

Description of the Chairman's Mark

The Children's Health Insurance Program Reauthorization Act of 2009

Scheduled for Markup
By the Senate Committee on Finance
On January 15, 2009

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

Current Law

No provision.

Chairman's Mark

This act would be cited as the "Children's Health Insurance Program Reauthorization Act of 2009." Unless otherwise noted, this act would amend, or repeal provisions of the Social Security Act. When this act references "CHIP" it would be referring to the State Children's Health Insurance Program established under Title XXI; "Medicaid" would refer to the program for medical assistance established under Title XIX; "Secretary" would refer to the Secretary of Health and Human Services (HHS).

Sec. 2. Purpose.

Current Law

No provision.

Chairman's Mark

The purpose of this Act [CHIPRA 2009] is to provide dependable and stable funding for children's health insurance under titles XXI [CHIP] and XIX [Medicaid] of the Social Security Act in order to enroll all six million uninsured children who are eligible, but not enrolled, for coverage today through such titles.

Sec. 3. General effective date; exception for State legislation; contingent effective date; reliance on law.

Current Law

Three sources of Federal CHIP funding are no longer available after March 31, 2009: (1) unspent balances of FY2008 CHIP allotments, (2) unspent balances of FY2009 CHIP allotments, and (3) additional appropriations previously provided to cover projected shortfalls of Federal CHIP funds through March 31, 2009, the first half of the Federal fiscal year.

Chairman's Mark

The Chairman's Mark would be effective April 1, 2009, which is the beginning of the second half of the Federal fiscal year. States would be given additional time to come into compliance with the requirements of the Chairman's Mark, if applicable, based on the timing of state legislative sessions. If FY2009 CHIP allotment amounts provided for the first two quarters of FY2009 have not been obligated, they would be rescinded and would effectively be replaced with funding provided in this act. The amount of allotments provided under the Chairman's Mark in the second half of FY2009 would be reduced by spending that occurred from a state's FY2009 allotment in the first half of the fiscal year. Provisions in the Chairman's Mark would be considered effective on the dates specified regardless of whether implementing regulations have been issued. In addition, states cannot be denied Medicaid and CHIP payments if they acted in good faith reliance on the provisions of the Chairman's Mark, even if those expenditures do not comply with the final regulations ultimately issued.

TITLE I—FINANCING

Subtitle A—Funding

Sec. 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 CHIP:

\$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, FY2008 and FY2009. The FY2008 and FY2009 amounts are only available through March 31, 2009.

These amounts are allotted to states, including the District of Columbia, except for (1) 0.25 percent 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, FY2008 and FY2009.

Chairman's Mark

The Chairman's Mark would specify the following national appropriation amounts for CHIP in §2104(a):

\$10,562,000,000 in FY 2009;
\$12,520,000,000 in FY 2010;
\$13,459,000,000 in FY 2011;
\$14,982,000,000 in FY 2012; and
\$2,850,000,000 for the first half of FY2013 and \$2,850,000,000 for the second half of FY2013.

Sec. 102. Allotments for states and territories for fiscal years 2009 through 2013.

Current Law

The annual CHIP 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 CHIP 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 percent 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 FY2009 allotments, the three most recent supplements available before January 1, 2008, were used. Thus, states' FY2009 allotments were based on the "number of children" using data that covered calendar years 2004, 2005 and 2006.

The adjustment for geographic variation in health costs is 85 percent 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 CHIP appropriation, against which the floors and ceiling are compared.

Since the beginning of CHIP, 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 percent of last year's share, and (2) no state's share could be less than 70 percent 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 percent 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 percent 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 CHIP allotment for that fiscal year.

Chairman's Mark

For FY2009, CHIP allotments to states would be the largest of the following three amounts, increased by 10 percent:

- The state's FY2008 CHIP *spending*, multiplied by the state's allotment increase factor (which is based on (a) the projected increase in per capita health expenditures and (b) state-level child population growth, if any, plus one percentage point);
- The state's FY2008 CHIP *allotment*, multiplied by the state's allotment increase factor; and
- The state's FY2009 CHIP *projected spending* (based on states' official projections to the Centers for Medicare and Medicaid Services (CMS) provided in February 2009, with states qualified to have additional spending under Sec. 111 of the legislation to update their projections accordingly).

FY2009, CHIP allotments to territories would be calculated as the largest amount of Federal CHIP spending from FY1999 to 2008, multiplied by the allotment increase factor based on national estimates.

If the appropriated amounts for allotments (e.g., \$10.562 billion in FY2009) are inadequate to cover all the allotments for the states and territories, then their allotments would be reduced proportionally.

For FY2010, the allotment for a state (or territory) would be calculated as the sum of the following four amounts, if applicable, multiplied by the allotment increase factor for the year:

- FY2009 CHIP allotment as provided under the Chairman's Mark;
- FY2006 unspent allotments redistributed to and spent by shortfall states in the first half of FY2009;
- Spending of funds provided to shortfall states in the first half of FY2009; and
- Spending of Contingency Fund payments (Sec. 103) in FY2009.

For FY2011, the allotment for a state (or territory) would be "rebased," based on FY2010 spending. This would be done by multiplying the allotment increase factor for the year by the new base, FY2010 Federal CHIP spending from allotments, redistribution and Contingency Fund payments.

For FY2012, the allotment for a state (or territory) would be calculated as the FY2011 allotment and any Contingency Fund spending, multiplied by the allotment increase factor for the year.

For FY2013, the allotment for a state (or territory) would be "rebased," based on FY2012 spending. This would be done by multiplying the allotment increase factor for the year by the new base: FY2012 Federal CHIP spending from allotments, redistribution and Contingency Fund payments. This "full year amount" would be allotted based on the ratio of the appropriations available for the first half of the year versus the second half. For the first half of FY2013, the appropriated amount would be the semi-annual \$2.85 billion plus the one-time FY2013 appropriation of \$11.706 billion in Sec. 108; for the second half of FY2013, the appropriated amount would be the semi-annual \$2.85 billion. Combined, a total of \$17.406 billion would be available for FY2013 allotments.

For FY2010 and FY2012 (that is, years in which allotments are based on the prior year's allotment, redistribution and Contingency Fund payments), a state that has altered its CHIP plan to expand eligibility or benefits would be able to obtain an allotment increase to account for the amount of expenditures attributable to that change, subject to certain conditions.

Sec. 103. Child Enrollment Contingency Fund.

Current Law

No provision.

Chairman's Mark

A Child Enrollment Contingency Fund would be established in the U.S. Treasury. The Contingency Fund would receive deposits through a separate appropriation. For FY2009, the appropriation to the Fund would be equal to 20 percent of the available national allotment for CHIP. For FY2010 through FY2013, the appropriation would be such sums as are necessary for making payments to eligible states for the fiscal year, as long as the annual payments do not exceed 20 percent 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 additional income to the Fund, as long as the annual payments would not cause the Fund to exceed 20 percent of the available national allotment for CHIP. Amounts in excess of the 20 percent limit would be available for performance bonuses, described in Sec. 104.

If a state's Federal CHIP spending in FY2009 through FY2013 exceeds its available allotments (excluding unspent allotments redistributed from other states) and if the state experienced enrollment that exceeded its target average number, payments from the Contingency Fund would be the product of (1) the amount by which the average monthly caseload exceeds the target number, (2) the projected per capita costs of those individuals, and (3) the Federal share of CHIP expenditures paid by the Federal government for that state.

The target average number of child enrollees for a state for FY2009 would be the monthly average enrollment in FY2007 plus child population growth plus four percentage points. For FY 2010, 2011, and 2012, the target average number would be the prior year's amount increased by the state's child population growth plus 3.5 percentage points for FY 2013, 2014, and 2015, the target average number would be the prior year's amount increased by the state's child population growth plus 3 percentage points. The projected per capita expenditures for FY2009 would be the expenditures for CHIP children in FY2008 increased by the percentage increase projected for per capita National Health Expenditures for 2009. For later fiscal years, the projected per capita expenditures would be the prior-year amounts increased by the percentage increased projected for per capita National Health Expenditures for that year.

