February 13, 2009

TO: Chapter Presidents
Chapter Vice Presidents
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CC: AAP Board of Directors
AAP District ViceChairpersons
AAP Executive Committee
Committee on State Government Affairs(COSGA)
Committee on Federal Government Affairs(COFGA)
Committee on Child Health Financing (COCHF)
Council on Community Pediatrics (COCP) Executive Committee
Subcommittee on Access to Care
Relevant AAP Staff

FR: Dan Walter
Sr Policy & Government Affairs Analyst

RE: SUMMARY OF CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA) OF 2009; ELIMINATION OF AUGUST 17, 2007 DIRECTIVE

On February 4, 2009, President Obama signed the CHIPRA of 2009 (HR2), reauthorizing the Children's Health Insurance Program (CHIP). Attached please find a summary of the major provisions of this legislation.

Also on February 4, President Obama issued a memorandum to the US Department of Health and Human Services (HHS) rescinding the August 17, 2007 directive that effectively prohibits states from expanding CHIP coverage above 250% of the federal poverty level (FPL), without first meeting very stringent conditions.

The passage of CHIPRA and the elimination of the August 17 directive are major steps in protecting and strengthening care provided in Medicaid and CHIP. AAP chapters with questions are encouraged to contact me at 800/433-9016 ext 4086 or dwalter@aap.org or Bob Hall in the Department of Federal Affairs at 202/347-8600 ext 3309 or rhall@aap.org.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (HR 2): What it Means for States

On February 4, 2009, President Obama signed CHIPRA of 2009 (HR 2), reauthorizing the Children's Health Insurance Program (CHIP)*. This reauthorization provides significant new funding to the program and also makes a number of changes to CHIP. The following analysis provides a summary of the major provisions of this legislation:

Effective Date
April 1, 2009

New Spending
$32.8 billion through FY 2013, to be funded largely by a $0.62 increase in federal cigarette tax, and increases in other tobacco product taxes.

New Children Covered
Estimates indicate that CHIPRA will allow states to provide coverage to an additional 4.1 million children who would otherwise be uninsured by 2013.

State Allotments
State allotments will be based on both previous and future projected expenses, per capita health expenses, and child population growth. Allotments will be "rebased" beginning in FY 2011. State allotments can be used by states for 2 years (reduced from previous 3 years). This move to base state allotments on actual expenses creates an incentive for states to spend state dollars in CHIP.

Shortfall States
CHIPRA creates a Child Enrollment Contingency Fund, capped at 20% of all federal CHIP allotments over the timeframe of the reauthorization, to meet the needs of states that experience shortfalls due to insufficient federal funding.

State Enrollment and Retention Performance Bonus Payments
The new law creates performance bonus payments to states that exceed their enrollment baselines for children in Medicaid. The law establishes a Medicaid enrollment baseline, set on 2007 enrollment levels, adjusted by state child population growth plus an additional yearly percentage increase. To obtain these

* Among the many changes to the program in this reauthorization was the program's name. Widely known as SCHIP, short for the State Children's Health Insurance Program, the requirement to call the program "SCHIP" was repealed, thereby emphasizing children as recipients rather than states.

bonus payments, states must also implement 5 of 8 enrollment and retention strategies:

1) Twelve (12)-month continuous eligibility
2) Liberalization of asset requirements (elimination of the assets test or state administrative verification of assets)
3) Elimination of face-to-face interview requirements
4) Use of a joint application for Medicaid and CHIP
5) Automatic renewal procedures
6) Presumptive eligibility
7) "Express lane eligibility" (using eligibility data from other state programs, such as Head Start or the National School Lunch Program, to determine Medicaid/CHIP eligibility)
8) Premium assistance subsidies

Children's Eligibility Changes

States that expand CHIP to 300% of the federal poverty level (FPL) will continue to receive the Enhanced Federal Medical Assistance Percentage (FMAP) on CHIP expenditures. Those states that expand CHIP eligibility above 300% FPL after July 1, 2008 will receive the lower, Medicaid FMAP on those state expenditures above 300% FPL. Those states that currently have Centers for Medicare and Medicaid Services (CMS) approval to expand above 300% FPL (New Jersey and New York) and those states that have enacted state laws to expand above 300% FPL will be granted an exemption, and receive the Enhanced FMAP for expenditures above 300% FPL under these programs.

Immigrant Children's Health Improvement Act (ICHIA) Provision

The new law gives states the option to cover legal immigrant children and pregnant women during their first 5 years in the US, if otherwise eligible.

Pregnant Women

States will be allowed to cover pregnant women under CHIP without a waiver, instead via a state plan amendment. States must cover pregnant women to 185% FPL, and children under 19 to 200% FPL, and meet other requirements.

Childless Adults

New CHIP waivers to cover childless adults are prohibited. Existing waivers to cover childless adults will be phased-out at the end of 2010, at which time states may transition such adults to a separate program under the block grant.

Parents

The new law prohibits new CHIP waivers to cover parents of Medicaid/CHIP children, although it allows states to extend existing waivers through 2011. In 2012, states with existing parental coverage can continue extensions only if they meet child outreach and enrollment benchmarks, and in FY 2013 states with extended plans receive a federal match on such spending that is between the FMAP and the

enhanced-FMAP, called a "REMAP," or Reduced Enhanced Medical Assistance Percentage.

States with Pre CHIP Expansions

States that expanded Medicaid coverage of children before the enactment of CHIP can draw down unused CHIP allotment dollars to fund children in these programs with family incomes above 133% FPL.

Outreach and Enrollment Funding

The new law provides $100 million in a new national enrollment campaign and state and local outreach and enrollment program grants. Entities eligible for outreach and enrollment grants include states, local governments, Indian tribes, federal health safety net organizations, nonprofit and faith based organizations, and schools.

Enhanced Administrative Funding of Translation/Interpretation

The new law increases the Medicaid/CHIP federal financial participation (FFP) for translation and interpretation services for persons with limited English proficiency (LEP). Under the law, the federal match will be 75% in Medicaid, and the greater of 75% or the existing enhanced-FMAP for the state plus 5% in CHIP.

Express Lane Eligibility

Express Lane Eligibility is instituted as a state option under the new law. States are allowed to accept eligibility data from other means-tested programs (such as Head Start or the National School Lunch Program) rather than Medicaid/CHIP.

Citizenship and Identity Documentation

The law extends the Medicaid citizenship and identity documentation requirement to CHIP. States are now allowed the option of accepting applicants' Social Security numbers in order to submit them to the federal Commissioner of Social Security for purposes of determining matching citizenship and identity via the Social Security Administration's database. This provides a streamlined alternative for states to verify the citizenship and identity of applicants, potentially reducing a barrier to enrollment.

Premium Assistance

Provisions of the new law give states the option of providing premium assistance subsidies for qualified employer-sponsored health insurance for children eligible for Medicaid and CHIP who have access to such coverage and voluntarily elect to receive it. Coverage must be actuarially equivalent to CHIP benefit packages, and employers must contribute at least 40% of the premium. States will additionally provide supplemental CHIP coverage for items or services not covered by the qualified employer-sponsored coverage, as well as cost-sharing protections. Plans receiving premium assistance funds through Medicaid or CHIP are required to provide benefit information to states, upon request. The new law also amends Internal Revenue Service (IRS) and Employee Retirement Income Security Act (ERISA) code to make gaining or losing Medicaid/CHIP coverage a "qualifying event" for purposes of enrolling in employer-sponsored coverage. This would allow such persons to receive employer-sponsored coverage without waiting for the next enrollment period.

Children's Health Care Quality

The new law provides significant funding to improve pediatric health care quality measurement in Medicaid and CHIP. The reauthorization allocates $225 million in total – $45 million per year – to this cause.

Specifically, the new law requires the Secretary of Health and Human Services (HHS) to identify and publish for comment an initial, core set of health care quality measures for children in Medicaid and CHIP by January 1, 2010. These measures would examine availability and effectiveness of care and would be applicable to all Medicaid and CHIP programs, as well as insurers, managed care entities, and providers that contract with such programs.

No later than 2 years after enactment of HR2, the Secretary is required to develop a standardized format for reporting information, procedures, and approaches that encourage states to voluntarily use the core measurement set. The Secretary will also be required to issue best practices as to measuring and reporting quality, and report to Congress as to quality of care under Medicaid and CHIP.

By January 1, 2011, the Secretary of HHS is required to establish a pediatric quality measures program to improve and expand upon the initial core measurement set. The Secretary is required to consult with states as well as pediatricians, children's hospitals, dental professionals, and national organizations representing children and children's health care in this endeavor. The Secretary is also directed to award grants and contracts for the development, testing, and validation of children's quality measures; the dissemination of such measures to purchasers of health care for children; and the updating of such measures.

States will be required to continue their annual reports on state-specific child health quality measures applied by the states, to be published annually by the Secretary of HHS beginning no later than September 30, 2010. State use of the core measurement set or expanded measures remains voluntary, however.

In addition, between 2009-2013, the Secretary is required to award up to 10 grants to states and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of measures or testing new measures, promote the use of health information technology, evaluate provider-based models that improve care, or demonstrate the impact of the model electronic health record format for children on improving quality and reducing cost. (Note: The medical home would likely meet the criteria for the provider-based model project.) A total of $20 million per year is allocated for such grants.

The Secretary is also required to conduct a demonstration to develop a comprehensive and systematic model for reducing childhood obesity through grants to local government, Indian tribes, community based organizations, universities, local health departments, etc. This would be authorized at $25 million over 5 years, and the Secretary must report to Congress on this demonstration.

In addition, the Secretary is required to establish a program to encourage the creation and dissemination of model electronic health record format for children in Medicaid and CHIP, with $5 million per year appropriated for this purpose. The Institutes of Medicine (IOM) is also required to study and report to Congress on the extent and quality of efforts to measure child health quality, with $1 million per year appropriated for such activity.

Public Information in Medicaid/CHIP

The new law requires additional information in each state's annual Medicaid/CHIP reports, including information on eligibility and access to primary and specialty care, care networks, and care coordination, to be provided in a standardized reporting format to be created by the Secretary. The law also requires a Government Accountability Office (GAO) study on access to primary and specialty care in Medicaid and CHIP.

Dental/Mental Health Benefits

The new law requires dental services for children in CHIP, and gives states different benchmark or supplemental options for providing such dental services. The bill also requires mental health parity in CHIP for states that choose to cover mental health services, ensuring that mental health services are offered at no more restrictive cost sharing or benefit limitations than medical services for CHIP recipients.

Medicaid and CHIP Payment and Access Commission (MACPAC)

The new law creates a MACPAC, not unlike Medicare's MedPAC, to review Medicaid and CHIP policies affecting children's access to covered items and services, and requiring the MACPAC to report to Congress annually beginning no later than March 1, 2010. The MACPAC is required to review Medicaid and CHIP payment policies, including expenditures for items and services, payment methodologies, and the relationship of such factors to access and quality of care for Medicaid/CHIP enrollees. The MACPAC is also charged with creating an early-warning system to identify provider shortage areas or other problems that threaten access in Medicaid/CHIP. The MACPAC will be comprised of 17 members appointed by the Comptroller General of the United States.

Deficit Reduction Act of 2005 Corrections

The new law corrects a provision of the Deficit Reduction Act of 2005 (DRA), clarifying that all children enrolled in Medicaid "benchmark benefit" plans must receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

The reauthorization also prohibits the Secretary from approving any new Health Opportunity Account demonstration programs.

The new law also extends disproportionate share hospital (DSH) payments for Hawaii and Tennessee, requires a GAO study on Medicaid managed care payment rates by states, and establishes a task force to conduct a nationwide campaign of concerns of small business regarding availability of children's health care coverage, among other provisions.

Please contact Dan Walter in the AAP Division of State Government Affairs at 800/433-9016 ext 4086 or dwalter@aap.org, or Bob Hall in the AAP Department of Federal Affairs at 202/347-8600 ext 3309 or rhall@aap.org if you have additional questions or need more information.