways: (1) via a special waiver of program rules (through Section 1115 authority), or (2) by providing coverage as permitted through regulation. In the latter case, coverage includes prenatal and delivery services only.

In general, SCHIP allows states to cover targeted low-income children with family income that is above applicable Medicaid eligibility levels in a given state. States can set the upper income level up to 200% FPL, or if the applicable Medicaid income level was at or above 200% FPL before SCHIP, the upper income limit may be raised an additional 50 percentage points above that level. Other SCHIP eligibility restrictions include (1) the child must be uninsured, (2) the child must be otherwise ineligible for regular Medicaid,

and (3) the child cannot be an inmate of a public institution or a patient in an institution for mental disease, or eligible for coverage under a state employee health plan. States may provide SCHIP coverage to children who are covered under a health insurance program that has been in operation since before July 1, 1997 and that is offered by a state that receives no federal funds for this program. States may use enrollment restrictions such as capping total program enrollment, creating waiting lists, and instituting a minimum period of no insurance (e.g., 6 months) before being eligible.

Under regular Medicaid, states must provide coverage for pregnant women with income up to 133% FPL, and at state option, may extend such coverage to pregnant women with income up to 185% FPL. States must also provide coverage to first-time pregnant women with income that meets former cash assistance program rules (which were generally well below 100% FPL). The period of coverage for these mandatory and optional pregnant women is during pregnancy through the end of the month in which the 60 days postpartum period ends. In addition, waiver authority may be used to cover pregnant women at even higher income levels and for extended periods of time (e.g., 18 or 24 months postpartum).

Under regular Medicaid, states may temporarily enroll pregnant women whose family income appears to be below Medicaid income standards for up to 2 months until a final formal determination of eligibility is made. Entities that may qualify to make such presumptive eligibility determinations for pregnant women include Medicaid providers that are outpatient hospital departments, rural health clinics and certain other clinics, and other entities including certain primary care health centers and rural health care programs funded under Sections 330 and 330A of the Public Health Service Act, grantees under the Maternal and Child Health Block Grant Program, entities receiving funds under the Health Services for Urban Indians program, and entities that participate in WIC, the Commodity Supplemental Food Program, a state perinatal program (as designated by the state), or is the Indian Health Service or a health program or facility operated by tribes or tribal organizations under the Indian Self Determination Act.

Mandatory Medicaid eligibility applies to children under age 6 in families with income at or below 133% FPL. In addition, states may cover newborns under age 1 up to 185% FPL under Medicaid. Children born to Medicaid-eligible pregnant women must be deemed to be eligible for Medicaid from the date of birth up to age 1 so long as the child is a member of the mother's household, and the mother remains eligible for Medicaid (or would remain eligible if pregnant). During this period of deemed eligibility for the newborn, for claiming and payment purposes, the Medicaid identification (ID) number of the mother must also be used for the newborn, unless the state issues a separate ID number for the child during this period. In general, newborns may also be enrolled in SCHIP if they meet the applicable financial standards in a given state, which build on top of Medicaid's rules.

For families with income below 150% FPL, premiums cannot exceed nominal amounts specified in Medicaid regulations, and service-related cost-sharing is limited to nominal Medicaid amounts for the subgroup under 100% FPL and slightly higher

amounts in SCHIP regulations for the subgroup with income between 100-150% FPL. For families with income above 150% FPL, premiums and cost-sharing may be imposed in any amount as long as such costs for higher-income children are not less than the costs for lower-income children. Total premiums and cost-sharing incurred by all SCHIP children cannot exceed 5% of annual family income.

Other cost-sharing protections also apply. Applicable premium and cost-sharing amounts cannot favor children from families with higher income over children in families with lower income. No cost-sharing may be applied to preventive services.

*Explanation of Provision*

The provision would allow states to provide optional coverage under CHIP to pregnant women, through a state plan amendment, if certain conditions are met, including (1) the state has established an income eligibility level of at least 185% FPL for mandatory, welfare-related qualified pregnant women and optional poverty-related pregnant women under Medicaid, (2) the state does not apply an effective income level under the state plan amendment for pregnant women that is lower than the effective income level (expressed as a percent of poverty and accounting for applicable income disregards) for mandatory, welfare-related qualified pregnant women and optional poverty-related pregnant women under Medicaid on the date of enactment of this provision to be eligible for Medicaid as a pregnant women, (3) the state does not provide coverage for pregnant women with higher family income without covering such pregnant women with a lower family income, (4) the state provides pregnancy-related assistance (defined below) for targeted low-income pregnant women in the same manner, and subject to the same requirements, as the state provides child health assistance for targeted low-income children under the state CHIP plan, and in addition to providing child health assistance for such women, (5) the state does not apply any exclusion of benefits for pregnancy-related assistance based on any pre-existing condition or any waiting period (including waiting periods to ensure that CHIP does not substitute for private insurance coverage), and (6) the state must provide the same cost-sharing protections to pregnant women as applied to CHIP children, and all cost-sharing incurred by targeted low-income pregnant women under CHIP would be capped at 5% of annual family income.

States that elect this new optional coverage for pregnant women under CHIP and that meet all the above conditions associated with this option, may also elect to provide presumptive eligibility for pregnant women, as defined in the Medicaid statute, to targeted low-income pregnant women under CHIP.

Pregnancy-related assistance would include all the services covered as child health assistance under the state's CHIP program, and includes medical assistance that would be provided to a pregnant woman under Medicaid, during pregnancy through the end of the month in which the 60 day postpartum period ends. The upper income limit for coverage of targeted low-income pregnant women under CHIP could be up to the level for coverage of targeted low-income children in the state. As with targeted low-income children under CHIP, the new group of targeted low-income pregnant women must be

determined eligible, be uninsured, and must not be an inmate of a public institution or a patient in an institution for mental disease or eligible for coverage under a state employee health benefit plan. Also as with targeted low-income children, pregnant women may include those covered under a health insurance program that has been in operation since before July 1, 1997 and that is offered by a state that receives no federal funds for this program.

The provision would also deem children born to the new group of targeted low-income pregnant women under CHIP to be eligible for Medicaid or CHIP, as applicable. Such newborns would be covered from birth to age 1. During this period of eligibility, the mother's identification number must also be used for filing claims for the newborn, unless the state issues a separate identification number for that newborn.

The provision would also address States that provide assistance through other options. The option to provide assistance in accordance with the preceding subsections of this section shall not limit any other option for a State to provide (A) child health assistance through the application of sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) of title 42, Code of Federal Regulations, or (B) pregnancy-related services through the application of any other waiver authority (as in effect on June 1, 2007).

Any State that provides child health assistance under any authority described in paragraph (1) may continue to provide such assistance, as well as postpartum services, through the end of the month in which the 60-day period (beginning on the last day of the pregnancy) ends, in the same manner as assistance and postpartum services would be provided if provided under the State plan under title XIX, but only if the mother would otherwise satisfy the eligibility requirements that apply under the State child health plan (other than with respect to age) during such period.

A rule of construction clarifies that nothing in this subsection shall be construed to (A) infer the congressional intent regarding the legality or illegality of the content of sections of title 42, Code of Federal Regulations, specified in paragraph (1)(A), or (B) modify the authority to provide pregnancy-related services under a waiver specified in paragraph (1)(B).

For the new group of targeted low-income pregnant women, additional conforming amendments would prohibit cost-sharing for pregnancy-related services and waiting periods prior to enrollment or for the purpose of preventing crowd-out of private health insurance.

## Section 108. CHIP contingency fund

*Current Law*

No provision.

*Explanation of Provision*

A CHIP Contingency Fund is established in the U.S. Treasury. The Contingency Fund receives deposits through a separate appropriation. For FY2008, the appropriation to the Fund is equal to 12.5% of the available national allotment for CHIP. For FY2009 through FY2012, the appropriation is such sums as are necessary for making payments to eligible states for the fiscal year, as long as the annual payments do not exceed 12.5% of that fiscal year's available national allotment for CHIP. Balances that are not immediately required for payments from the Fund are to be invested in U.S. securities that provide addition income to the Fund, as long as the annual payments do not cause the Fund to exceed 12.5% of the available national allotment for CHIP. Amounts in excess of the 12.5% limit shall be deposited into the Incentive Pool. For purposes of the CHIP Contingency Fund, amounts set aside for block grant payments for transitional coverage of childless adults shall not count as part of the available national allotment.

Payments from the Fund are to be used only to eliminate any eligible state's shortfall (that is, the amount by which a state's available federal CHIP allotments are not adequate to cover the state's federal CHIP expenditures, on the basis of the most recent data available to the Secretary or requested from the state by the Secretary).

The Secretary shall separately compute the shortfalls attributable to children and pregnant women, to childless adults, and to parents of low-income children. No payment from the Contingency Fund shall be made for nonpregnant childless adults. Any payments for shortfalls attributable to parents shall be made from the Fund at the relevant matching rate. Contingency funds are not transferable among allotments.