If the amounts for Contingency Fund payments are inadequate to cover amounts for that year, then the amounts would be reduced proportionally. Contingency Fund payments would be made before the end of the fiscal year, based on the most recent data available.

For purposes of Contingency Fund payments and redistributions (Sec. 106) states would continue reporting to the Secretary their projected Federal CHIP expenditures, even if the amount exceeds the amount of allotments available to the state.

No Contingency Fund payment would be made to territories until the Secretary determines that there are effective methods for collecting and reporting reliable data to make the necessary determinations.

Sec. 104. CHIP performance bonus payment to offset additional enrollment costs resulting from enrollment and retention efforts.

Current Law

No provision.

Chairman's Mark

Funds for bonus payments would be payable in FY2009 to FY2013 to states that (1) increase their Medicaid enrollment among low-income children above a defined baseline, and (2) implement five of the following eight outreach and enrollment activities:

- 12 months of continuous eligibility for Medicaid and CHIP children;
- Elimination of an assets test in Medicaid and CHIP, or use of administrative verification of assets;
- Elimination of in-person interview requirement;
- Use of a joint application for Medicaid and CHIP;
- Implement certain options to ease enrollees' renewal processes;
- Presumptive eligibility for children;
- Implement "Express Lane" (Sec. 203); and
- Premium assistance (Title III)

Bonus payments would only be used to reduce the number of low-income children who do not have health insurance coverage. The payments would be funded by an initial appropriation in FY2009 of \$3,225,000,000 billion, along with transfers from different potential sources (with payments reduced proportionally if necessary):

- National appropriation amounts for FY2009 through FY2013 provided but not used for allotments;
- Redistribution amounts not spent; and
- On October 1 of FY2010 through FY2013, any amounts in the CHIP Contingency Fund in excess of the fund's aggregate cap.

For FY2009, the Medicaid bonus baseline would be equal to the average monthly number of children in 2008, increased by child population growth rate for the state plus one percentage point. For subsequent years, the Medicaid bonus baseline would be the

prior year's amount increased by child population growth rate for the state plus one percentage point.

The first tier of bonus payments would be for enrollees that represent growth above the baseline less than 10 percent. For these Medicaid child enrollees, the bonus payment would be equal to 15 percent of the state share of these enrollees' projected per capita Medicaid expenditures. (Projected per capita Medicaid expenditures would be the average per capita expenditures for children for the most recent year with actual data, increased by projected increases in per capita National Health Expenditures.) For the second tier, 10 percent or more above baseline, the bonus payment would be equal to 62.5 percent of the state share of these enrollees' projected per capita expenditures.

In order to ensure bonus payments do not go toward eligibility expansions, children for whom states might obtain bonus payments would be those who would have been Medicaid eligible based on the eligibility criteria in effect in the state on July 1, 2008. If a state elects to expand Medicaid to children through the flexibility described in Sec. 115, those children would not count toward bonus payments for the first three fiscal years of such an election. After the third fiscal year, the number of enrollees in that third fiscal year would count toward the baseline.

Bonus payments would be received as a single payment no later than the end of the first quarter after the end of the fiscal year.

No bonus payment would be made to territories until the Secretary determines that there are effective methods for collecting and reporting reliable data to make the necessary determinations.

Sec. 105. Two-year availability of CHIP allotments.

Current Law

CHIP allotments from FY1998 through FY2007 were available for three years. The FY2008 and FY2009 allotments are no longer available after March 31, 2009.

Chairman's Mark

CHIP allotments through FY2008 would be available for three years. CHIP allotments made for FY2009 and each fiscal year after would be available for two years. Redistributed funds would be available to the state through the end of the fiscal year in which they were redistributed.

Sec. 106. Redistribution of unused allotments.

Current Law

After three years of availability, unspent CHIP allotments were generally available to states that had spent those allotments in the three-year window, with the state-level determination done by the Secretary. In the past several years, legislation has specified that redistributed funds go to shortfall states.

Chairman's Mark

The general provision in CHIP statute regarding redistributions would be amended so that the Secretary would redistribute future unspent allotments to shortfall states, defined as those projected to exhaust all available Federal CHIP allotments as well as Contingency Fund payments. If amounts available for redistribution are inadequate to eliminate shortfalls, amounts would be reduced proportionally. The Secretary would be permitted to adjust the redistributions on the basis of actual expenditure data.

Sec. 107. 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 CHIP funds toward the coverage of certain children already enrolled in regular Medicaid (that is, not CHIP-funded expansions of Medicaid). Specifically, these Federal CHIP funds are used to pay the difference between CHIP'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 percent of the state's original CHIP allotment amounts (if available) from FY1998, FY1999, FY2000, FY2001, FY2004, FY2005, FY2006, FY2007, FY2008 and FY2009 (hence the terms "20 percent allowance" and "20 percent 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 percent of the Federal poverty level or higher prior to the enactment of CHIP. 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.

CHIP spending under §2105(g) can be used by qualifying states only for Medicaid enrollees (excluding those covered by an CHIP-funded expansion of Medicaid)

who are under age 19 and whose family income exceeds 150 percent of poverty to pay the difference between the CHIP enhanced FMAP and the regular Medicaid FMAP.

Chairman's Mark

Qualifying states under §2105(g) would also be permitted use available balances (not limited to 20 percent of the original allotment) from their CHIP allotments from FY2009 to FY2013 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 percent of poverty.

Sec. 108. One-time appropriation.

Current Law

No provision.

Chairman's Mark

As described in Sec. 102, in FY 2013, a one-time appropriation of \$11,706,000,000 would be made to add to the funds already provided for allotments. This appropriation would be provided in FY2013.

Sec. 109. Improving funding for the territories under CHIP and Medicaid.

Current Law

The Federal Medicaid matching rate, which determines the Federal share of most Medicaid expenditures, is statutorily set at 50 percent in the territories (an enhanced match is also available for certain administrative costs). Therefore, the Federal government generally pays 50 percent of the cost of Medicaid items and services in the territories up to the spending caps.

Chairman's Mark

Beginning with FY2009, if a territory qualifies for the enhanced Federal match (90 percent or 75 percent) that is available under Medicaid for improvements in data reporting systems, such reimbursement would not count towards its Medicaid spending cap. The provision would also require a GAO study (due to Congress no later than September 30, 2010) regarding Federal funding under Medicaid and CHIP in the territories.

Subtitle B—Focus on Low-Income Children and Pregnant Women

Sec. 111. State option to cover low-income pregnant women under CHIP through a state plan amendment.

Current Law

Under current CHIP law, states can cover pregnant women ages 19 and older through waiver authority or by providing coverage to unborn children as permitted through regulation. In the latter case, coverage is limited to prenatal and delivery services only.

Chairman's Mark

The Chairman's Mark would allow states to cover pregnant women under CHIP through a state plan amendment when certain conditions are met (e.g., the Medicaid income standard for pregnant women must be at least 185 percent FPL, but in no case lower than the percent in effect as of July 1, 2008; no coverage for higher income pregnant women without covering lower income pregnant women; no pre-existing conditions or waiting periods may be imposed; CHIP cost-sharing protections for children would apply). Other eligibility restrictions applicable to CHIP children would also apply to this new group (e.g., must be uninsured, ineligible for state employee coverage, etc.). The upper income level for the new group could be as high as the standard applicable to CHIP children in the state. The period of coverage would be during pregnancy through the end of the month in which the 60-day period (beginning on the last day of the pregnancy) ends. Benefits would include all services available to CHIP children in the state as well as prenatal, delivery and postpartum care. States choosing this option would also be allowed to temporarily enroll such pregnant women for up to two months until a formal determination of eligibility is made (also known as presumptive eligibility). Children born to these pregnant women would be deemed eligible for Medicaid or CHIP, as appropriate, and would be covered up to age one year. States may continue to provide coverage to pregnant women through waivers and the unborn child regulation. States covering pregnant women through the unborn child regulation would be allowed to provide postpartum services to those women at state option.

Sec. 112. Phase-out of coverage for nonpregnant childless adults under CHIP; conditions for coverage of parents.

