

**MOA MEMBERS
FROM SUE A. WEINGARTNER, EXECUTIVE DIRECTOR
APRIL 17, 2009**

CMS RELEASES FIRST CHIPRA STATE HEALTH OFFICIAL LETTER

CMS Issues State Health Official (SHO) Letter on the Children's Health Insurance Program Reauthorization Act

Today, the Centers for Medicare & Medicaid Services (CMS) is releasing the first in a series of formal technical assistance letters to States to assist them in implementing the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. Under CHIPRA, States will be able to strengthen their existing programs and provide coverage to additional low-income, uninsured children and pregnant women. The purpose of this letter is to provide a general overview of the key provisions in the new law. CMS will issue a series of State Health Official and State Medicaid Director letters over the next few months to provide more detailed guidance on CHIPRA provisions.

The letter is attached for your convenience.

Molly Smith
Intergovernmental Affairs
Centers for Medicare and Medicaid Services
202-205-9288
<http://www.cms.hhs.gov/states/>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850



Center for Medicaid & State Operations

April 17, 2009

SHO #09-002
CHIPRA #1

Dear State Health Official:

On February 4, 2009, the President signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3. The law contains provisions that directly affect both the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act (the Act) and the Medicaid Program under title XIX of the Act. Under CHIPRA, States will be able to strengthen their existing programs and provide coverage to additional low-income, uninsured children and pregnant women. The purpose of this letter is to provide a general overview of the key provisions in the new law, with the understanding that technical issues will be addressed in the coming weeks and months. We want to ensure that States can fully avail themselves of the new options as soon as possible, and the Department of Health and Human Services (HHS) stands ready to assist States in achieving this goal.

The Centers for Medicare & Medicaid Services (CMS) will issue a series of State Health Official and State Medicaid Director letters over the next few months to provide more detailed guidance on CHIPRA provisions. Additionally, we will be having regularly scheduled conference calls with States to listen to questions and implementation concerns related to the new law. If you have any questions regarding CHIPRA, please e-mail them to CMSOCHIPRAQuestions@cms.hhs.gov.

Funding

Sections 101 through 109 of CHIPRA amend existing provisions of the Act related to funding (specific statutory references from the Act are provided in parentheses).

Funding levels (Section 2104(a)). CHIPRA reauthorizes CHIP for four and a half years – through fiscal year (FY) 2013 -- and invests approximately \$44 billion in new funding for the program.

Allotments to States (Section 2104(m)). The annual allotment formula is revised to more accurately reflect projected State and program spending. The previous allotment formula accounted for factors such as the number of low-income children and average wages in the health care industry. For 2009, the new allotment formula for each of the 50 States and the District of Columbia is determined as 110 percent of the highest of three amounts:

- Total Federal payments under title XXI to the State for FY 2008, multiplied by an “allotment increase factor” for FY 2009;
- FY 2008 CHIP allotment multiplied by the “allotment increase factor” for FY 2009; or
- The projected Federal payments under title XXI for FY 2009 as determined on the basis of the February 2009 estimates submitted and certified by the States no later than March 31, 2009.

CHIPRA also amends section 2104(e) to maintain the 3-year availability for FY 1998-FY 2008 allotments but changes to a 2-year availability for allotments beginning with FY 2009. Additionally, section 2104(f) is amended so that unexpended allotments for FY 2007 and subsequent years are redistributed to States that are projected to have funding shortfalls after considering all available allotments and Contingency Fund payments (described below).

Child Enrollment Contingency Fund (Section 2104(n)). CHIPRA establishes a “Child Enrollment Contingency Fund” that will provide payments to States that have a CHIP funding shortfall in any fiscal year through FY 2013 where enrollment exceeds target levels. A State may qualify for contingency fund payments for FY 2009 and following fiscal years if it has a funding shortfall for the fiscal year (not counting any redistributed amounts it may receive) and it has exceeded its target average number of enrollees for the State fiscal year. If both of these criteria are met for a fiscal year, the State’s Contingency Fund payment for such fiscal year will equal the State’s average per capita CHIP payments multiplied by the number of enrolled children above the State’s target. Commonwealths and Territories are precluded from Contingency Fund payments until the Secretary has determined they have satisfactory and reliable methods for child enrollment data collection and reporting.