Eligible states, which cannot be a territory, for a month in FY2008 to FY2012 are those that meet any of the following criteria:

- The state's available federal CHIP allotments are at least 95% but less than 100% of its projected federal CHIP expenditures for the fiscal year (i.e., less than 5% shortfall in federal funds), without regard to any payments provided from the Incentive Fund; or
- The state's available federal CHIP allotments are less than 95% of its projected federal CHIP expenditures for the fiscal year (i.e., more than 5% shortfall in federal funds) and that such shortfall is attributable to one or more of the following: (1) One or more parishes or counties has been declared a major disaster and the President has determined individual and public assistance has been warranted from the federal government pursuant to the Stafford Act, or a public health emergency was declared by the Secretary pursuant to the Public Health Service Act; (2) the state unemployment rate is at least 5.5% during any 13 consecutive week period during the fiscal year and such rate is at least 120% of the state unemployment rate for the same period as averaged over the last three fiscal years; (3) the state experienced a recent event that resulted in an increase in the percentage of low-income children in the state without health insurance (as determined on the basis of the most timely and

accurate published estimates from the Census Bureau) that was outside the control of the state and warrants granting the state access to the Fund, as determined by the Secretary.

The Secretary shall make monthly payments from the Fund to all states determined eligible for a month. If the sum of the payments from the Fund exceeds the amount available, the Secretary shall reduce each payment proportionally.

If a state was determined to be eligible in a given fiscal year, that does not make the state eligible in the following fiscal year. In the case of an event that occurred after July 1 of the fiscal year that resulted in the declaration of a Stafford Act or public health emergency that increased the number of uninsured low-income children as described above, any related Contingency Fund payment shall remain available until the end of the following fiscal year

The Secretary shall provide annual reports to Congress on the Contingency Fund, the payments from it, and the events that caused states to apply for payment.

## Section 109. 2-year availability of allotments; expenditures counted against oldest allotments

*Current Law*

SCHIP allotments (currently through FY2007) are available for three years. Allotments unspent after three years are available for reallocation. For example, the FY2004 allotment was available through the end of FY2006; any remaining balances at the end of FY2006 were redistributed to other states.

*Explanation of Provision*

CHIP allotments through FY2005 are available for three years. CHIP allotments made for FY2006 through FY2012 are available for two years.

Payments to states from the Incentive Pool are available until expended by the state. Payments for a month from the Contingency Fund are available through the end of the fiscal year, except in the case of an event that occurred after July 1 of the fiscal year that resulted in the declaration of a Stafford Act or public health emergency that increased the number of uninsured low-income children.

States' federal CHIP expenditures on or after October 1, 2007, shall be counted first against the Contingency Funds from the earliest available month in the earliest fiscal year, then against the earliest available allotments.

A State may elect, but is not required, to count CHIP expenditures against any incentive bonuses paid to the State.

Expenditures for coverage of nonpregnant childless adults in FY2009 and of parents of targeted low-income children in FY2010 through FY2012 shall be counted only against the amount set aside for such coverage

## Section 110. Limitation on matching rate for States that propose to cover children with effective family income that exceeds 300 percent of the poverty line

*Current Law*

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. There are statutory exceptions to the FMAP formula for the District of Columbia (since FY1998) and Alaska (for FY1998-FY2007). In addition, the territories have FMAPs set at 50% and are subject to federal spending caps.

The enhanced FMAP (E-FMAP) for SCHIP equals a state's Medicaid FMAP increased by the number of percentage points that is equal to 30% multiplied by the number of percentage points by which the FMAP is less than 100%. For example, in states with an FMAP of 60%, the E-FMAP equals the FMAP increased by 12 percentage points (60% + [30% multiplied by 40 percentage points] = 72%). The E-FMAP has a statutory minimum of 65% and maximum of 85%.

*Explanation of Provision*

For child health assistance or health benefits coverage furnished in any fiscal year beginning with FY2008 to a targeted low-income child whose effective family income would exceed 300% of the federal poverty line but for the application of a general exclusion of a block of income that is not determined by type of expense or type of income, states would be reimbursed using the FMAP instead of the E-FMAP for services provided to that child. An exception would be provided for states that, on the date of enactment of the Children's Health Insurance Program (CHIP) Reauthorization Act of 2007 has an approved State plan amendment or waiver or has enacted a State law to submit a State plan amendment to provide child health assistance or health benefits under their state child health plan or its waiver of such plan to children above 300% of the poverty line.

## Section 111. Option for qualifying States to receive the enhanced portion of the CHIP matching rate for Medicaid coverage of certain children

*Current Law*

Section 2105(g) of the Social Security Act permits qualifying states to apply federal SCHIP funds toward the coverage of certain children already enrolled in regular Medicaid (that is, not SCHIP-funded expansions of Medicaid). Specifically, these federal SCHIP funds are used to pay the difference between SCHIP's enhanced Federal Medical Assistance Percentage (FMAP) and the Medicaid FMAP that the state is already receiving for these children. Funds under this provision may only be claimed for expenditures occurring after August 15, 2003.

Qualifying states are limited in the amount they can claim for this purpose to the lesser of the following two amounts: (1) 20% of the state's original SCHIP allotment amounts (if available) from FY1998, FY1999, FY2000, FY2001, FY2004, FY2005, FY2006, and FY2007 (hence the terms "20% allowance" and "20% spending"); and (2) the state's available balances of those allotments. If there is no balance, states may not claim Section 2105(g) spending.

The statutory definitions for qualifying states capture most of those that had expanded their upper-income eligibility levels for children in their Medicaid programs to 185% of the federal poverty level or higher prior to the enactment of SCHIP. Based on statutory definitions, 11 states were determined to be qualifying states: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington and Wisconsin.

SCHIP spending under §2105(g) can be used by qualifying states only for Medicaid enrollees (excluding those covered by an SCHIP-funded expansion of Medicaid) who are under age 19 and whose family income exceeds 150% of poverty, to pay the difference between the SCHIP enhanced FMAP and the regular Medicaid FMAP.

*Explanation of Provision*

Qualifying states under §2105(g) may also use available balances from their CHIP allotments from FY2008 to FY2012 to pay the difference between the regular Medicaid FMAP and the CHIP enhanced FMAP for Medicaid enrollees under age 19 (or age 20 or 21, if the state has so elected in its Medicaid plan) whose family income exceeds 133% of poverty.

# Title II – Outreach and Enrollment

## Section 201. Grants for outreach and enrollment

*Current Law*

The federal and state governments share in the costs of both Medicaid and SCHIP, based on formulas defining the federal contribution in federal law. States are responsible for the non-federal share, using state tax revenues, for example, but can also use local government funds to comprise a portion of the non-federal share. Generally, the non-

federal share of costs under Medicaid and SCHIP cannot be comprised of other federal funds.

Under Medicaid, there are no caps on administrative expenses that may be claimed for federal matching dollars. Title XXI specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance, which meets certain requirements. Apart from these benefit payments; SCHIP payments for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of SCHIP children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, payments for other specific health care activities cannot exceed 10% of the total amount of expenditures for SCHIP benefits and other specific health care activities combined.

*Explanation of Provision*

The provision would establish a new grant program under CHIP to finance outreach and enrollment efforts that increase participation of eligible children in both Medicaid and CHIP. For the purpose of awarding grants, the provision would appropriate $100 million for each of fiscal years 2008 through 2012. These amounts would be in addition to amounts appropriated for CHIP allotments to states (as per Section 2104 of the CHIP statute) and would not be subject to restrictions on expenditures for outreach activities under current law.

For each fiscal year, the provision would require that ten percent of the funds appropriated for this new grant would be set aside to finance a national enrollment campaign (described below), and an additional 10 percent would be set-side to be used by the Secretary to award grants to Indian Health Service providers and Urban Indian Organizations that receive funds under title V of the Indian Health Care Improvement Act for outreach to, and enrollment of, children who are Indians.

The provision would require the Secretary to develop and implement a national enrollment campaign to improve the enrollment of under-served child populations in Medicaid and CHIP. Such a campaign may include: (1) the establishment of partnerships with the Secretary of Education and the Secretary of Agriculture to develop national campaigns to link the eligibility and enrollment systems for the programs each Secretary administers that often serve the same children, (2) the integration of information about Medicaid and CHIP in public health awareness campaigns administered by the Secretary, (3) increased financial and technical support for enrollment hotlines maintained by the Secretary to ensure that all states participate in such hotlines, (4) the establishment of joint public awareness outreach initiatives with the Secretary of Education and the Secretary of Labor regarding the importance of health insurance to building strong communities and the economy, (5) the development of special outreach materials for Native Americans or for individuals with limited English proficiency, and (6) such other outreach initiatives as the Secretary determines would increase public awareness of Medicaid and CHIP.

In awarding grants, the Secretary would be required to give priority to entities that propose to target geographic areas with high rates of eligible but not enrolled children who reside in rural areas, or racial and ethnic minorities and health disparity populations, including proposals that address cultural and linguistic barriers to enrollment, and which submit the most demonstrable evidence that (1) the entity includes members with access to, and credibility with, ethnic or low-income populations in the targeted communities, and (2) the entity has the ability to address barriers to enrollment (e.g., lack of awareness of eligibility, stigma concerns, punitive fears associated with receipt of benefits) as well as other cultural barriers to applying for and receiving coverage under CHIP or Medicaid.

To receive grant funds, eligible entities would be required to submit an application to the Secretary in such form and manner, and containing such information as the Secretary chooses. As noted above, such applications must include evidence that the entity (a) includes members with access to, and credibility with, ethnic or low-income populations in the targeted communities, and (b) has the ability to address barriers to enrollment (e.g., lack of awareness of eligibility, stigma concerns, punitive fears associated with receipt of benefits) as well as other cultural barriers to applying for and receiving CHIP or Medicaid benefits. The applicable must also include specific quality or outcome performance measures to evaluate the effectiveness of activities funded by the grant. In addition, the applicable must contain an assurance that the entity will (1) conduct an assessment of the effectiveness of such activities against the performance measures, (2) cooperate with the collection and reporting of enrollment data and other information in order for the Secretary to conduct such assessment, and (3) in the case of an entity that is not a state, provide the state with enrollment data and other information necessary for the state to make projections of eligible children and pregnant women. The Secretary would be required to make publicly available the enrollment data and information collected and reported by grantees, and would also be required to submit an annual report to Congress on the funded outreach and enrollment activities conducted under the new grant.