Current Law

Under current law, Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) broad authority to modify virtually all aspects of the Medicaid and CHIP programs including expanding eligibility to populations who are not otherwise eligible for Medicaid or CHIP (e.g., childless adults). Approved CHIP Section 1115 waivers are deemed to be part of a state's CHIP state plan for purposes of Federal reimbursement. Costs associated with waiver programs are subject to each state's enhanced FMAP. Under CHIP Section 1115 waivers, states must meet an "allotment neutrality test" where combined Federal expenditures for the state's regular CHIP program and for the state's CHIP demonstration program are capped at the state's individual CHIP allotment. The Deficit Reduction Act of 2005 prohibited the approval of new demonstration projects that allow Federal CHIP funds to be used to provide coverage to nonpregnant childless adults, but allowed for the continuation of such existing Medicaid or CHIP waiver projects affecting Federal CHIP funds that were approved before February 8, 2006.

Chairman's Mark

The Chairman's Mark would phase out CHIP coverage of nonpregnant childless adults by the end of calendar year 2009. States with existing CHIP waivers to provide coverage to nonpregnant childless adults that would otherwise expire before January 1, 2010 would be permitted to request an extension, but only through calendar year 2009. States with existing childless adult waivers would be permitted to apply for Medicaid waivers to continue coverage for these individuals, but subject to a specified budget-neutrality standard (tied to the state's 2009 spending on this population). Budget-neutrality standards for succeeding fiscal years would be tied to waiver spending in the preceding calendar year.

Coverage of parents would still be allowed for states with existing CHIP parent coverage waivers at income eligibility levels that were in effect as of the date of enactment of this Act, but beginning in FY2012, allowable spending under the waivers would be subject to a set-aside amount from a separate allotment and would be matched at the state's regular Medicaid FMAP unless the state was able to prove it met certain coverage benchmarks (related to performance in providing coverage to children). In FY2012 and FY2013, even states meeting the coverage benchmarks would not get the enhanced FMAP for parents but an amount between the regular and enhanced FMAPs. The Chairman's Mark would also require a Government Accountability Office study regarding effects of adult coverage on the increase in child enrollment or quality of care.

Sec. 113. Elimination of counting Medicaid child presumptive eligibility costs against Title XXI allotment

Current Law

CHIP statute sets the Federal share of costs incurred during periods of presumptive eligibility for Medicaid children (i.e., up to two months of coverage while a

final determination of eligibility is made) at the Medicaid matching rate. The law also allows payment out of CHIP allotments for Medicaid benefits received by Medicaid children during periods of presumptive eligibility. A number of entities may make presumptive eligibility determinations for children (e.g., medical providers, entities that determine eligibility for Head Start, and for a special supplemental nutrition program for women, infants and children or WIC). Under Medicaid, newborns are deemed eligible for coverage through age 1 as long as they remain in the mother's household and the mother remains eligible for Medicaid during this period.

Chairman's Mark

The Chairman's Mark would eliminate the counting of Medicaid child presumptive eligibility costs against state CHIP allotments. This provision would also amend Medicaid statute with respect to (1) providing continuous eligibility of newborns through age 1, regardless of the living arrangements and mothers' eligibility, and (2) allowing entities that make presumptive eligibility determinations for children under Medicaid to make such determinations for pregnant women under Medicaid.

Sec. 114. Limitation on matching rate for states that propose to cover children with effective family income that exceeds 300 percent of the poverty level.

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 percent and maximum of 83 percent. 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 percent and are subject to Federal spending caps.

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

Chairman's Mark

For child health assistance or health benefits coverage to a targeted low-income child whose effective family income would exceed 300 percent 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 2009, have 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 percent of the poverty line.

Sec. 115. State authority under Medicaid.

Current Law

States may provide CHIP 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 CHIP allotments.

Chairman's Mark

With respect to expenditures for Medicaid, the Chairman's Mark would allow states to elect (1) to cover optional low-income children and may apply less restrictive income methodologies to such individuals, 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.

TITLE II—OUTREACH AND ENROLLMENT

Subtitle A—Outreach and Enrollment Activities

Sec. 201. Grants and enhanced administrative funding for outreach and enrollment.

Current Law

Under current law, title XXI specifies that Federal CHIP funds can be used for CHIP health insurance coverage that meets certain requirements. Apart from these benefit payments, CHIP 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 CHIP 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 ten percent of the total amount of expenditures for CHIP benefits and other specific health care activities combined. The Federal and state governments share in the costs of both Medicaid and CHIP, based on formulas defining the Federal contribution in Federal law. The Federal match for administrative expenditures does not vary by state and is generally 50 percent, but certain administrative functions have a higher Federal matching rate.

Chairman's Mark

The Chairman's Mark would authorize \$100 million in outreach and enrollment grants above and beyond the regular CHIP allotments for fiscal years 2009 through 2013. Ten percent of the funding would be directed to a national enrollment campaign, and ten percent would be targeted to outreach and enrollment of Native American children. The remaining 80 percent would be distributed to eligible entities (e.g., state and local governments and community-based organizations) for purposes of conducting outreach campaigns with a particular focus on rural areas and underserved populations. Grant funds would also be targeted at proposals that address cultural and linguistic barriers to enrollment. The Chairman's Mark would provide the greater of 75 percent, or the sum of the enhanced FMAP for the state plus five percentage points under CHIP, and a 75 percent FMAP rate under Medicaid for translation and interpretation services for individuals for whom English is not their primary language. Finally, the Chairman's Mark would allow for the use of Community Health Workers for outreach activities.

Sec. 202. Increased outreach and enrollment of Indians.

Current Law

State CHIP plans must include a description of procedures used to ensure the provision of child health assistance to American Indian and Alaskan Native children. Certain non-benefit payments under CHIP (e.g., for other child health assistance, health service initiatives, outreach and program administration) cannot exceed 10 percent of the total amount of expenditures for benefits and these non-benefit payments combined.

Chairman's Mark

The Chairman's Mark would encourage states to take steps to enroll Indians residing in or near reservations in Medicaid and CHIP. These steps may include outstationing eligibility workers entering into agreements with Indian entities (i.e., the IHS, tribes, tribal organizations) to provide outreach; education regarding eligibility, benefits, and enrollment; and translation services. The Secretary would be required to facilitate cooperation between states and Indian entities in providing benefits to Indians under Medicaid and CHIP. The Chairman's Mark would also exclude costs for outreach

to potentially eligible Indian children and families from the 10 percent cap on non-benefit expenditures under CHIP.

Sec. 203. State option to rely on finding for an Express Lane Agency to conduct simplified eligibility determinations.

Current Law

Medicaid law and regulations contain requirements regarding determinations of eligibility and applications for assistance. In limited circumstances, outside agencies are permitted to determine eligibility for Medicaid. For example, when a joint TANF-Medicaid application is used, the state TANF agency may make the Medicaid eligibility determination. Medicaid applicants must attest to the accuracy of the information submitted on their applications and sign application forms under penalty of perjury.

Subsequent to initial application, states must request information from other Federal and state agencies, to verify applicants' income, resources, citizenship status, and validity of Social Security number (e.g., income from the Social Security Administration (SSA), unearned income from the Internal Revenue Service (IRS), unemployment information from the appropriate state agency, qualified aliens must present documentation of their immigration status, which states must then verify with the Immigration and Naturalization Service, and the state must verify the SSN with the Social Security Administration). States must also establish a Medicaid eligibility quality control (MEQC) program designed to reduce erroneous expenditures by monitoring eligibility determinations.

CHIP defines a targeted low-income child as one who is under the age of 19 years with no health insurance, and who would not have been eligible for Medicaid under the rules in effect in the state on March 31, 1997. Federal law requires that eligibility for Medicaid and CHIP be coordinated when states implement separate CHIP programs. In these circumstances, applications for CHIP coverage must first be screened for Medicaid eligibility.

Chairman's Mark

Under the Express Lane Eligibility provision of the Chairman's Mark, states would be permitted to rely on income and other information previously collected from public agencies that determine eligibility for other public programs (e.g., Temporary Assistance for Needy Families (TANF), CHIP, Medicaid, or the school lunch program) to facilitate child enrollment in CHIP and Medicaid. The Chairman's Mark would require states to verify citizenship or nationality status. This applies to eligibility determinations made on or before September 30, 2013.