Bonus Payments (Section 2105(a)). CHIPRA provides “CHIP Performance Bonus Payments” (Bonus Payments) for FY 2009 through FY 2013 for purposes of providing additional funds to offset the costs of increased Medicaid enrollment. States are eligible for Bonus Payments only if enrollment and retention conditions are met as provided under new section 2105(a)(4) of the Act.

Qualifying States (Section 2105(g)). CHIPRA allows Qualifying States to use up to 100 percent of their available FY 2009 through FY 2013 allotments for Medicaid expenditures for children under age 19 who are not optional targeted low-income children, and whose family income is in excess of 133 percent of the Federal poverty level (FPL). In fiscal years prior to FY 2009, these Qualifying States could only use up to 20 percent of such available allotment funds for Medicaid expenditures and only for children whose family income level was in excess of 150 percent of the FPL.

Funding for the Territories (Section 1108(g)). Federal matching payments related to improvements to State Medicaid Management Information Systems and incentive payments for electronic health records do not apply against the Medicaid funding cap.

Eligibility under Medicaid and CHIP

CHIPRA amends the Act to add the coverage of pregnant women and legal immigrants, as well as alter the matching rate for the coverage of children in families with incomes above 300 percent of the FPL, and the coverage of non-pregnant adult populations under CHIP demonstrations (per sections 111, 214, 114, and 112 respectively).

Pregnant Women (Section 2112). CHIPRA gives States the option to provide coverage to targeted low-income pregnant women under the CHIP State plan if certain conditions are met. Infants born to these women are automatically eligible for Medicaid or CHIP, through age one. States may choose to apply presumptive eligibility to these pregnant women under CHIP.

Legal Immigrants (Sections 1903(v) and 2107(e)(1)). CHIPRA provides States the option to extend Medicaid/CHIP coverage to qualified alien children and/or pregnant women who are residing lawfully in the United States (such as, for example, lawful permanent residents) and who have not met the 5-year waiting period or “5-year bar” otherwise required under sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (as long as the individuals are otherwise eligible for such assistance). Therefore, States now have the option to cover legal immigrant children and/or pregnant women under CHIP and Medicaid during this initial 5-year period.

Children in Families with Income Above 300 Percent FPL (Section 2105(c)). CHIPRA provides that, beginning with FY 2009, the regular Medicaid Federal Medical Assistance Percentage (FMAP) will apply for expenditures for children in families with incomes in excess of 300 percent of the FPL (determined without regard to the application of a general exclusion of a block of income that is not determined by type of expense or type of income). For States that, as of February 4, 2009 (the date of enactment of CHIPRA), had an approved State plan or demonstration providing coverage up to this income eligibility level, or for States that had enacted a State law for such coverage, the enhanced FMAP will apply.

Non-pregnant Childless Adults and Parents of Targeted Low-income Children (Section 2111). CHIPRA prohibits new demonstrations for childless adults and terminates existing demonstrations for coverage of childless adults funded through CHIP by December 31, 2009. If a current demonstration would expire prior to that date, an extension is available through December 31, 2009, only if requested by September 30, 2009. Under CHIPRA, States with existing demonstrations may also request, by September 30, 2009, a Medicaid demonstration project that meets statutory budget neutrality standards for continued funding and coverage.

Existing CHIP demonstrations that provide coverage for parents may continue through September 30, 2011. If a State has a demonstration that would expire before October 1, 2011, the State may request an automatic extension of the demonstration through September 30, 2011. The enhanced FMAP is available under title XXI of the Act for coverage of parents under these conditions for the third and fourth quarters of FY 2009, FY 2010, and FY 2011.