Seven types of entities would be eligible to receive grants, including (1) a state with an approved CHIP plan, (2) a local government, (3) an Indian tribe or tribal consortium, a tribal organization, an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act, or an Indian Health Service provider, (4) a federal health safety net organization , (5) a national, local, or community-based public or nonprofit organization, including organizations that use community health workers or community-based doula programs , (6) a faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with requirements of section 1955 of the Public Health Service Act relating to a grant award to non-governmental entities, or (7) an elementary or secondary school.

Federal health safety net organizations include a number of different types of entities, including for example: (1) federally qualified health centers, (2) hospitals that receive disproportionate share hospital (DSH) payments, (3) entities described in Section 340B(a)(4) of the Public Health Service Act (e.g., certain family planning projects,

certain grantees providing early intervention services for HIV disease, certain comprehensive hemophilia diagnostic treatment centers, and certain Native Hawaiian health centers), and (4) any other entity or consortium that serves children under a federally-funded program, including the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Head Start programs, school lunch programs, and elementary or secondary schools.

The provision defines "community health worker" as an individual who promotes health or nutrition within the community in which the individual resides by (1) serving as a liaison between communities and health care agencies, (2) providing guidance and social assistance to residents, (3) enhancing residents' ability to effectively communicate with health care providers, (4) providing culturally and linguistically appropriate health or nutrition education, (5) advocating for individual and community health or nutrition needs, and (6) providing referral and follow-up services.

In the case of a State that is awarded an Outreach and Enrollment grant, the State would be required to meet a maintenance of effort requirement with regard to the state share of funds spent on outreach and enrollment activities under the CHIP state plan. For such states, the funds spent on outreach and enrollment under the state plan for a fiscal year would not permitted to be less than the State share of funds spent in the fiscal year preceding the first fiscal year for which the grant is awarded.

The provision would add translation and interpretation services to the specific health care activities that can be reimbursed under CHIP. Translation or interpretation services in connection with the enrollment and use of services under CHIP by individuals for whom English is not their primary language (as found by the Secretary for the proper and efficient administration of the state plan) would be matched at either 75% or the sum of the enhanced FMAP for the state plus five percentage points, whichever is higher.

In addition, the 10% limit on payments for other specific health care activities in current CHIP statute would not apply to expenditures for outreach and enrollment activities funded under this section.

## Section 202. Increased outreach and enrollment of Indians

(a) Agreements with States for Medicaid and CHIP Outreach on or Near Reservations to Increase the Enrollment of Indians in Those Programs

*Current Law*

No provision in the Social Security Act.

Section 404(a) of the IHCIA requires the Secretary to make grants or enter into contracts with Tribal Organizations for establishing and administering programs on or near federal Indian reservations and trust areas and in or near Alaska Native villages. The purpose of the programs is to assist individual Indians to enroll in Medicare, apply

for Medicaid and pay monthly premiums for coverage due to financial need of such individuals. Section 404(b) of the IHCIA directs the Secretary, through the IHS, to set conditions for any grant or contract. The conditions include, but are not limited to: (1) determining the Indian population that is, or could be, served by Medicare and Medicaid; (2) assisting individual Indians to become familiar with and use benefits; (3) providing transportation to Indians to the appropriate offices to enroll or apply for medical assistance; and (4) developing and implementing both an income schedule to determine premium payment levels for coverage of needy individuals and methods to improve Indian participation in Medicare and Medicaid. Section 404(c) of the IHCIA authorizes the Secretary, acting through the IHS, to enter into agreements with tribes, Tribal Organizations, and Urban Indian Organizations to receive and process applications for medical assistance under Medicaid and benefits under Medicare at facilities administered by the IHS, or by a tribe, Tribal Organization or Urban Indian Organization under the Indian Self-Determination Act.

*Explanation of Provision*

The provision would amend Section 1139 of the Social Security Act (replacing the current Section 1139 provision dealing with an expired National Commission on Children).

The provision would encourage states to take steps to provide for enrollment of Indians residing on or near a reservation in Medicaid and CHIP. The steps could include outreach efforts such as: outstationing of eligibility workers; entering into agreements with the IHS, Indian Tribes (ITs), Tribal Organizations (TOs), and Urban Indian Organizations (UIOs) to provide outreach; education regarding eligibility, benefits, and enrollment; and translation services. The provision would not affect the arrangements between states and Indian Tribes, Tribal Organizations, and Urban Indian Organizations to conduct administrative activities under Medicaid and CHIP.

The provision would require the Secretary, acting through CMS, to take such steps as necessary to facilitate cooperation with and agreements between states, and the IHS, ITs, TOs, or UIOs relating to the provision of benefits to Indians under Medicaid and CHIP.

The provision would specify that the following terms have the meanings given to these terms in Section 4 of the Indian Health Care Improvement Act: Indian, Indian Tribe, Indian Health Program, Tribal Organization, and Urban Indian Organization.

(b) Nonapplication of 10 Percent Limit On Outreach and Certain Other Expenditures

*Current Law*

Title XXI of the Social Security Act provides states with annual federal SCHIP allotments based on a formula set in law. State SCHIP payments are matched by the

federal government at an enhanced rate that builds on the base rate applicable to Medicaid. The SCHIP statute also specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance that meets certain requirements. States may also provide benefits to SCHIP children, called targeted low-income children, through enrollment in Medicaid. Apart from these benefit payments, SCHIP payments for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, SCHIP statute specifies that payments for these four other specific health care activities cannot exceed 10% of the total amount of expenditures for benefits (excluding payments for services rendered during periods of presumptive eligibility under Medicaid) and other specific health care activities combined.

*Explanation of Provision*

The provision would exclude from the 10% cap on CHIP payments for the four other specific health care activities described above: (1) expenditures for outreach activities to families of Indian children likely to be eligible for CHIP or Medicaid, or under related waivers, and (2) related informing and enrollment assistance activities for Indian children under such programs, expansions, or waivers, including such activities conducted under grants, contracts, or agreements entered into under Section 1139 of this Act.

# Title III – Removal of Barriers to Enrollment

## Section 301. Verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP

*Current Law*

To be eligible for the full range of benefits offered under Medicaid, an individual must be a citizen or national of the United States or a qualified alien. Nonqualified aliens can only receive limited emergency Medicaid benefits. Noncitizens who apply for full Medicaid benefits have been required since 1986 to present documentation that indicates a "satisfactory immigration status."

Due to recent changes in federal law, citizens and nationals also must present documentation that proves citizenship and documents personal identity in order for states to receive federal Medicaid reimbursement for services provided to them. This citizenship documentation requirement was included in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and modified by the Tax Relief and Health Care Act of 2006 (P.L. 109-432). Before the DRA, states could accept self-declaration of citizenship for Medicaid, although some chose to require additional supporting evidence.

The citizenship documentation requirement is outlined under Section 1903(x) of the Social Security Act and applies to Medicaid eligibility determinations and redeterminations made on or after July 1, 2006. The law specifies documents that are acceptable for this purpose and exempts certain groups from the requirement, including people who receive Medicare benefits, Social Security benefits on the basis of a disability, Supplemental Security Income benefits, child welfare assistance under Title IV-B of the Social Security Act, or adoption or foster care assistance under Title IV-E of the Social Security Act. An interim final rule on the requirement was issued in July 2006, and a final rule was issued in July 2007.

The citizenship documentation requirement does not apply to SCHIP. However, some states use the same enrollment procedures for all Medicaid and SCHIP applicants. As a result, it is possible that some SCHIP enrollees would be asked to present evidence of citizenship.

*Explanation of Provision*

As part of its Medicaid state plan and with respect to individuals declaring to be U.S. citizens or nationals for purposes of establishing Medicaid eligibility, a state would be required to provide that it satisfies existing Medicaid citizenship documentation rules under Section 1903(x) or new rules under Section 1902(dd). The Secretary would not be allowed to waive this requirement.

Under a new Section 1902(dd), a state could meet its Medicaid state plan requirement for citizenship documentation by: (1) submitting the name and Social Security number (SSN) of an individual to the Commissioner of Social Security as part of a plan established under specified rules and (2) in the case of an individual whose name or SSN is invalid, providing the individual with 90 days to present evidence of citizenship as defined in Section 1903(x) and disenrolling the individual within 30 days after the end of the 90-day period if evidence is not provided.

A state opting for name and SSN validation would be required to establish a program under which it submits each month to the Commissioner of Social Security for verification the name and SSN of each individual enrolled in Medicaid that month who has attained the age of 1 before the date of the enrollment. In establishing its program, a state could enter into an agreement with the Commissioner to provide for the electronic submission and verification of name and SSN before an individual is enrolled in Medicaid.

At such times and in such form as the Secretary may specify, states would be required to provide information on the percentage of invalid names and SSNs submitted each month. If the average monthly percentage for any fiscal year is greater than 7%, the state shall develop and adopt a corrective plan and pay the Secretary an amount equal to total Medicaid payments for the fiscal year for individuals who provided invalid information multiplied by the ratio of the number of individuals with invalid information in excess of the 7% limited divided by the total number of individuals with invalid

information. The Secretary could waive, in certain limited cases, all or part of such payment if a state is unable to reach the allowable error rate despite a good faith effort by the state. This provision shall not apply to a State for a fiscal year, if there is an agreement with the Commissioner to provide for the electronic submission and verification of name and SSN before an individual is enrolled in Medicaid, as of the close of the fiscal year.