States would be permitted to meet the CHIP screen and enroll requirements by using either or both of the following requirements: (1) establishing a threshold percentage of the Federal poverty level that exceeds the highest income eligibility threshold applicable under Medicaid for the child by a minimum of 30 percentage points (or such other higher number of percentage points) as the state determines reflects the income methodologies of the program administered by the Express Lane Agency, or (2) with respect to any individual within such population for whom an Express Lane Agency finds has income that does not exceed such threshold percentage, such individual would be eligible for Medicaid. If a finding from an Express Lane Agency results in a child not being found eligible for Medicaid or CHIP, the state would be required to determine Medicaid or CHIP eligibility using its regular procedures and to inform the family that it may qualify for lower premium payments if the family's income was directly evaluated for an eligibility determination by the state using its regular policies. The Chairman's Mark would drop the requirement for signatures under penalty of perjury. The provision would permit signature requirements for a Medicaid application to be satisfied through an electronic signature. Error rates associated with incorrect eligibility determinations would be monitored.

The Chairman's Mark would authorize and appropriate \$5 million in new Federal funds for fiscal years 2009 through FY2012 for the purpose of conducting an evaluation of the effectiveness of this state plan option, and the Secretary would be required to submit a report to Congress with regard to the evaluation findings no later than September 30, 2012.

Finally, the Chairman's Mark would increase states' access to other data sources that would facilitate enrollment and minimize administrative burdens on families while still protecting beneficiary privacy. Specifically, the provision would authorize Federal or state agencies or private entities with data sources that are directly relevant for the determination of eligibility under Medicaid to share such information with the Medicaid agency if: (1) there is no family objection to such disclosure, (2) the data would be used solely for the purpose of determining Medicaid eligibility, and (3) there is an interagency agreement in place to prevent the unauthorized use or disclosure of such information. Individuals involved in such unauthorized use would be subject to criminal penalty. In addition, for the purposes of the Express Lane Demonstration states only, the provision would allow the Medicaid and CHIP programs to receive such data from the National New Hires Database, or data about enrollment in insurance that may help to facilitate outreach and enrollment under Medicaid, CHIP, and certain other programs.

Subtitle B—Reducing Barriers to Enrollment

Sec. 211. Verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP.

Current Law

Under current law, 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, 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. It does not apply to CHIP. However, since some states use the same enrollment procedures for all Medicaid and CHIP applicants, it is possible that some CHIP enrollees would be asked to present evidence of citizenship.

Chairman’s Mark

The Chairman’s Mark would provide a new option for meeting citizenship documentation requirements. 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) of the Social Security Act or new rules under section 1902(dd). Under 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, the state would have to make a reasonable effort to identify and address the causes of such invalid match (including through typographical or other clerical errors) by contacting the individual to confirm the accuracy of the name or SSN submitted and taking such additional actions as the Secretary or the state may identify, and continue to provide the individual with medical assistance while making such effort. If the name or SSN remains invalid after such effort, the state would be required to notify the individual, provide him or her with a period of 90 days to either present evidence of citizenship as defined in section 1903(x) or cure the invalid determination with the Commissioner of Social Security (and continue to provide the individual with medical assistance during such 90- day period), and disenroll the individual within 30 days after the end of the 90-day period if evidence is not provided or the invalid determination is not cured.

States electing the name and SSN validation option would be required to establish a program under which the state submits each month to the Commissioner of Social Security for verification the name and SSN of each individual enrolled in the State plan

under this title that month who are not exempt from the citizenship documentation requirement.

In establishing the program, the state would be allowed to enter into an agreement with the Commissioner: (1) to provide for the electronic submission and verification, through an on-line system or otherwise, of the name and SSN of an individual enrolled in the state plan under this title at least on a monthly basis; or (2) to provide for the verification of the names and SSNs of such individuals through such other method as agreed to by the state and the Commissioner and approved by the Secretary, provided that such method is no more burdensome for individuals to comply with than any burdens that may apply under a method described in (1). The program would be required to provide that, in the case of any individual who is required to submit a SSN to the state and who is unable to provide the state with such number, shall be provided with at least the same reasonable opportunity to present evidence that is provided under section 1137(d)(4)(A) of the Social Security Act to noncitizens who are required to present evidence of satisfactory immigration status.

The Chairman's Mark would require states to provide information to the Secretary on the percentage of invalid names and SSNs submitted each month, and could be subject to a penalty if the average monthly percentage for any fiscal year is greater than 3 percent. A name or SSN would be treated as invalid and included in the determination of such percentage only if: (1) the name or SSN does not match Social Security Administration records; (2) the inconsistency between the name or SSN could not be resolved by the state; (3) the individual was provided with a reasonable period of time to resolve the inconsistency with the Social Security Administration or provide satisfactory documentation of citizenship and did not successfully resolve such inconsistency; and (4) payment has been made for an item or service furnished to the individual under this title. If a state entered into an agreement with the Commissioner of Social Security as described above, the invalid name and SSN percentages and penalties described here would not apply.

States would be required to receive 90 percent 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 percent for the operation of such systems.

The Chairman's Mark would also clarify requirements under the existing section 1903(x). The provision would require the inclusion of an additional permanent exemption for children who are deemed eligible for Medicaid coverage by virtue of being born to a woman on Medicaid, additional documentation options for Federally recognized Indian tribes, and the reasonable opportunity to present evidence. 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. The Chairman's Mark would remove the requirement that a newborn remain in his or her Medicaid-eligible mother's household in order to qualify for deemed eligibility under 1902(e)(4).

The Chairman's Mark would make citizenship documentation a requirement for CHIP. 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 percent and 75 percent reimbursement for name and SSN validation would be available under CHIP, and would not count towards a state's CHIP administrative expenditures cap.

Except for clarifications made to the existing citizenship documentation requirement, which would be retroactive, the provision would be effective on January 1, 2010. States would be allowed to provide retroactive eligibility for certain individuals who had been determined ineligible under previous citizenship documentation rules.

Sec. 212. Reducing administrative barriers to enrollment.

Current Law

During the implementation of CHIP, states instituted a variety of enrollment facilitation and outreach strategies to bring eligible children into Medicaid and CHIP. 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.

Chairman's Mark

The Chairman's Mark 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 be in compliance with these requirements if they implement joint Medicaid and CHIP application and renewal processes, and drop requirements for face-to-face interviews.

Sec. 213. Model of interstate coordinated enrollment and coverage process.

Current Law

No provision.

Chairman's Mark

The Chairman’s Mark would require the Secretary of HHS, in consultation with state Medicaid, CHIP directors, and organizations representing program beneficiaries to develop a model process (and report for Congress) for the coordination of enrollment, retention, and coverage of children who frequently change their residency due to migration of families, emergency evacuations, educational needs, etc.

TITLE III—REDUCING BARRIERS TO PROVIDING PREMIUM ASSISTANCE

Subtitle A—Additional State Option for Providing Premium Assistance

Sec. 301. Additional state option for providing premium assistance.

Current Law

Under Medicaid, states may pay a Medicaid beneficiary’s share of costs for group (employer-based) health coverage for any Medicaid enrollee for whom coverage is available, 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. States were also to provide coverage for those Medicaid covered services that are not included in the private plans.

Under CHIP, the Secretary has the authority to approve funding for the purchase of “family coverage” under an employer-sponsored health insurance plan 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 otherwise being provided to the children. In addition, states using CHIP funds for employer-based plan premiums must ensure that CHIP minimum benefits are provided and CHIP cost-sharing ceilings are met. Because of these requirements, implementation of premium assistance programs under Medicaid and CHIP are not widespread.

Under the Bush Administration’s Health Insurance Flexibility and Accountability (HIFA) Initiative, states were encouraged to seek approval for Section 1115 waiver programs to direct unspent CHIP funds to extend coverage to uninsured populations with annual income less than 200 percent FPL and to use Medicaid and CHIP funds to pay premium costs for waiver enrollees who have access to Employer Sponsored Insurance (ESI). ESI programs approved under the Section 1115 waiver authority are not subject to

the same current law constraints required under Medicaid's Health Insurance Premium Payment (HIPP) program or CHIP's family coverage variance option (i.e., the comprehensiveness and cost effectiveness tests).