CHIPRA then provides payments through a block grant for existing demonstrations covering parents through FY 2012 or FY 2013, subject to the existing demonstration terms and conditions. The Secretary shall set aside an amount equal to the Federal share of 110 percent of the State's projected demonstration expenditures for parents that the State has certified were enrolled in the demonstration as of August 31 of the preceding fiscal year. For fiscal year 2013 the amount set aside shall be computed separately for: the period beginning on October 1, 2012 and ending on March 31, 2013 and the period beginning on April 1, 2013 and ending on September 30, 2013. States will only receive enhanced FMAP for existing parent demonstrations in FY 2012 or FY 2013 if significant child outreach, as defined under CHIPRA, has been achieved.

CHIPRA also does not allow States with existing parent demonstrations to increase the income eligibility level applied as of the date of CHIPRA enactment or February 4, 2009.

Presumptive Eligibility (Sections 1902(e)(4) and 2105(a)(1))

Effective with the quarter beginning April 1, 2009, no Federal matching funding for presumptive eligibility expenditures for Medicaid children under section 1920A of the Act will be deducted from the CHIP allotment.

Match Rate for Medicaid Expansion Expenditures

CHIPRA gives States the option to claim expenditures for Medicaid expansion populations under section 1905(u) of the Act, at the enhanced FMAP using title XXI funds or at the regular FMAP rate using title XIX funds. Under section 2105(a), only expenditures for such populations that the State has elected to claim at the enhanced FMAP are applied against a State's available CHIP allotment.

Outreach and Enrollment

Sections 201 through 203 of CHIPRA provide for increased outreach and enrollment efforts through grants, outreach to Indians, and express lane eligibility.

Outreach Funding (Sections 2113 and 2105(a)(1)). CHIPRA provides \$100 million over five years to fund outreach and enrollment efforts that increase coverage of eligible children in Medicaid and CHIP. Ten percent of the funds are for a national enrollment campaign and another 10 percent are set aside for grants to Indian Health Service providers and Urban Indian organizations. Grants may be provided to State, local, and tribal governments, Federal health safety net organizations or other consortia serving children under a Federally-funded program, elementary or secondary schools, and non-profit and faith-based organizations.

Also, section 201(b) of CHIPRA provides enhanced administrative funding for translation or interpretation services under CHIP and Medicaid, equal to 75 percent for Medicaid and the greater of 75 percent or the sum of the enhanced FMAP plus five percentage points for CHIP. The funds are for services in connection with the enrollment

of, retention of, and use of services by children of families for whom English is not their primary language.

Outreach to Indians (Section 1139). CHIPRA requires the Secretary of HHS to encourage States to increase enrollment of Indians, whether living on or off tribal lands, into Medicaid and CHIP. States are encouraged to increase outstationing of eligibility workers and enter into agreements with the Indian Health Service and Tribes to provide outreach, translation services, and education regarding Medicaid and CHIP.

Express Lane Option (Sections 1902(e), 2107(e)(1), 1902(dd), and 1942). The new law allows States to use findings from a specified public agency, to be known as an “Express Lane” agency (e.g., public agencies that determine eligibility for TANF, Food Stamps, National School Lunch, etc.) to evaluate a child’s initial eligibility or renewal status for Medicaid or CHIP.

Citizenship Documentation Requirements (Sections 1902, 1903(x) and 2105(c)).

CHIPRA modifies the Deficit Reduction Act of 2005 (DRA) Medicaid citizenship documentation requirements and extends those requirements to CHIP. Effective as if included in the DRA, the new law specifies that documentation from a Federally-recognized Tribe (such as a Tribal enrollment card or certificate of degree of Indian blood) is satisfactory evidence of citizenship and identity. For Tribes having an international border, and whose membership includes non-U.S. citizens, the Secretary is directed to issue regulations as to what documentation will be satisfactory. Until such regulations are effective, however, those from cross-border Tribes may use Tribal enrollment/membership documents for purposes of proving both citizenship and identity.