States would receive 90% reimbursement for costs attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement name and SSN validation, and 75% for the operation of such systems.

The provision would also clarify requirements under the existing Section 1903(x). It would add "a document issued by a federally-recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe" to the list of documents that provide satisfactory documentary evidence of citizenship or nationality, except for tribes located within states having an international border whose membership includes noncitizens, who would only be allowed to use such documents until the Secretary of HHS issues regulations authorizing the presentation of other evidence. It would require states to provide citizens with the same reasonable opportunity to present evidence that is provided under Section 1137(d)(4)(A) to noncitizens who must present evidence of satisfactory immigration status. Groups that are exempt from the Section 1903(x) citizenship documentation requirement would remain the same as under current law, except for the inclusion of a permanent exemption for children who are deemed eligible for Medicaid coverage by virtue of being born to a mother on Medicaid. The provision would clarify that deemed eligibility applies to children born to noncitizen women on emergency Medicaid, and would require separate identification numbers for children born to these women.

In order to receive reimbursement for an individual who has, or is, declared to be a U.S. citizen or national for purposes of establishing CHIP eligibility, a state would be required to meet the Medicaid state plan requirement for citizenship documentation described above. The 90% and 75% reimbursement for name and SSN validation would be available under SCHIP, and would not count towards a state's CHIP administrative expenditures cap.

Except for technical amendments made by the provision and the application of citizenship documentation to CHIP, which would be effective upon enactment, the provision would be effective as if included in the Deficit Reduction Act of 2005. States would be allowed to provide retroactive eligibility for certain individuals who had been determined ineligible under previous citizenship documentation rules.

## Section 302. Reducing administrative barriers to enrollment

*Current Law*

During the implementation of SCHIP states instituted a variety of enrollment facilitation and outreach strategies to bring eligible children into Medicaid and SCHIP. As a result, substantial progress was made at the state level to simplify the application and enrollment processes to find, enroll, and maintain eligibility among those eligible for the program.

*Explanation of Provision*

The provision would require the State plan to describe the procedures used to reduce the administrative barriers to the enrollment of children and pregnant women in Medicaid and CHIP, and to ensure that such procedures are revised as often as the State determines is appropriate to reduce newly identified barriers to enrollment. States would be deemed to comply with the above-listed requirement if (1) the State's application and renewal forms, and information verification processes are the same under Medicaid and CHIP for establishing and renewing eligibility for children and pregnant women, and (2) the state does not require a face-to-face interview during the application process.

## Title IV – Elimination of Barriers to Providing Premium Assistance

# Subtitle A– Additional State Option for Providing Premium Assistance

## Section 401. Additional State option for providing premium assistance

*Current Law*

Under Medicaid, a provision in the Omnibus Budget Reconciliation Act (OBRA) of 1990 created the health insurance premium payment (HIPP) program. The original HIPP provision required state Medicaid programs to pay a Medicaid beneficiary's share of costs for group (employer-based) health coverage for any Medicaid enrollee for whom employer-based coverage is available when that coverage is both comprehensive and cost effective for the state. An individual's enrollment in an employer plan is considered cost effective if paying the premiums, deductibles, coinsurance and other cost-sharing obligations of the employer plan is less expensive than the state's expected cost of directly providing Medicaid-covered services. Under the original provision, states were also required to purchase employer-based health insurance for non-Medicaid eligible family members if such family coverage was necessary for Medicaid-eligible individual to receive coverage, and as long as it was still cost-effective. States were also to provide coverage for those Medicaid covered services that are not included in the private plans. In August 1997, as part of the Balanced Budget Act, Congress amended the mandatory nature of the HIPP provision. Today, states can opt to use Medicaid funds to pay for

premiums and other cost-sharing for Medicaid beneficiaries when coverage is available, comprehensive, and cost-effective.

Under SCHIP, the Secretary has the authority to approve funding for the purchase of "family coverage" if it is cost effective relative to the amount paid to cover only the targeted low-income children and does not substitute for coverage under group health plans that would otherwise be provided to the children. While the term "family coverage" is not specifically defined in the statute, it has been interpreted to refer to either coverage for the entire family under an SCHIP program or under an employer-sponsored health insurance plan. In addition, states using SCHIP funds for employer-based plan premiums must ensure that SCHIP minimum benefits are provided and SCHIP cost-sharing ceilings are met.

Because of these requirements, implementation of premium assistance programs under Medicaid and SCHIP are not widespread. States cited difficulty in identifying potential enrollees, determining whether the subsidy would be cost-effective, and obtaining necessary information (e.g., information about the availability of employer-sponsored plans, covered benefits, available contributions, and the remaining costs) as some of the barriers to the implementation of such programs.

In August 2001, the Bush Administration introduced the Health Insurance Flexibility and Accountability (HIFA) Initiative under the Section 1115 waiver authority. Under HIFA, states were to direct unspent SCHIP funds to extend coverage to uninsured populations with annual income less than 200% FPL and to use Medicaid and SCHIP funds to pay premium costs for waiver enrollees who have access to Employer Sponsored Insurance (ESI). This resulted in an increased emphasis on states' use of the Section 1115 waiver authority to offer premium assistance for employer-based health coverage in lieu of full Medicaid and/or SCHIP coverage. ESI programs approved under the Section 1115 waiver authority are not subject to the same current law constraints required under Medicaid's HIPP program or SCHIP's family coverage variance option (i.e., the comprehensiveness and cost-effectiveness tests).

*Explanation of Provision*

The provision would allow states to offer a premium assistance subsidy for qualified employer sponsored coverage to all targeted low-income children who are eligible for child health assistance and have access to such coverage. Qualified employer sponsored coverage would be defined as a group health plan or health insurance coverage offered through an employer that (1) qualifies as credible health coverage as a group health plan under the Public Health Service Act, (2) for which the employer contributes at least 40 percent toward the cost of the premium, and (3) is non-discriminatory in a manner similar to section 105(h)of the Internal Revenue Code but would not allow employers to exclude workers who had less than 3 years of service. Qualified employer-sponsored insurance would not include (1) benefits provided under a health flexible spending arrangement, (2) a high deductible health plan purchased in conjunction with a health savings account as defined in the Internal Revenue Code of 1986.

The provision would establish a new cost effectiveness test for ESI programs. A group health plan or health insurance coverage offered through an employer would be considered qualified employer sponsored coverage if the state establishes that (1) the cost of such coverage is less than the expenditures that the State would have made to enroll the child or the family (as applicable) in CHIP, or (2) the State establishes that the aggregate amount of State expenditures for the purchase of all such coverage for targeted low-income children under CHIP (including administrative expenses) does not exceed the aggregate amount of expenditures that the State would have made for providing coverage under the CHIP state plan for all such children.

Premium assistance subsidies would be considered child health assistance for the purpose of making federal matching payments under the CHIP program, and the state would be considered a secondary payor for any items or services provided under ESI coverage. The provision defines premium assistance subsidies as an amount equal to the difference between the employee contribution for the employee only, and the employee contribution for the employee and CHIP-eligible child, less applicable premium cost sharing imposed under title XXI (including the employee contribution toward the 5% total annual aggregate cost-sharing limit under CHIP). States would be permitted to provide a premium assistance subsidy as reimbursement for out-of-pocket expenses directly to an employee, or directly to the employer. At the employer's option, the provision permits the employer to notify the State that it elects to opt out of being directly paid a premium assistance subsidy on behalf of an employee. In the event of such notification, the employer would be required to withhold the total amount of the employee contribution required for enrollment of the employee (and the child) in the ESI coverage and then the State would then pay the premium subsidy directly to the employee.

States would be required to provide supplemental coverage for each targeted low-income child enrolled in the ESI plan consisting of items or services that are not covered, or are only partially covered, and cost-sharing protections consistent with the requirements of CHIP. States would be permitted to directly pay out-of-pocket expenditures for cost-sharing imposed under the qualified ESI coverage and collect all (or any) portion for cost-sharing imposed on the family.

Waiting periods (to prevent crowd-out of private coverage with public coverage) imposed under the CHIP state plan would also apply to premium assistance coverage. Parents would be permitted to disenroll their child(ren) from ESI coverage and enroll them in CHIP coverage effective on the first day of any month for which the child is eligible for such coverage.

States that provide ESI coverage to parents of targeted low-income children, would be permitted to offer a premium assistance subsidy to eligible parents in the same manner as that State offers such subsidy to eligible child(ren). The amount of the premium subsidy would be increased to take into account the cost of enrollment of the parent in the

ESI coverage, or at state option, the cost of the enrollment of the child's family (if the states determines that it is cost-effective).

This provision would not limit the state's authority to offer premium assistance under the Medicaid HIPP program, a section 1115 demonstration waiver, or any other authority in effect prior to the enactment of this Act. States would be required to inform parents about the availability of premium assistance subsidies for CHIP eligible children in qualified employer-sponsored insurance, how the family would elect such subsides during the application process and ensure that parents are fully informed of the choices for receiving child health assistance under the CHIP or through the receipt of a premium assistance subsidy.