Chairman's Mark

The Chairman's Mark would allow states to offer a premium assistance subsidy for qualified employer sponsored coverage (ESI) to all Medicaid and/or CHIP-eligible children, and parents of Medicaid and/or CHIP-eligible children where the family has access to ESI coverage and the family chooses to participate in such coverage. Coordination with Medicaid is required for targeted low-income Medicaid children who voluntarily elect premium assistance subsidies under CHIP. 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 nondiscriminatory 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 three years of service. The provision would explicitly exclude (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 as qualified coverage.

The Chairman's Mark would establish a new cost effectiveness test for employer sponsored insurance (ESI) programs that are approved after the date of enactment of this Act. The state would be required to establish that (1) the cost of such coverage is less than state expenditures to enroll the child or the family (as applicable) in CHIP and administrative costs would be taken into account when determining the cost-effectiveness of extending ESI coverage to the child or family, as applicable (individual test), or (2) 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 or families, as applicable (aggregate test).

States would be required to provide supplemental coverage for individuals 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. Plans that meet the CHIP benefit coverage requirements (i.e., as determined to be actuarially equivalent to CHIP benchmark or benchmark equivalent coverage) would not be required to provide supplemental coverage for benefits and cost-sharing protections as required under 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. 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 would be permitted to establish an employer-family premium assistance purchasing pool for employers with less than 250 employees who have at least one employee who is a CHIP-eligible pregnant woman or at least one member of the family is a CHIP-eligible child. Eligible families would have access to not less than two private health plans where the health benefits coverage is equivalent to the benefits coverage available through a CHIP benchmark benefit package or CHIP benchmark equivalent coverage benefits package. In addition, the Chairman's Mark specifies that administrative costs associated with the start up or operation of such purchasing pools would only be permitted in so far as they meet the definition of allowable administrative expenditures under CHIP.

Finally The Chairman's Mark would require the Government Accountability Office to submit a report to Congress not later than January 1, 2010 regarding cost and coverage issues under state premium assistance programs.

Sec. 302. Outreach, education, and enrollment assistance.

Current Law

CHIP state plans are required to include a description of the procedures in place to provide outreach to children eligible for CHIP child health assistance, or other public or private health programs to (1) inform these families of the availability of public and private health coverage and (2) to assist them in enrolling such children in CHIP. There is a limit on Federal spending for CHIP administrative expenses (i.e., 10 percent of a state's spending on benefit coverage in a given fiscal year). Administrative expenses include activities such as data collection and reporting, as well as outreach and education. In addition, states are required to provide a description of the state's efforts to ensure coordination between CHIP and other health insurance coverage applies to State administrative expenses.

Chairman's Mark

The Chairman's Mark 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 §1115. For employers likely to provide qualified employer-sponsored coverage, the state is required to include the specific resources the state intends to use to educate employers about the availability of premium assistance subsidies under the CHIP state plan. Expenditures for such outreach activities would be limited to 1.25 percent of the state's limit on spending for administrative costs associated with their CHIP program (i.e. 10 percent of the state's spending on benefit coverage in a given fiscal year).

Subtitle B—Coordinating Premium Assistance With Private Coverage

Sec. 311. Special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage of eligibility for assistance in purchase of employment-based coverage; coordination of coverage.

Current Law

Under the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act, a group health plan is required to provide special enrollment opportunities to qualified individuals. 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 order to enroll in a group health plan without having to wait until a late enrollment opportunity or open season. The individual still must meet the 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.

Chairman's Mark

The Chairman's Mark would amend applicable Federal laws to streamline coordination between public and private coverage, including making the loss of Medicaid/CHIP eligibility a "qualifying event" for the purpose of purchasing employer-sponsored coverage. Individuals may request for such coverage up to 60 days after the qualifying event. The Chairman's Mark would require health plan administrators to disclose to the state, upon request, information about their benefit packages so states can evaluate the need to provide wraparound coverage. The Chairman's Mark would also require employers to notify families of their potential eligibility for premium assistance.

TITLE IV—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES

Sec. 401. 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 activities. The Federal share of states' Medicaid costs varies by type of expenditure. For benefits, the Federal Medical Assistance Percentage (FMAP) is based on a formula that provides higher reimbursement to states with lower per capita incomes (and vice versa); it has a statutory minimum of 50 percent and a maximum of 83 percent. All states receive a 90 percent match for family planning services. The Federal matching rates for administrative expenses does not vary by state and is generally 50 percent, but certain administrative functions have a higher Federal match. For example, a 75 percent match rate applies to the operation of an approved Medicaid management information system (MMIS) for claims and information processing. Start-up expenses for MMISs are matched at 90 percent.

Chairman's Mark

The Chairman's Mark would direct the Secretary of HHS to develop (1) child health quality measures for children enrolled in Medicaid and CHIP, and (2) a standardized format for reporting information, and procedures that encourage states to voluntarily report on the quality of pediatric care in these programs. The Secretary would be required to disseminate information to states regarding best practices in measuring and reporting such data. A total of \$45 million would be appropriated for these provisions, of which specific amounts would be earmarked for certain activities (identified below). (The childhood obesity demonstration also described below would have its own separate appropriation.) The Secretary would be required to award grants and contracts to develop, test and update (as needed) evidence-based measures, and to disseminate such measures. Each state would be required to report annually to the Secretary on a variety of measures. In addition, the Secretary would be required to award up to ten grants to states and child health providers to conduct demonstrations to evaluate promising ideas for improving the quality of children's health care under Medicaid and CHIP, for which \$20 million would be appropriated. The Secretary would also be required to conduct a demonstration to develop a comprehensive and systematic model for reducing childhood obesity through grants to eligible entities (e.g., local government agencies, Indian tribes, community based organizations). This demonstration would be authorized at \$25 million over five years. The Secretary would be required to submit a report to Congress on this demonstration. The Secretary would also be required to establish a program to encourage the creation and dissemination of model electronic health record format for children enrolled in Medicaid and CHIP. A total of \$5 million would be appropriated for this purpose. The Institute of Medicine would be required to study and report to Congress on the extent and quality of efforts to measure child health status and quality of care for children. Up to \$1 million would be appropriated for this activity. Finally, 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 would be based on the FMAP rate for benefits used under Medicaid (rather than one of the various matching rates applied to different types of administrative expenses).

Sec. 402. Improved availability of public information regarding enrollment of children in CHIP and Medicaid.

Current Law

Annually, states submit reports to the Secretary of HHS assessing the operation of their CHIP programs, including for example, progress made in reducing the number of uninsured low-income children, progress made in meeting other strategic objectives and performance goals, effectiveness in preventing crowd-out, identifying expenditures by type of beneficiary, and current income standards and methodologies.

Chairman's Mark

The Chairman's Mark would add several reporting requirements to states' annual CHIP reports, including for example, data on eligibility criteria, use of self-declaration of income for applications and renewals, denials of eligibility, access to primary and specialty care, and data regarding premium assistance for employer-sponsored coverage (if applicable), such as the range of monthly premiums, monthly caseload of participating families, income levels of participants, and cost-sharing protections. The GAO would be required to conduct a study on access to primary and specialty care under Medicaid and CHIP, and report to Congress its findings and recommendations for addressing existing barriers to children's access to care under these programs. The Secretary must also specify a standardized format for states to use to report the new data required by this legislation. States would be given up to three reporting periods to transition to the new reporting requirements. With respect to the Medicaid Statistical Information System (MSIS) maintained by CMS, the Chairman's Mark would require the Secretary to improve the timeliness of the enrollment and eligibility data reported and analyzed for children under Medicaid and CHIP. CMS would be required to provide guidance to states regarding any related, new MSIS reporting requirements. For this purpose, the provision would appropriate \$5 million in FY2009, to remain available until expended. Beginning no later than October 1, 2009, annual (fiscal year) MSIS data on enrollment of low-income children in Medicaid and CHIP must be collected and analyzed by the Secretary within six months of submission.