Also effective as if included in the DRA, States are directed to provide individuals a reasonable opportunity to present satisfactory documentary evidence of citizenship, after a declaration of such citizenship has been made.

Additionally, effective January 1, 2010, States are offered an alternative to meeting the citizenship verification requirements by asking the Social Security Administration to verify names and Social Security numbers and the declaration of citizenship provided by Medicaid and CHIP applicants and recipients. Individuals are given an opportunity to resolve any inconsistencies, or provide documentation of citizenship, before being disenrolled. Certain payments must be returned by the State if a threshold percentage of individuals are erroneously provided Medicaid/CHIP using the alternative process.

Interstate Coordinated Enrollment and Coverage Process (No Specific Reference in the Act)

Section 213 of CHIPRA requires the Secretary of HHS to consult with State Medicaid and CHIP directors and other stakeholders to develop a model process for the coordination of enrollment, retention, and coverage under Medicaid and CHIP of children who frequently change their State of residency because of family migration, emergency evacuations, or educational needs.

Premium Assistance for Employer Sponsored Insurance

Premium assistance subsidies, outreach, and the provision for a special enrollment period under group health plans are described under sections 301, 302, and 311 of CHIPRA.

Premium Assistance Subsidies (Sections 2105(c) and 1906A). CHIPRA allows States to offer premium assistance subsidies to CHIP and Medicaid-eligible children who have access to qualified employer-sponsored insurance to which the employer contributes at least 40 percent of the premium cost.

Outreach, Education, and Enrollment related to Premium Assistance (Section 2102(c)). CHIPRA adds a requirement for States electing to offer premium assistance that they educate eligible families and their employers about the availability of this option, and assist families in enrolling their children in such subsidies.

Special Enrollment Period under Group Health Plans (Amends the Internal Revenue Code of 1986, the Employee Retirement Income Security Act of 1974 and the Public Health Service Act). CHIPRA amends the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act to require employer-sponsored group health plans to permit employees or their dependents to enroll in the plan if they lose eligibility for Medicaid or CHIP, or if they become eligible for premium assistance under Medicaid or CHIP. An individual who requests enrollment within 60 days of losing or becoming eligible for Medicaid or CHIP must be enrolled, even if there is otherwise no open enrollment period, and without any penalties for late enrollment.

Child Health Quality Initiatives

Child Health Quality Measures (Sections 1139A and 1903(a)(3)(A)). Section 401 of CHIPRA requires HHS to develop child health quality measures for children enrolled in CHIP or Medicaid. By January 1, 2010, the Secretary, in consultation with States, providers, and consumer groups, will identify and publish an initial core set of child health quality measures for CHIP and Medicaid. The Secretary of HHS also will develop a standardized report format for reporting information and encourage States to voluntarily report on the measures. The Secretary will disseminate to States best practices for measuring and reporting quality and will provide technical assistance to States to help them adopt and utilize quality measures.

Grants for New Measures. The new law also requires the Secretary to establish a pediatric quality measures program to strengthen the initial core quality measures, expand other measures, and develop new measures. Grants and contracts will be awarded to develop, test, validate, and disseminate new measures. Beginning January 1, 2013, and each year thereafter, recommended changes to the core measures will be published.

Demonstrations to Evaluate Quality Improvement. In addition, grants will be awarded to States and providers to conduct demonstration projects to evaluate quality improvement strategies within four categories. These demonstrations include 1) experimenting with new measures, 2) promoting health information technology, 3) evaluating provider-based models such as care management, and 4) demonstrating the impact of a model electronic health format on improving pediatric health.

Demonstrations to Reduce Childhood Obesity. CHIPRA also authorizes the awarding of demonstration projects to develop systematic models for reducing childhood obesity. These grantees shall develop a curriculum, form partnerships, and carry out community-based activities to reduce childhood obesity.