The provision would also allow States to provide premium assistance subsidies for enrollment of targeted low-income children in coverage under a group health plan or health insurance coverage offered through an employer if it is determined that such coverage is actuarially equivalent to CHIP benchmark benefits coverage, or CHIP benchmark-equivalent coverage. Plans that meet the CHIP benefit coverage requirements would not be required to provide supplemental coverage for benefits and cost-sharing protections as required under CHIP. Such provisions would be applied to Medicaid-eligible children and to the parents of Medicaid-eligible children in the same manner as they are applied to CHIP.

Finally, the provision would require the General Accountability Office to submit a report to the appropriate committees of Congress on cost and coverage issues relating to any State premium assistance programs for which federal matching payments are made under Medicaid, CHIP, or the Section 1115 waiver authority. Such report will be due to Congress no later than January 1, 2009.

## Section 402. Outreach, education, and enrollment assistance

*Current Law*

SCHIP states plans are required to include a description of the procedures in place to provide outreach to children eligible for SCHIP child health assistance, or other public or private health programs to (1) inform these families of the availability of SCHIP coverage, and (2) to assist them in enrolling such children in SCHIP. In addition, states are required to provide a description of the state's efforts to ensure coordination between SCHIP and other public and private health coverage.

There is a limit on federal spending for SCHIP administrative expenses, which include activities such as data collection and reporting, as well as outreach and education. For federal matching purposes, a 10% cap applies to state administrative expenses. This cap is tied to the dollar amount that a state draws down from its annual allotment to cover benefits under SCHIP, as opposed to 10% of a state's total annual allotment. In other words, no more than 10% of the federal funds that a state draws down for SCHIP benefit expenditures can be used for administrative expenses.

*Explanation of Provision*

The provision would require states to include a description of the procedures in place to provide outreach, education, and enrollment assistance for families of children likely to be eligible for premium assistance subsidies under CHIP or a waiver approved under Section 1115. For employers likely to provide qualified employer-sponsored coverage, the state is required to include the specific resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the CHIP state plan. Expenditures for such outreach activities would not be subject to the 10 percent limit on spending for administrative costs associated with the CHIP program.

## Subtitle B– Coordinating Premium Assistance With Private Coverage

## Section 411. 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

*Current Law*

Under the Internal Revenue Code, a group health plan is required to provide special enrollment opportunities to qualified individuals. Special enrollment refers to the opportunity given to qualified individuals to enroll in a health plan without having to wait until a late enrollment opportunity or open season. Such individuals must have lost eligibility for other group coverage, or lost employer contributions towards health coverage, or added a dependent due to marriage, birth, adoption, or placement for adoption. In addition, the individual must meet the health plan's substantive eligibility requirements, such as being a full-time worker or satisfying a waiting period. Health plans must give qualified individuals at least 30 days after the qualifying event (e.g., loss of eligibility) to make a request for special enrollment.

The same special enrollment opportunities apply to group health plans and health insurance issuers offering group health insurance under the Employee Retirement Income Security Act.

The Employee Retirement Income Security Act specifies the persons who may bring civil action to enforce the provisions under this statute. Such persons include a plan participant or beneficiary, a fiduciary, the Secretary of Labor, and a State. Current law allows the Secretary to assess a maximum financial penalty against a plan administrator or employer for certain violations, including failure to meet the existing notice requirement.

*Explanation of Provision*

The provision would require (under the Internal Revenue Code) a group health plan to permit an eligible but not enrolled employee (or dependent(s) of such an employee) to enroll for coverage under the group health plan if either of the following conditions are met: (1) the employee or dependent(s) is/are covered under Medicaid or CHIP, and coverage of the employee or dependent(s) is terminated as a result of loss of eligibility and the employee requests coverage under the group health plan not later than 60 days after the date of coverage termination, or (2) the employee or dependent(s) becomes eligible for assistance, with respect to coverage under the group health plan under Medicaid or CHIP (including under any waiver or demonstration project), if the employee requests coverage under the group health plan no later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

Each employer that maintains a group health plan in a State that provides premium assistance under Medicaid or CHIP would be required to provide each employee a written notice of the potential opportunities for premium assistance available in the State under Medicaid and CHIP. For compliance purposes, the employer may use any State-specific model notice issued by the Secretary of Labor or the Secretary of Health and Human Services in accordance with the model notice requirements established under this section of the bill.

The plan administer of the group health plan would be required to disclose to the State, upon request, information about the benefits available under the group health plan so as to permit the State to make a determination concerning cost-effectiveness, and in order for the State to provide supplemental benefits if required.

The provision includes conforming amendments. A group health plan and a health insurance issuer offering group health insurance (under the Employee Retirement Income Security Act) would be required to permit an eligible but not enrolled employee (or dependent(s) of such an employee) to enroll for coverage under the group health plan if either of the following conditions are met: (1) the employee or dependent(s) is/are covered under Medicaid or CHIP, and coverage of the employee or dependent(s) is terminated as a result of loss of eligibility and the employee requests coverage under the group health plan not later than 60 days after the date of coverage termination, or (2) the employee or dependent(s) becomes eligible for assistance, with respect to coverage under the group health plan under Medicaid or CHIP (including under any waiver or demonstration project), if the employee requests coverage under the group health plan not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

Each employer that maintains a group health plan in a State that provides premium assistance under Medicaid or CHIP would be required to provide each employee a written notice of the potential opportunities for premium assistance available in the State under Medicaid and CHIP. Not later than 1 year after the date of enactment, the Secretary of Labor and the Secretary of Health and Human Services (HHS), in consultation with State Medicaid Directors and State CHIP Directors, would be required

to develop model notices to enable employers to comply with notice requirements in a timely manner. Model notices would include information regarding how an employee would contact the State for information regarding premium assistance and how to apply for such assistance.

The plan administer of the group health plan would be required to disclose to the State, upon request, information about the benefits available under the group health plan so as to permit the State to make a determination concerning cost-effectiveness, and in order for the State to provide supplemental benefits if required.

The HHS Secretary and the Labor Secretary would be required to jointly establish a Medicaid, CHIP, and Employer-Sponsored Coverage Coordination Working Group not later than 60 days after the date of enactment. The purpose of the Working Group would be to develop the model coverage coordination disclosure form, and to identify the impediments to effective coordination of coverage available to families. The purpose of the disclosure form would be to allow the State to determine the availability and cost-effectiveness of coverage, and allow for coordination of coverage for enrollees of such plans. The forms will include (1) information that will allow for the determination of an employee's eligibility for coverage under the group health plan, (2) the name and contact information of the plan administrator of the group health plan, (3) benefits offered under the plan, (4) premiums and cost-sharing under the plan, and (5) any other information relevant to coverage under the plan.

The Working Group would consist of no more than 30 members and be composed of representatives from the Department of Labor, the Department of Health and Human Services, State directors of Medicaid and CHIP programs, employers (including owners of small businesses and their trade or industry representatives and certified human resource and payroll professionals), plan administrations and plan sponsors of group health plans, and children and other beneficiaries of Medicaid and CHIP. Members would be required to serve without compensation. The Department of Health and Human Services and the Department of Labor would be required to jointly provide appropriate administrative support to the Working Group, including technical assistance. The Working Group would be required to submit the model coverage coordination disclosure form, along with a report containing recommendations for appropriate measures to address impediments to effective coordination of coverage between Medicaid, CHIP and group health plans, to the Labor Secretary and the HHS Secretary no later than 18 months after the date of enactment. The Secretaries shall jointly submit a report regarding the Working Group report recommendations to each chamber of the Congress no later than 2 months after receipt of the report from the Working Group. The Working Group shall terminate 30 days after the issuance of its report.

The Labor Secretary and the HHS Secretary would be required to develop the initial model notices, and the Labor Secretary would provide such notices to employers no later than 1 year after the date of enactment. Each employer would be required to provide initial annual notices to its employees beginning the first year after the date on which the model notices are first issued. The model coverage coordination disclosure form would

also apply to requests made by States beginning the first year after the date on which the model notices are first issued.

The provision would amend current law by allowing the Labor Secretary to assess a civil penalty (up to $100 a day) against an employer for failure to meet the new notice requirement established under this section of the bill. Each violation with respect to any employee would be treated as a separate violation. The Labor Secretary would also be allowed to assess a civil penalty (up to $100 a day) against a plan administrator for failure to comply with the new disclosure requirement established under this section of the bill. Each violation with respect to any participant or beneficiary would be treated as a separate violation.

# Title V – Strengthening Quality of Care and Health Outcomes of Children

## Section 501. Child health quality improvement activities for children enrolled in Medicaid or CHIP

*Current Law*

The Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) are both actively involved in funding and implementing an array of quality improvement initiatives, though only AHRQ has engaged in activities specific to children.

In November 2002, CMS started the Quality Initiative (QI), a multi-faceted effort to improve health care quality. This program includes the Nursing Home Quality Initiative, the Home Health Quality Initiative, the National Voluntary Hospital Quality Reporting Initiative, and the Physician Focused Quality Initiative. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) included provisions for hospitals to report data on quality indicators. In addition, the MMA included a variety of provisions designed to promote quality care, such as demonstrations that focus on improving the treatment of chronic illnesses and on identifying effective approaches for rewarding superlative performance. In 2005, quality reporting was expanded for inpatient hospital services and extended to home health. The development of plans for value-based purchasing in hospitals and home health settings was also required. In 2006, quality reporting was extended to hospital outpatient services and ambulatory service centers. Additionally, the 2007 Physician Quality Reporting Initiative (PQRI) implemented a voluntary quality reporting system for physicians and other eligible professionals with incentive payments for covered professional services tied to the reporting of claims data.

None of the CMS QI programs to date have focused on children. Rather, most have focused on the general population, adults with chronic conditions, or the frail elderly.

AHRQ has made quality improvement for children a priority in recent years. In part, this is because of the high costs incurred by children on Medicaid/SCHIP.

Many AHRQ projects to implement and evaluate improved health care strategies for the care of children are underway. These include:

1. Pediatric Quality Indicators that includes a set of measures that can be used with hospital inpatient discharge data to detect patient safety events and potentially avoidable hospitalizations.
2. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care. Medicaid uses CAHPS to measure quality of care for children with special health care needs.
3. AHRQ's Child Health Care Quality Toolbox lists tips and tools for evaluating health care quality for children. It is available to providers and consumers at www.ahrq.gov/chtoolbx/index.htm.

Other AHRQ-supported initiatives to improve the quality and safety of health care for children and adolescents, focusing on health care IT, and the development of pediatric electronic medical records, among other quality improvement activities.

*Explanation of Provision*

(a) Development of Child Health Quality Measures For Children Enrolled in Medicaid or CHIP.

The provision would add a new section to the Social Security Act defining child health quality improvement activities for children enrolled in Medicaid and CHIP. Not later than January 1, 2009, the Secretary would be required to identify and publish for general comment an initial recommended core set of child health quality measures for use by states with respect to Medicaid and CHIP, health insurance issuers and managed care entities that enter into contracts under Medicaid and CHIP, and providers under those two programs.

With consultation with specific groups (identified below), the Secretary must identify existing quality of care measures for children that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time. Based on such measures, the Secretary publish an initial core set of child health quality measures that includes, but is not limited to, the following: (1) duration of insurance coverage over a 12-month period, (2) availability of a full range of preventive services, treatments, and services for acute conditions, and treatments to correct or ameliorate the effects of chronic physical and mental conditions, (3) availability of care in a range of ambulatory and inpatient settings, and (4) measures that, taken together, 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 socio-economic disparities in child health and health care for children.

Not later than 2 years after the enactment of the Children's Health Insurance Program Reauthorization Act of 2007, the Secretary, in consultation with the states, must develop a standardized format for reporting information and procedures and approaches that encourage states to use the initial core measurement set to voluntarily report information regarding quality of pediatric care under Medicaid and CHIP.

In addition, the Secretary must disseminate information to states regarding best practices with respect to measuring and reporting quality of care for children, and must facilitate adoption of such best practices. In developing these best practices approaches, the Secretary must give particular attention to state measurement techniques that ensure timeliness and accuracy of provider reporting, encourage provider reporting compliance and encourage successful quality improvement strategies, and improve efficiency in data collection using health information technology.

Not later than January 1, 2010, and every 3 years thereafter, the Secretary must report to Congress on (1) the status of the Secretary's efforts to improve quality related to the duration and stability of health insurance coverage for children under Medicaid and CHIP, (2) the quality of children's health care under those programs, including preventive health services, health care for acute conditions, chronic health care, and health services to ameliorate the effects of physical and mental conditions, as well as to aid in growth and development of children, and (3) quality of children's health care, including clinical quality, health care safety, family experience with health care, health care in the most integrated setting, and elimination of racial, ethnic, and socioeconomic disparities in health and health care. In these reports to Congress, the Secretary must also describe the status of voluntary reporting by states under Medicaid and CHIP utilizing the initial core set of quality measures, and provide any recommendations for legislative changes needed to improve quality of care provided to Medicaid and CHIP children, including recommendations for quality reporting by states. The Secretary must also provide technical assistance to states to assist them in adopting and utilizing core child health quality measures for their Medicaid and CHIP programs.

The provision defines "core set" to mean a group of valid, reliable and evidence-based quality measures for children that provide information regarding the quality of health coverage and health care for children, address the needs of children throughout the developmental age span, and that allow purchasers, families, and health care providers to understand the quality of care in relation to the preventive needs of children, treatments aimed at managing and resolving acute conditions, and diagnostic and treatment services to correct or ameliorate physical, mental or developmental conditions that could become chronic if left untreated or poorly treated.

(b) Advancing and Improving Pediatric Quality Measures.

The provision would also require the Secretary to establish a pediatric quality measures program not later than January 1, 2010. The purpose of this program would be to (1) improve and strengthen the initial core child health care quality measures, (2) expand on existing pediatric quality measures used by both public and private purchasers and advance the development of new and emerging measures, and (3) increase the portfolio of evidence-based, consensus pediatric quality measures available to public and private purchases of children's health care services, providers and consumers.

At a minimum, the pediatric quality measures developed under this program must be (1) evidence-based and where appropriate, risk-adjusted, (2) designed to identify and eliminate racial and ethnic disparities in child health and the provision of health care, (3) designed to ensure that the data required for such measures is collected and reported in a standard format that permits comparisons at the state, plan and provider level, (4) periodically adjusted, and (5) responsive to child health needs, services and stability of coverage.

In identifying gaps in existing pediatric quality measures and establishing priorities for the development and use of such measures, the Secretary must consult with a variety of entities, including (1) states, (2) institutional and non-institutional providers that specialize in the care and treatment of children, particularly those with special needs, (3) dental professionals, including pediatric dental professionals, (4) primary care providers for children and families living in medically under-served areas, or who are members of population subgroups at heightened risk for poor health outcomes, (5) national organizations representing consumers and purchasers of children's health care, (6) national organizations and individuals with expertise in pediatric health quality measurement, and (7) voluntary consensus standard setting organizations and other organizations involved in the advancement of evidence-based measures of health care.

In addition, the Secretary must award grants and contracts for the development, testing, and validation of new, emerging, and innovative evidence-based measures for children's health care services across the domains of quality identified above, and must also award grants and contracts for the (1) development of consensus on evidence-based measures for children's health care services, (2) dissemination of such measures to public and private purchasers of health care for children, and (3) updating of such measures as necessary.

Beginning no later than January 1, 2012 and annually thereafter, the Secretary must publish recommended changes to the core measures described above that must reflect the testing, validation, and consensus process for the development of pediatric quality measures also described above.

The term "pediatric quality measure" means a measurement of clinical care that is capable of being examined through the collection and analysis of relevant information, that is developed in order to assess one or more aspects of pediatric health care quality in various institutional and ambulatory health care settings, including the structure of the

clinical care system, the process of care, the outcome of care, or patient experiences in care.

(c) Annual State Reports Regarding State-Specific Quality of Care Measures Applied Under Medicaid or CHIP.

Each state with an approved state plan for Medicaid or CHIP must report annually to the Secretary the following: (1) state-specific child health quality measures, including measures of duration and stability of insurance coverage; quality with respect to preventive services and care for acute and chronic conditions as well as services to ameliorate the effects of physical and mental conditions, and to aid in growth and development; clinical quality, health care safety, family experience with health care, care delivered in the most integrated setting, and elimination of racial, ethnic and socioeconomic disparities in health care; and other measures in the initial core quality measurement set identified above, and (2) state-specific information on the quality of care provided to children under Medicaid and CHIP, including information collected through external quality reviews of Medicaid managed care organizations (under Section 1932) and Medicaid benchmark plans (under Section 1937), and CHIP benchmark plans (under Section 2103). Not later than September 30, 2009, and annually thereafter, the Secretary must collect, analyze and make publicly available the information reported by states as described above.

(d) Demonstration Projects for Improving the Quality of Children's Health Care and the Use of Health Information Technology.

During FY2008 through FY2012, the Secretary must award not more than 10 grants to states and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of children's health care furnished under Medicaid and CHIP. Such projects would include efforts designed to: (1) experiment with and evaluate new measures of the quality of children's health care (including testing the validity and suitability for reporting of such measures), (2) promote the use of health information technology in care delivery for children, or (3) evaluate provider-based models that improve the delivery of services to children, including care management for children with chronic conditions and the use of evidence-based approaches to improve the effectiveness, safety and efficiency of health care for children.

In awarding these grants, the Secretary must ensure that (1) only one demonstration project funded by such a grant shall be conducted in a state, and (2) such demonstration projects must be conducted evenly between states with large urban areas and states with large rural areas. Grants may be conducted on a multi-state basis, as needed.

Of the total amount appropriated for this new grant program for a fiscal year (described below), $20 million must be used to carry out these activities.

(e) Development of Model Electronic Health Record Format for Children Enrolled in Medicaid or CHIP.

Not later than January 1, 2009, the Secretary must establish a program to encourage the development and dissemination of a model electronic health record format for children enrolled under state plans for Medicaid or CHIP. Such an electronic health record would be (1) subject to state laws, accessible to parents, caregivers and other consumers for the sole purpose of demonstrating compliance with school or leisure activity requirements, (2) designed to allow interoperable exchanges that conform with federal and state privacy and security requirements, (3) structured in a manner that permits parents and caregivers to view and understand the extent to which the care their children receive is clinically appropriate and of high quality, and (4) capable of being incorporated into, and otherwise compatible with, other standards developed for electronic health records. Of the total amount appropriated for this new grant program for a fiscal year, $5 million must be used to carry out these activities.

(f) Study of Pediatric Health and Health Care Quality Measures.

Not later than July 1, 2009**,** the Institute of Medicine must study and report to Congress on the extent and quality of efforts to measure child health status and the quality of health care for children across the age span and in relation to preventive care, treatments for acute conditions, and treatments to ameliorate or correct physical, mental, and developmental conditions in children. In conducting this study, the IOM must: (1) consider all the major national population-based reporting systems sponsored by the federal government, including reporting requirements under federal grant programs and national population surveys and estimates conducted directly by the federal government, (2) identify the information regarding child health and health care quality that each system is designed to capture and generate, the study and reporting periods covered by each system, and the extent to which the information is made widely available through publication, (3) identify gaps in knowledge related to children's health status, health disparities among subgroups of children, the effects of social conditions on children's health status and use and effectiveness of health care, and the relationship between child health status and family income, family stability and preservation, and children's school readiness and educational achievement and attainment, and (4) make recommendations regarding improving and strengthening the timeliness, quality, and public transparency and accessibility of information about child health and health care quality**.** Of the total amount appropriated for this new grant program, up to $1 million must be used to carry out these activities.

(g) Rule of Construction.

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 assistance under Medicaid or CHIP.

(h) Appropriations.

An appropriation of $45 million for FY2008 through FY2012 would be made for the purpose of carrying out the provisions of this section. Such funds would remain available until expended.

The provision would also use the federal medical assistance percentage (FMAP) applicable to a given state to determine the federal share of costs incurred by states for the development or modification of existing claims processing and retrieval systems as is necessary for the efficient collection and reporting on child health measures.

## Section 502. Improved information regarding access to coverage under CHIP

*Current Law*

Under SCHIP, states must assess the operation of the SCHIP state plan in each fiscal year, including the progress made in reducing the number of uncovered low-income children. They must also report to the Secretary of HHS, by January 1 following the end of the fiscal year, the results of that assessment.

Federal regulations stipulate that each annual report include the following additional information: (1) progress in meeting strategic objectives and performance goals identified in the state SCHIP plan, (2) effectiveness of policies to discourage the substitution of public coverage for private coverage, (3) identification of successes and barriers in state plan design and implementation, and the approaches the state is considering to overcome these barriers, (4) progress in addressing any specific issues (such as outreach) that the state plan proposed to periodically monitor and assess, (5) an updated 3-year budget, including any changes in the sources of non-federal share of state plan expenditures, (6) identification of total state expenditures for family coverage and total number of children and adults, respectively, provided family coverage during the preceding fiscal year, and (7) current income standards and methodologies for its SCHIP Medicaid expansion program, separate SCHIP program, and its regular Medicaid program, as appropriate.

*Explanation of Provision*

(a) Inclusion of Process and Access Measures in Annual State Reports.

The provision would require each state to include the following information in its annual CHIP report to the Secretary of HHS: (1) eligibility criteria, enrollment, and retention data (including information on continuity of coverage or duration of benefits), (2) data regarding the extent to which the state uses process measures with respect to determining the eligibility of children, including measures such as 12-months of continuous eligibility, self-declaration of income for applications or renewals, or presumptive eligibility, (3) data regarding denials of eligibility and redeterminations of eligibility, (4) data regarding access to primary and specialty services, access to networks

of care, and care coordination provided under the state CHIP plan, using quality of care and consumer 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 provision of such assistance, including the extent to which employer-sponsored health insurance coverage is available for children eligible for CHIP, the range of the monthly amount of such assistance provided on behalf or a child or family, the number of children or families provided such assistance on a monthly basis, the income of the children or families provided such assistance, the benefits and cost-sharing protection provided under the state CHIP plan to supplement the coverage purchased with such premium assistance, the effective strategies the state engages in to reduce any administrative barriers to the provision of such assistance, and, the effects, if any, of the provision of such assistance on preventing the coverage under CHIP from substituting for coverage provided under employer-sponsored health insurance offered in the state, and (6) to the extent applicable, a description of any state activities that are designed to reduce the number of uncovered children in the state, including through a state health insurance connector program or support for innovative private health coverage initiatives.

(b) GAO Study and Report on Access to Primary and Specialty Services.

The provision would require GAO to conduct a study of children's access to primary and specialty services under Medicaid and CHIP, including (1) the extent to which providers are willing to treat children eligible for such programs, (2) information on such children's access to networks of care, (3) geographic availability of primary and specialty services under such programs, (4) the extent to which care coordination is provided for children's care under Medicaid and CHIP, and (5) as appropriate, information on the degree of availability of services for children under such programs.

In addition, not later than 2 years after the date of enactment of this Act, GAO must submit a report to the appropriate committees of Congress on this study that includes recommendations for such federal and state legislative and administrative changes as GAO determines are necessary to address any barriers to access to children's care under Medicaid and CHIP that may exist

## Section 503. Application of certain managed care quality safeguards to CHIP

*Current Law*

A number of sections of the Social Security Act apply to states under title XXI (SCHIP) in the same manner as they apply to a state under title XIX (Medicaid). These include:

- Section 1902(a)(4)(C) (relating to conflict of interest standards).
- Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

- Section 1903(w) (relating to limitations on provider taxes and donations).
- Section 1920A (relating to presumptive eligibility for children).

*Explanation of Provision*

The provision would add the same requirements for CHIP managed care entities as currently exist under Medicaid. Specifically, the provision would add reference to Medicaid's statutory requirements on: the process for plan enrollment, termination, and change of enrollment; the type of information provided to enrollees and potential enrollees on providers, covered services, enrollee rights, and other forms of information; beneficiary protections; quality assurance standards; protections against fraud and abuse; and sanctions against managed care plans for noncompliance.

# Title VI – Miscellaneous

## Section 601. Technical correction regarding current State authority under Medicaid

*Current Law*

States may provide SCHIP through an expansion of their Medicaid programs. Expenditures for such populations of targeted low-income children are matched at the enhanced FMAP rate and are paid out of SCHIP allotments.

*Explanation of Provision*

With respect to expenditures for Medicaid for fiscal years 2007 and 2008 only, a state may elect (1) to cover optional poverty-related children and, may apply less restrictive income methodologies to such individuals (via authority in Section 1902(r) or through Section 1931(b)(2)(C)), for which the regular Medicaid FMAP, rather than the enhanced FMAP applicable to CHIP, would be used to determine the federal share of such expenditures, or (2) to receive the regular Medicaid FMAP, rather than the enhanced CHIP FMAP, for CHIP children under an expansion of the state's Medicaid program. This provision would be repealed as of October 1, 2008 (i.e., the beginning of fiscal year 2009). States electing these options would be "held harmless" for related expenditures in FY2007 and FY2008, once this repeal takes effect.

## Section 602. Payment Error Rate Measurement ("PERM")

*Current Law*

P.L. 107-300 requires the heads of Federal agencies annually to review programs they oversee that are susceptible to significant erroneous payments, and to estimate the amount of improper payments, to report those estimates to Congress, and to submit a report on actions the agency is taking to reduce erroneous expenditures.

The Center for Medicare and Medicaid Services (CMS), the federal agency within HHS that administers the Medicaid and SCHIP programs, issued an interim final rule with comment period on August 28, 2006, regarding Payment Error Rate Measurement (PERM) for the Medicaid and SCHIP programs. This rule was effective on October 1, 2006. In addition to P.L. 107-300, this regulation points to Sections 1102, 1902(a)(6) and 2107(b)(1) of the Social Security Act which contains the Secretary's general rulemaking authority and obligation of the states to provide information, as the Secretary may require, to monitor program performance. Section 1902(a)(27)(B) also requires states to require providers to furnish State Medicaid Agencies and the Secretary with information regarding payments claimed by Medicaid providers for furnishing Medicaid services. Payment error rates will be calculated for fee-for-service (FFS) claims, managed care claims and for eligibility determinations. The preamble to this regulation notes that CMS will hire Federal contractors to review Medicaid and SCHIP FFS and managed care claims and to calculate the state-specific and national error rates for both programs. States will calculate the state-specific eligibility error rates. Based on those rates, the Federal contractor will calculate the national eligibility error rate for each program. CMS plans to sample a subset of states each year rather than measure every state every year.

With respect to Medicaid and SCHIP eligibility reviews under PERM, states selected for review in a given year must conduct reviews of a statistically valid random sample of beneficiary claims to determine if improper payments were made based on errors in the state agency's eligibility determinations. States must have a CMS-approved sampling plan. In addition to reporting error rates, states must also submit a corrective action plan based on its error rate analysis, and must return overpayments of federal funds.

Medicaid Eligibility Quality Control (MEQC) is operated by State Medicaid agencies to monitor and improve the administration of its Medicaid program. The traditional MEQC program is based on State reviews of Medicaid beneficiaries identified through a statistically reliable statewide sample of cases selected from the eligibility files. These reviews are conducted to determine whether the sampled cases meet applicable Title XIX eligibility requirements and to determine if a State has made erroneous excess payments in its program. Erroneous excess payments for medical assistance" reflect: a) payments made on behalf of ineligible individuals and families, and b) overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.

The SCHIP statute specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance that meets certain requirements. States may also provide benefits to SCHIP children, called targeted low-income children, through enrollment in Medicaid. Apart from these benefit payments, SCHIP payments for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, SCHIP

statute specifies that payments for these four other specific health care activities cannot exceed 10% of the total amount of expenditures for benefits (excluding payments for services rendered during periods of presumptive eligibility under Medicaid) and other specific health care activities combined.

*Explanation of Provision*

The provision would apply a federal matching rate of 90 percent to expenditures related to administration of PERM requirements applicable to CHIP.

The provision would also exclude from the 10% cap on CHIP administrative costs all expenditures related to the administration of PERM requirements applicable to CHIP in accordance with P.L. 107-300, existing regulations, and any related or successor guidance or regulations.

In addition, the Secretary must not calculate or publish any national or state-specific error rate based on the application of PERM requirements to CHIP until after the date that is 6 months after the date on which a final rule implementing such requirements (described below) is in effect for all states. Any calculation of a national error rate or a state specific error rate after such a final rule is in effect for all states may only be inclusive of errors, as defined in such final rule or in guidance issued within a reasonable time frame after the effective date for such final rule that includes detailed guidance for the specific methodology for error determinations.

The final rule implementing the PERM requirements must include: (1) clearly defined criteria for errors for both states and providers, (2) a clearly defined process for appealing error determinations by review contractors, and (3) clearly defined responsibilities and deadlines for states in implementing any corrective action plans.

After the final PERM rule is in effect for all states, a state for which the PERM requirements were first in effect under an interim final rule for FY2007 may elect to accept any payment error rate determined in whole or in part for the state on the basis of data for that fiscal year or may elect to not have an payment error rate determined on the basis of such data and, instead, must be treated as if FY2010 were the first year for which the PERM requirements apply to the state.

If the final PERM rule is not in effect for all states by July 1, 2008, a state for which the PERM requirements were first in effect under an interim final rule for FY2008 may elect to accept any payment error rate determined in whole or in part for the state on the basis of data for that fiscal year, or may elect to not have any payment error rate determined on the basis of such data and, instead, must be treated as if FY2011 were the first fiscal year for which the PERM requirements apply to the state.

In addition, the provision would require the Secretary to review the Medicaid Eligibility Quality Control (MEQC) requirements with the PERM requirements and coordinate consistent implementation of both sets of requirements, while reducing

redundancies. A state may elect, for purposes of determining the erroneous excess payments for medical assistance ratio applicable to the state under MEQC, to substitute data resulting from the application of PERM requirements after the final PERM rule is in effect for all states for the data used for the MEQC requirements.

The Secretary must also establish state-specific sample sizes for application of the PERM requirements with respect to CHIP for FY2009 and thereafter, on the basis of information as the Secretary determines is appropriate. In establishing such sample sizes, the Secretary must, to the greatest extent possible (1) minimize the administrative cost burden on states under Medicaid and CHIP, and (2) maintain state flexibility to manage these programs.

## Section 603. Elimination of counting Medicaid child presumptive eligibility costs against Title XXI Allotment.

*Current Law*

Under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll (for up to 2 months) children whose family income appears to be below applicable Medicaid income standards, until a formal determination of eligibility is made. Payments on behalf of Medicaid children during periods of presumptive eligibility are matched at the regular Medicaid FMAP, but are paid out of state SCHIP allotments.

*Explanation of Provision*

The provision would strike the language in existing CHIP statute that sets the federal share of costs incurred during periods of presumptive eligibility for children at the Medicaid FMAP rate, and also strikes the language that allows payment out of CHIP allotments for Medicaid benefits received by Medicaid children during periods of presumptive eligibility.

## Section 604. Improving data collection

*Current Law*

As discussed in Section 102, the percentage of the SCHIP appropriation that is allotted to individual states is based primarily on state-level estimates of (1) the number of low-income children and (2) the number of uninsured low-income children, based on a three-year average of the Annual Social and Economic (ASEC) Supplements (formerly known as the March supplements) to the Census Bureau's Current Population Survey (CPS). Based on these CPS estimates, some states' share of the available national allotment in the second year of SCHIP (FY1999) was going to differ markedly from the prior year's (e.g., a share of the available national allotment in FY1999 that would have been approximately 40% lower or higher than in FY1998). As a result, legislation was enacted to base the FY1999 SCHIP allotments on the states' share of the available national allotment as calculated for FY1998.

Separate legislation was also enacted to add two new floors and a ceiling to ensure that a state's share of the available national allotment did not change by more than certain amounts, as compared to the state's prior-year share and the state's FY1998/FY1999 share.

Another piece of legislation was also enacted that required appropriate adjustments to the CPS (1) to produce statistically reliable annual state data on the number of low-income children who do not have health insurance coverage, so that real changes in the uninsurance rates of children can reasonably be detected; (2) to produce data that categorizes such children by family income, age, and race or ethnicity; and (3) where appropriate, to expand the sample size used in the state sampling units, to expand the number of sampling units in a state, and to include an appropriate verification element. For this purpose, $10 million was appropriated annually, beginning in FY2000. Because of this legislation, the number of sampled households in the ASEC CPS increased by about 50% (34,500 households). Even with the sample expansion, the margins of error of the state-level estimates of the number of low-income children, and particularly the estimates of low-income children without health insurance, can be relatively high, especially in smaller states.

*Explanation of Provision*

Besides the $10 million provided annually for the CPS since FY2000, an additional $10 million (for a total of $20 million additionally) is appropriated. In addition to the current-law requirements of the additional appropriation, for data collection beginning in FY2008, in appropriate consultation with the HHS Secretary, the Secretary of Commerce shall do the following:

- Make appropriate adjustments to the CPS to develop more accurate state-specific estimates of the number of children enrolled in CHIP or Medicaid;
- Make appropriate adjustments to the CPS to improve the survey estimates used to compile the state-specific and national number of low-income children without health insurance for purposes of determining annual CHIP allotments, and for making payments to states from the CHIP Incentive Pool, the CHIP Contingency Fund, and, to the extent applicable to a State, from the block grant set aside for CHIP payments on behalf of parents in FY2010 through FY2012;
- Include health insurance survey information in the American Community Survey (ACS) related to children;
- Assess whether ACS estimates, once such survey data are first available, produce more reliable estimates than the CPS for CHIP allotments and payments;
- On the basis of that assessment, recommend to the HHS Secretary whether ACS estimates should be used in lieu of, or in some combination with, CPS estimates for CHIP purposes; and
- Continue making the adjustments to expansion of the sample size used in State sampling units, the number of sampling units in a State, and using an appropriate verification element.

If the Commerce Secretary recommends to the HHS Secretary that ACS estimates should be used instead of, or in combination with, CPS estimates for CHIP purposes, the HHS Secretary may provide a transition period for using ACS estimates, provided that the transition is implemented in a way that avoids adverse impacts on states.

## Section 605. Deficit Reduction Act Technical Correction

State Flexibility in Benefit Packages

*Current Law*

Under the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit under Medicaid, most children under age 21 receive comprehensive basic screening services (i.e., well-child visits including age-appropriate immunizations) as well as dental, vision and hearing services. In addition, EPSDT guarantees access to all federally coverable services necessary to treat a problem or condition among eligible individuals.

Under Medicaid, categorically needy (CN) eligibility groups include families with children, the elderly, certain individuals with disabilities, and certain other pregnant women and children who meet applicable financial eligibility standards. Some CN eligibility groups must be covered while others are optional. Medically needy (MN) groups include the same types of individuals, but different, typically higher financial standards apply. All MN eligibility groups are optional.

The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) gave states the option to provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage which is nearly identical to plans available under SCHIP (described above). For any child under age 19 in one of the major mandatory and optional CN eligibility groups (defined in Section 1902(a)(10)(A)), wrap-around benefits to the DRA benchmark and benchmark-equivalent coverage includes EPSDT (described above). In traditional Medicaid, EPSDT is available to individuals under age 21 in CN groups, and may be offered to individuals under 21 in MN groups.

DRA identifies a number of groups as exempt from mandatory enrollment in benchmark or benchmark equivalent plans. One such exempted group is children in foster care receiving child welfare services under Part B of title IV of the Social Security Act and children receiving foster care or adoption assistance under Part E of such title.

*Explanation of Provision*

The provision would require that EPSDT be covered for any individual under age 21 who is eligible for Medicaid through the state plan under one of the major mandatory and optional CN groups and is enrolled in benchmark or benchmark-equivalent plans authorized under DRA. The provision would also give states flexibility in providing

coverage of EPSDT services through the issuer of benchmark or benchmark-equivalent coverage or otherwise.

The provision would also make a correction to the reference to children in foster care receiving child welfare services.

Finally, not later than 30 days after the date the Secretary approves a state plan amendment to provide benchmark or benchmark-equivalent coverage under Medicaid, the Secretary must publish in the Federal Register and on the internet website of CMS, a list of the provisions in Title XIX that the Secretary has determined do not apply in order to enable the state to carry out such a state plan amendment and the reason for each such determination.

The amendments made by this provision would become effective as if included in Section 6044(a) of the DRA (i.e., March 31, 2006).

## Section 606. Elimination of confusing program references

*Current Law*

P.L. 106-113 directed the Secretary of HHS or any other Federal officer or employee, with respect to references to the program under Title XXI of the Social Security Act, in any publication or official communication to use the term "SCHIP" instead of "CHIP" and to use the term "State children's health insurance program" instead of "children's health insurance program."

*Explanation of Provision*

The provision would repeal the section in P.L 106-113 providing the program references to "SCHIP" and "State children's health insurance program" for official publication and communication purposes.

# Title VII – Revenue Provisions

*See attached "Description of the Revenue Provisions for Markup of the State Children's Health Insurance Program" prepared by the staff of the Joint Committee on Taxation.*

# Title VIII – Effective Date

## Section 801. Effective date

*Current Law*

No provision.

*Explanation of Provision*

The effective date of this bill would be October 1, 2007, whether or not final regulations to carry out provisions in the bill have been promulgated by that date. In the case of both current state CHIP and Medicaid plans, if the Secretary of HHS determines that a state must pass new state legislation to implement the requirements of this bill, the state's existing CHIP and/or Medicaid plans, if applicable, would not be considered to be out of compliance solely on the basis of its failure to meet such requirements before 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 enactment of this bill. In the case of a state that has a 2-year legislative session, each year of such session must be considered to be a separate regular session of the state legislature.