Sec. 403. 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 (CHIP) in the same manner as they apply to a state under Title XIX (Medicaid). These include section 1902(a)(4)(C) [conflict of interest standards]; paragraphs (2), (16), and (17) of section 1903(i) [limitations on payment]; section 1903(w) [limitations on provider taxes and donations]; and section 1920A [presumptive eligibility for children].

Chairman's Mark

The Chairman's Mark would add specific subsections of section 1932, which relates to requirements for managed care, to the list of Title XIX provisions that apply to Title XXI. These subsections of section 1932 would include (a)(4) [process for enrollment and termination and change of enrollment]; (a)(5) [provision of information to beneficiaries]; (b) [beneficiary protections]; (c) [quality assurance standards]; (d) [protections against fraud and abuse]; and (e) [sanctions for noncompliance]. This provision would apply to contract years for health plans beginning on or after July 1, 2009.

TITLE V—IMPROVING ACCESS TO BENEFITS

Sec. 501. Dental Benefits.

Current Law

Under CHIP, states may provide coverage under their Medicaid programs (MXP), create a new separate CHIP program (SSP), or both. Under SSPs, states may elect any of three benefit options: (1) a benchmark plan, (2) a benchmark-equivalent plan, or (3) any other plan that the Secretary of HHS deems would provide appropriate coverage for the target population (Secretary-approved coverage). Benchmark plans include (1) the standard Blue Cross/Blue Shield preferred provider option under FEHBP, (2) the coverage generally available to state employees, and (3) the coverage offered by the largest commercial HMO in the state. Benchmark-equivalent plans must cover basic benefits (i.e., inpatient and outpatient hospital services, physician services, lab/x-ray, and well-child care including immunizations), and must include at least 75 percent of the actuarial value of coverage under the selected benchmark plan for specific additional benefits (i.e., prescription drugs, mental health services, vision care and hearing services). Among other items, a state CHIP plan must include a description of the methods (including monitoring) used to (1) assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan, and (2) assure access to covered services, including emergency services. Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit under Medicaid, most children under age 21 must have access to 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. The EPSDT provision in Medicaid law also includes annual reporting requirements for states. The tool used to capture these EPSDT data is called the CMS 416 form. Three separate measures capture the unduplicated number of EPSDT eligibles receiving any dental services, preventive dental services and dental treatment services.

Chairman's Mark

Under the Chairman's Mark, dental services would be a required benefit under CHIP and would include services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions. States would have the option to provide dental services equivalent to "benchmark dental benefits packages." These would include: (1) a dental benefits plan under FEHBP that has been selected most frequently by employees seeking dependent coverage, among such plans that offer such coverage, in either of the previous two plan years, (2) a dental benefits plan offered and generally available to state employees that has been selected most frequently by employees seeking dependent coverage, among such plans that offer such coverage, in either of the previous 2 plan years, or (3) a dental benefits plan that has the largest commercial, non-Medicaid enrollment of dependent covered lives among such plans offered in the state. States would be required to assure access to dental services under CHIP. The effective date would be October 1, 2009. The provision also includes provisions for: (1) dental education for parents of newborns, (2) dental services through FQHCs, and (3) reporting information on dental services for children. Information on dental providers and descriptions of covered dental services under Medicaid and CHIP would be made available to the public via the Insure Kids Now website and hotline. The provision would expand measurement of the availability of dental care to include dental treatment and services to maintain dental health under the child health quality improvement activities (Section 401 of the Chairman's Mark). The provision would require the GAO to conduct a study (due within two years after the date of enactment of this Act) on children's access to oral health care, including preventive and restorative services under Medicaid and CHIP. The report on this study must include recommendations for such Federal and state legislative and administrative changes necessary to address barriers to access to dental care under Medicaid and CHIP, and an assessment of the feasibility and appropriateness of using qualified mid-level dental providers to improve access.

Sec. 502. Mental health parity in CHIP plans.

Current Law

Medicaid and CHIP state plans may define what constitutes mental health benefits (if any). Current law prohibits group health plans from imposing annual and lifetime dollar limits on mental health and substance abuse benefits that are more restrictive than those applicable to medical and surgical coverage. Similarly, group health plans may not impose more restrictive treatment limits (e.g., with respect to total outpatient hospital visits or inpatient days) or cost-sharing requirements on mental health or substance abuse coverage compared to medical and surgical services. Under EPSDT, most individuals under age 21 receive comprehensive basic screening services (i.e., well child visits, immunizations) as well as dental, vision and hearing services. In addition, EPSDT guarantees access to all Federally coverage services necessary to treat a problem or condition among eligible individuals.

Chairman's Mark

The Chairman's Mark would ensure that the financial requirements (e.g., such as annual and lifetime dollar limits) and treatment limitations applicable to mental health or substance abuse benefits (when such benefits are covered) are no more restrictive than the financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered under the state CHIP plan. State CHIP plans that include coverage of EPSDT services (as defined in Medicaid statute) would be deemed to satisfy this mental health parity requirement.

Sec. 503. Application of Prospective Payment System for services provided by Federally-Qualified Health Centers and Rural Health Clinics.

Current Law

Under current Medicaid law, payments to Federally-Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are based on a prospective payment system. Beginning in FY2001, per visit payments were based on 100 percent of average costs during 1999 and 2000 adjusted for changes in the scope of services furnished. (Special rules applied to entities first established after 2000.) For subsequent years, the per visit payment for all FQHCs and RHCs equals the amounts for the preceding fiscal year increased by the percentage increase in the Medicare Economic Index applicable to primary care services, and adjusted for any changes in the scope of services furnished during that fiscal year. In managed care contracts, states are required to make supplemental payments to the facility equal to the difference between the contracted amount and the cost-based amounts.

Chairman's Mark

The Chairman's Mark would require states that operate separate and/or combination CHIP programs to reimburse FQHCs and RHCs based on the Medicaid prospective payment system. This provision would apply to services provided on or after October 1, 2009. For FY2009, \$5 million would be appropriated (to remain available until expended) to states with separate CHIP programs for expenditures related to transitioning to a prospective payment system for FQHCs/RHCs under CHIP. Finally, the Secretary would be required to report to Congress on the effects (if any) of the new prospective payment system on access to benefits, provider payment rates or scope of benefits.

Sec. 504. Premium grace period.

Current Law

No statutory provision specifies a grace period for payment of CHIP premiums. Federal regulations require states' CHIP plans to describe the consequences for an enrollee or applicant who does not pay required premiums and the disenrollment protections adopted by the state. These protections must include the following: (1) the state must give enrollees reasonable notice of, and an opportunity to pay, past due premiums prior to disenrollment, (2) the disenrollment process must give the individual the opportunity to show a decline in family income that may qualify the individual for lower or no cost-sharing, and (3) the state must provide the enrollee with an opportunity for an impartial review to address disenrollment from the program, during which time the individual will continue to be enrolled.

Chairman's Mark

The Chairman's Mark would require states to provide CHIP enrollees with a grace period of at least 30 days from the beginning of a new coverage period to make premium payments before the individual's coverage may be terminated. Within seven days after the first day of the grace period, the state would have to provide the individual with notice that failure to make a premium payment within the grace period will result in termination of coverage and that the individual has the right to challenge the proposed termination pursuant to the applicable Federal regulations. This provision would be effective for new coverage periods beginning on or after the date of enactment of this Act.

Sec. 505. Clarification of coverage of services provided through School-Based Health Centers.

Current Law

A number of coverable benefits are listed in the CHIP statute, such as "clinic services (including health center services) and other ambulatory health care services."

Chairman's Mark

The Chairman's Mark would provide that nothing in Title XXI shall be construed as limiting a state's ability to provide CHIP for covered items and services furnished through school-based health centers.

TITLE VI—PROGRAM INTEGRITY AND OTHER MISCELLANEOUS PROVISIONS

Subtitle A—Program Integrity and Data Collection

Sec. 601. Payment Error Rate Measurement (“PERM”).

Current Law

Federal agencies are required to annually review programs 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 payments. On August 21, 2007, CMS issued a final rule for PERM for Medicaid and CHIP (effective October 1, 2007) which responded to comments received on an interim final rule, and included some changes to that interim final rule. Assessments of payment error rates related to claims for both fee-for-service and managed care services, as well as eligibility determinations are made. A predecessor to PERM, called the Medicaid Eligibility Quality Control (MEQC) system, is operated by state Medicaid agencies for similar purposes.

Chairman’s Mark

The Chairman’s Mark would apply a Federal matching rate of 90 percent to expenditures related to administration of PERM requirements applicable to CHIP. The provision also would exclude from the 10 percent cap on CHIP administrative costs all expenditures related to the administration of PERM requirements applicable to CHIP.

The provision would prohibit the Secretary from calculating or publishing national or state-specific error rates based on PERM for CHIP until six months after the date on which a final PERM rule, issued after the date of enactment of this Act, is in effect for all states. Calculations of national- or state-specific error rates after such a final rule is in effect for all states could only be inclusive of errors, as defined in this rule or in guidance issued after the effective date that includes detailed instructions for the specific methodology for error determinations. The final PERM rule would be required to include (1) clearly defined criteria for errors for both states and providers, (2) a clearly defined process for appealing error determinations by review contractors, and (3) clearly defined responsibilities and deadlines for states in implementing any corrective action plans. The payment error rate for a state must not take into account payment errors resulting from the state’s verification of an applicant’s self-declaration or self-certification of eligibility for, and the correct amount of, Medicaid or CHIP assistance, if the state process for verifying such information satisfies the requirements for such a process applicable under regulations issued by or otherwise approved by the Secretary. Special provisions would apply to states for which the PERM requirements were first in effect under the interim final rule for FY2007 or the final rule for FY2008, and their application would depend on when the final PERM rule is in effect for all states.

The Chairman’s Mark would also require the Secretary to review the MEQC requirements with the PERM requirements and coordinate consistent implementation of

both sets of requirements, while reducing redundancies. For purposes of determining the erroneous excess payments ratio applicable to the state under MEQC, a state may elect to substitute data resulting from the application of PERM after the final PERM rule is in effect for all states, for the data used for the MEQC requirements. The provision would also give states the option to substitute MEQC data for Medicaid eligibility reviews for data required for PERM purposes, but only if the state MEQC reviews are based on a broad, representative sample of Medicaid applicants or enrollees.

The Secretary would also be required to establish state-specific sample sizes for application of PERM requirements to CHIP for the first fiscal year that begins after the date on which the new final rule is in effect for all states. In establishing such sample sizes, the Secretary must minimize the administrative cost burden on states under Medicaid and CHIP, and must maintain state flexibility to manage these programs.

Sec. 602. Improving data collection.

Current Law

The Secretary of Commerce was required to make appropriate adjustments to the Current Population Survey (CPS) which is the primary data source for determining states' CHIP allotments (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 be reasonably detected, (2) to produce data that categorizes such children by family income, age, and race or ethnicity, and (3) where appropriate, to expand the same 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.

Chairman's Mark

The Chairman's Mark would provide \$20 million for FY2009 and each subsequent year thereafter to produce these data for CHIP purposes. In addition to the current-law requirements of the appropriation, for data collection beginning with FY2009, in consultation with the Secretary of HHS, the Secretary of Commerce would be required to (1) make adjustments to the CPS to develop more accurate state-specific estimates of the number of children enrolled in CHIP or Medicaid, (2) make adjustments to the CPS to improve the survey estimates used to determine the child population growth factor in the new financing structure under this bill, and any other necessary data, (3) to include health insurance survey information for the American Community Survey (ACS) related to children, and (4) to assess whether estimates from the ACS produce more reliable estimates than the CPS for the child population growth factor in the new CHIP financing structure established under this bill. On the basis of that assessment, the Commerce Secretary would recommend to the HHS Secretary whether ACS estimates should be used in lieu of, or in some combination with, CPS estimates for these purposes. The Secretary of Commerce must also continue making adjustments, as needed, to the

sample size used in state sampling units, the number of such units per 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 these purposes, the HHS Secretary may establish a transition period for using ACS estimates, provided that the transition is implemented in a way that avoids adverse impacts on states.

Sec. 603. Updated Federal evaluation of CHIP.

Current Law

The Secretary of HHS was required to conduct an independent evaluation of ten states with approved CHIP plans, and to submit a report on that study to Congress by December 31, 2001. Ten million dollars was appropriated for this purpose in FY2000 and was available for expenditure through FY2002. The ten states chosen for the evaluation were to be ones that utilized diverse approaches to providing CHIP coverage, represented various geographic areas (including a mix of rural and urban areas), and contained a significant portion of uninsured children. A number of matters were included in this evaluation, including: (1) surveys of the target populations, (2) an evaluation of effective and ineffective outreach and enrollment strategies, and identification of enrollment barriers, (3) the extent to which coordination between Medicaid and CHIP affected enrollment, (4) an assessment of the effects of cost-sharing on utilization, enrollment and retention, and (5) an evaluation of disenrollment or other retention issues.

Chairman's Mark

The Chairman's Mark would require the Secretary of HHS to conduct a new, independent Federal evaluation of ten states with approved CHIP plans, directly or through contracts or interagency agreements, as before. The new evaluation would be submitted to Congress by December 31, 2011. Ten million dollars would be appropriated for this purpose in FY2010 and made available for expenditure through FY2012. The current-law language for the types of states to be chosen and the matters included in the evaluation would also apply to this new evaluation.

Sec. 604. Access to records for IG and GAO audits and evaluations.

Current Law

Every third fiscal year (beginning with FY2000), the Secretary (through the Inspector General of the Department of Health and Human Services) must audit a sample from among the states with an approved CHIP state plan that does not, as a part of that plan, provide health benefits coverage under Medicaid. The Comptroller General of the United States must monitor these audits and, no later than March 1 of each fiscal year

after a fiscal year in which an audit is conducted, submit a report to Congress on the results of the audit conducted during the prior fiscal year.

Chairman's Mark

Under the Chairman's Mark, for the purpose of evaluating and auditing the CHIP program, the Secretary, the Office of Inspector General, and the Comptroller General would have access to any books, accounts, records, correspondence, and other documents that are related to the expenditure of Federal CHIP funds and that are in the possession, custody, or control of states, political subdivisions of states, or their grantees or contractors. This provision would also apply for the purpose of evaluating and auditing the Medicaid program.

Sec. 605. No Federal funding for illegal aliens; disallowance for unauthorized expenditures.

Current Law

Under the Medicaid program, unauthorized aliens who meet all other program criteria are only eligible for emergency coverage. Under CHIP, states may opt to cover unauthorized aliens who are pregnant, but covered services must be related to the pregnancy or to conditions that could complicate the pregnancy or threaten the health of the unborn child (who will be a U.S. citizen if he or she is born in the United States).

Chairman's Mark

The Chairman's Mark would specify that nothing in the Chairman's Mark allows Federal payment for individuals who are not legal residents.

Subtitle B—Miscellaneous Health Provisions

Sec. 611. Deficit Reduction Act technical corrections.

Current Law

Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit under Medicaid, most individuals under age 21 must have access to 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.

The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) gave states the option to provide Medicaid to states-specified groups through enrollment in benchmark and benchmark-equivalent coverage that is nearly identical to plans available under CHIP. This law identifies a number of groups as exempt from mandatory enrollment in benchmark or benchmark-equivalent plans. These groups may be enrolled in such plans on a voluntary basis. 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. For any child under age 19 in one of the major mandatory and optional eligibility groups in Medicaid, wrap-around benefits to the DRA benchmark and benchmark-equivalent coverage includes EPSDT.

Chairman's Mark

The Chairman's Mark identifies specific sections of current Medicaid law (instead of all of Title XIX as specified in DRA) that would be disregarded in order to provide benchmark benefit coverage. It also specifies that an individual's entitlement to EPSDT services remains in tact under the benchmark benefit package option under DRA. The provision would also make a correction to the reference to children in foster care receiving child welfare services in P.L. 109-171. Lastly, the provision would require the Secretary of HHS to publish on the CMS internet website the list of provisions in Title XIX that do not apply in order to enable a state to provide benchmark coverage under Medicaid on the date that such approval is given (rather than within 30 days of such approval). It would also require the Secretary to publish these same findings in the Federal Register within 30 days of the date of approval. The effective date of these provisions would be the same as the original DRA provision (i.e., March 31, 2006).

Sec. 612. References to Title XXI.

Current Law

A provision in 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, 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."

Chairman's Mark

The Chairman's Mark would repeal this section of P.L. 106-113. Thus, for official publication and communication purposes, the provision would reinstate "CHIP" and "Children's Health Insurance Program," as applicable, when referencing Title XXI.

Sec. 613. Prohibiting initiation of new Health Opportunity Account demonstration programs.

Current Law

The Deficit Reduction Act of 2005 allowed the Secretary of HHS to establish no more than ten demonstration programs within Medicaid for Health Opportunity Accounts (HOAs). HOAs are used to pay (via electronic funds transfers) health care expenses specified by the state.

Chairman's Mark

The Chairman's Mark would prohibit the Secretary of HHS from approving any new Health Opportunity Account demonstrations as of the date of enactment of this Act.

Sec. 614. Adjustment in computation of Medicaid FMAP to disregard an extraordinary employer pension contribution.

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). When state FMAPs are calculated by HHS for the upcoming fiscal year, the state and U.S. per capita income amounts used in the formula are equal to the average of the three most recent calendar years of data on per capita personal income available from the Department of Commerce's Bureau of Economic Analysis (BEA). BEA revises its most recent estimates of state per capita personal income on an annual basis to incorporate revised and newly available source data on population and income. It also undertakes a comprehensive data revision every few years that may result in upward and downward revisions to each of the component parts of personal income, one of which is employer contributions for employee pension and insurance funds. In describing its 2003 comprehensive revision, BEA reported that upward revisions to employer contributions for pensions beginning with 1989 were the result of methodological improvements and more complete source data.

Chairman's Mark

The Chairman's Mark would make an adjustment in the computation of Medicaid FMAP to disregard an extraordinary employer pension contribution. For the purposes of computing Medicaid FMAPs beginning with FY2006, any significantly disproportionate employer pension or insurance fund contribution would be disregarded in computing state per capita income, but not U.S. per capita income. A significantly disproportionate employer pension and insurance fund contribution would be defined as any identifiable employer contribution towards pension or other employee insurance funds that is

estimated to accrue to residents of such state for a calendar year (beginning with calendar year 2003) if the increase in the amount so estimated exceeds 25 percent of the total increase in personal income in that state for the year involved. For estimating and adjusting an FMAP already calculated as of the date of enactment for a state with a significantly disproportionate employer pension and insurance fund contribution, the Secretary must use the personal income data set originally used in calculating such FMAP. If in any calendar year the total personal income growth in a state is negative, an employer pension and insurance fund contribution for the purposes of calculating the state's FMAP for a calendar year shall not exceed 125 percent of the amount of such contribution for the previous calendar year for the state. No state would have its FMAP for a fiscal year reduced as a result of the application of this provision. Not later than May 15, 2009, the Secretary must submit to the Congress a report on the problems presented by the current treatment of pension and insurance fund contributions in the use of Bureau of Economic Affairs calculations for the FMAP and for Medicaid and on possible alternative methodologies to mitigate such problems.

Sec. 615. Clarification treatment of Regional Medical Center

Current Law

The states and Federal government share in the cost of the Medicaid program. Sometimes hospitals fund the state share of some of its own Medicaid payments, thereby ensuring that Federal matching funds will be available even if the state cannot pay its share. Such "intergovernmental transfers" of certified public expenditures made by those types of health care providers to fund the non-Federal share of states' Medicaid expenditures are allowable but only under certain circumstances. Some of those circumstances are described in detailed Federal regulations. Other limitations are based on recent CMS administrative actions. For example, CMS has denied Federal matching payments when the state share was comprised of payments transferred from out-of-state hospitals.

Chairman's Mark

The Chairman's Mark would prohibit the Secretary from denying Federal matching payments when the state share has been transferred from certain publicly-owned regional medical centers in other states if the Secretary determines that the use of such funds is proper and in the interest of the Medicaid program. Centers would need to: 1) provide level one trauma and burn care services; 2) provide level three neonatal services; 3) is obligated to serve all patients, regardless of ability to pay; 4) is located within an SMSA that includes at least three states; 5) provides services as a tertiary care provider for patients residing within a 125 mile radius; and 6) meets Medicaid's disproportionate share hospital definition.

Sec. 616. Extension of Medicaid DSH allotments for Tennessee and Hawaii.

Current Law

When establishing hospital payment rates, state Medicaid programs are required to recognize the situation of hospitals that provide a disproportionate share of care to low-income patients with special needs. Such “disproportionate share hospital (DSH) payments” are subject to statewide allotment caps. Allotments for Tennessee and Hawaii, however, are equal to zero because the states operate their state Medicaid programs under the provisions of a Section 1115 research and demonstration waiver. Such waivers allow for states to waive various provisions of Medicaid law specified in Title XIX (such as the requirement to make DSH payments) to conduct demonstrations as long as the demonstrations are likely to assist in promoting the objectives of the Medicaid program. Congress has enacted special DSH provisions for Tennessee and Hawaii in the past. Tennessee’s allotments were set at \$30 million for each of FY2007 through FY2009, and one-quarter of that amount was made available for the first quarter of FY2010. Hawaii’s allotments were also set at \$10 million for each of FY2007 through FY2009, and \$2.5 million was made available for the first quarter of FY2010. Both states have, in addition, been allowed to submit state plan amendments describing their methodologies for distributing such payments for the Secretary’s approval.

Chairman’s Mark

The Chairman’s Mark would extend the special DSH allotment arrangements for Tennessee and Hawaii through a portion of FY2012. Allotment amounts would be equal to \$30 million for Tennessee for each full fiscal year – 2010 and 2011 – and one quarter of that amount would be available for the first quarter of FY2012. Hawaii’s \$10 allotment would be extended for each full fiscal year – 2010 and 2011 – and \$2.5 million would be available for the first quarter of FY2012.

Subtitle C—Other Provisions

Sec. 621. Outreach regarding health insurance options available to children.

Current Law

No provision.

Chairman’s Mark

The Chairman's Mark would establish a task force, consisting of the Administrator of the Small Business Administration (SBA) and the Secretaries of HHS, Labor, and the Treasury, to conduct a nationwide campaign of education and outreach for small businesses regarding the availability of coverage for children through private insurance, Medicaid, and CHIP. The campaign would include information regarding options to make insurance more affordable, including Federal and state tax deductions and credits and the Federal tax exclusion available under employer-sponsored cafeteria plans; it would also include efforts to educate small businesses about the value of health insurance coverage for children, assistance available through public programs, and the availability of the hotline operated as part of the Insure Kids Now program at HHS. The task force would be allowed to use any business partner of the SBA, enter into a memorandum of understanding with a chamber of commerce and a partnership with any appropriate small business or health advocacy group, and designate outreach programs at HHS regional offices to work with SBA district offices. It would require the SBA website to prominently display links to state eligibility and enrollment requirements for Medicaid and CHIP, and would require a report to Congress every two years.

Sec. 622. Sense of Senate regarding access to affordable and meaningful health insurance coverage.

Current Law

No provision.

Chairman's Mark

The Chairman's Mark includes a provision that would establish the Sense of the Senate-- The Senate finds the following: (1) there are approximately 45 million Americans currently without health insurance (2) more than half of uninsured workers are employed by businesses with less than 25 employees or are self-employed (3) health insurance premiums continue to rise at more than twice the rate of inflation for all consumer goods (4) individuals in the small group and individual health insurance markets usually pay more for similar coverage than those in the large group market (5) the rapid growth in health insurance costs over the last few years has forced many employers, particularly small employers, to increase deductibles and co-pays or to drop coverage completely.

The Senate (1) recognizes the necessity to improve afford ability and access to health insurance for all Americans; (2) acknowledges the value of building upon the existing private health insurance market; and (3) affirms its intent to enact legislation this year that, with appropriate protection for consumers, improves access to affordable and meaningful health insurance coverage for employees of small businesses and individuals by—(A) facilitating pooling mechanisms, including pooling across State lines, and (B) providing assistance to small businesses and individuals, including financial assistance and tax incentives, for the purchase of private insurance coverage.