Model Electronic Health Record for Children. CHIPRA also authorizes the Secretary to develop a program to encourage the development and dissemination of a model electronic health record for children by January 1, 2010.

Managed Care Safeguards in CHIP (Section 2103(f))

Section 403 of CHIPRA adds managed care requirements, which currently are applicable to Medicaid under 1932(a)(4), (a)(5), (b), (c), (d), and (e), to CHIP. These managed care requirements include those related to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations in the same manner as such provisions are applied under Medicaid. This provision applies to contract years for managed care plans beginning on or after July 1, 2009.

Dental Benefits

Dental Benefit Packages (Section 2103). CHIPRA includes new protections to expand coverage of dental services necessary to prevent disease, promote oral health, restore health and function, and treat emergency conditions. These protections may be satisfied through a State-defined dental benefit package or through one of three dental benchmark benefit packages. These dental benchmarks are 1) the supplemental dependent dental plan most frequently selected under the Federal Employees Health Benefit Plan in the past two years (MetLife); 2) the State employee dependent dental benefit that has been selected most frequently by employees seeking dependent coverage in the past two years; or 3) the dental benefit plan provided by the State's largest insured commercial non-Medicaid plan of dependent covered lives that is offered in the State involved.

Supplemental Dental Coverage (Sections 2110(b) and 2102). States have the option under CHIPRA to offer a supplemental dental wrap-around benefit for children who receive primary care services through a parent's employer plan but for whom no dental

services are included. Children eligible for the dental-only coverage must be children who would be eligible for CHIP if they are not enrolled in an employer-sponsored insurance program. Dental-only coverage must comply with all other requirements of the statute regarding cost sharing and income eligibility level, and a State may offer such coverage only if it has no waiting list for its entire CHIP program (not just for dental coverage), and does not provide more favorable treatment for this supplemental dental benefit than for dental benefits for targeted low-income children.

Mental Health Parity (Section 2103)

Section 502 of the new law prevents States that include mental health or substance abuse services in their CHIP plans from imposing financial requirements and treatment limitations for those benefits that are more restrictive than those for medical and surgical benefits. The law, however, does not require coverage of mental health or substance abuse treatment and is effective the first plan year that begins on or after October 4, 2009.

Miscellaneous Provisions

CHIPRA also includes provisions related to payments for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) (section 503), premium grace period requirements (section 504), school-based health centers (section 505), Payment Error Rate Measurement (PERM) (section 601), and improved data collection (section 602).

Federally Qualified Health Centers and Rural Health Clinics (Section 2107(e)(1)).

CHIPRA requires States with separate or combination CHIP programs to pay FQHCs and RHCs using the Medicaid prospective payment system. This provision applies to services provided on or after October 1, 2009.

Premium Grace Period (Section 2103(e)(3)). The new law requires States to have at least a 30-day grace period for individuals to make premium payments before losing their coverage. States must provide written notice and the opportunity for the family to challenge the decision before coverage is terminated.

School-Based Health Centers (Section 2103(c)). CHIPRA clarifies that States may cover CHIP services offered through school-based health centers.

Payment Error Rate Measurement (PERM) (Section 2105(c)). CHIPRA provides a 90 percent Federal match for CHIP spending related to PERM administration and excludes such expenditures from the 10 percent administrative cap. As required under CHIPRA, CMS is developing a new regulation on PERM requirements; and a CHIP payment error rate will not be published until 6 months beyond publication of the new regulation.

Improved Data Collection (Section 2109(b)). CHIPRA authorizes \$20 million for the Department of Commerce to improve the Current Population Survey and the American Community Survey so that estimates are more reliable.

Again, we look forward to working with you to ensure continued success of the CHIP program in your State.

Sincerely,

/s/

Jackie Garner
Acting Director
Center for Medicaid and State Operations

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Barbara Levine
Director of Policy and Programs
Association of State and Territorial Health Officials

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy