



# CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION SIDE-BY-SIDE



**PROVISION: CHIP APPROPRIATIONS**

**CURRENT LAW:** Section 2104(a) of the Social Security Act specifies the following: SCHIP appropriation amounts (of which the territories receive 0.25%): \$4.3 billion annually from FY1998 to FY2001; \$3.15 billion annually from FY2002 to FY2004; \$4.05 billion in FY2005 and FY2006; and \$5.0 billion in FY2007. No amounts are specified for FY2008 onward.

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| <p>H§101. Establishment of new base CHIP allotments. Appropriations for FY2008 onward would be provided without a national amount specified. The annual appropriation would be determined automatically as the sum total of the allotments calculated for all the states and territories. No end year would be specified; the program could receive annual appropriations in perpetuity.</p> | <p>S§101. Extension of CHIP. The following national appropriation amounts would be specified for CHIP in §2104(a): \$9.125 billion in FY2008; \$10.675 billion in FY2009; \$11.85 billion in FY2010; \$13.75 billion in FY2011; and two semiannual installments of \$1.75 billion each in FY2012.</p> <p>S§103. One-time appropriation. A separate appropriation of \$12.5 billion would be provided for CHIP allotments in the first half of FY2012.</p> | <p>A§101. Extension of CHIP. Same as Senate bill.</p> <p>A§108. One-time appropriation. Same as Senate bill.</p> | <p>Support the full \$50 billion over five years, as provided for in the budget resolution and House bill.</p> <p>Also, urge Congress to not create a funding cliff, as in the Senate bill or conference agreement, because it creates a crisis akin to the Medicare physician payment problem in out-years whereby SCHIP will go into FY 2015 facing an enormous funding shortfall. This may require waiving the Budget Act, but would be better than creating an enormous out-year shortfall.</p> |

**PROVISION: EXTENSION OF OPTION FOR QUALIFYING STATES**

**CURRENT LAW:** For qualifying states, federal SCHIP funds may be used to pay the difference between SCHIP's enhanced Federal Medical Assistance Percentage (FMAP) and the Medicaid FMAP that the state is already receiving for children above 150% of poverty who are enrolled in Medicaid. Qualifying states are limited in the amount they can claim for this purpose to the lesser of (1) 20% of the state's original SCHIP allotment amounts (if available) from FY1998-FY2001 and FY2004-FY2007; and (2) the state's available balances of those allotments. The statutory definitions for qualifying states capture most of those that had expanded their upper-income eligibility levels for children in their Medicaid programs to 185% of poverty prior to the enactment of SCHIP. Based on statutory definitions, 11 states were determined to be qualifying states: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington and Wisconsin.

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| <p>H§104. Extension of option for qualifying states. In addition to the current-law provisions, qualifying states would also be able to use the entirety of any allotment from FY2008 onward for CHIP spending under §2105(g).</p> | <p>S§111. Option for qualifying states to receive the enhanced portion of the CHIP matching rate for Medicaid coverage of certain children. Qualifying states under §2105(g) may also use available balances from their enrollees under age 19 (or age 20 or 21, if the state has so elected in its Medicaid plan) whose family income exceeds 133% of poverty. CHIP allotments from FY2008 to FY2012 to pay the difference between the regular Medicaid FMAP and the CHIP</p> | <p>A§107. Option for qualifying states to receive the enhanced portion of the CHIP matching rate for Medicaid coverage of certain children. Same as Senate bill.</p> | <p>Support allowing qualifying states to have equity with all other states in terms of covering optional children with the higher CHIP matching rate.</p> |

enhanced FMAP for Medicaid enrollees under age 19 (or age 20 or 21, if the state has so elected in its Medicaid plan) whose family income exceeds 133% of poverty.

**PROVISION: OPTIONAL COVERAGE OF OLDER CHILDREN UNDER CHIP**

**CURRENT LAW:** Generally, eligibility for children under Medicaid is limited to persons under age 19 (or in some cases, under age 18, 19, 20 or 21). Under SCHIP, children are defined as persons under age 19.

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| H§131. Optional coverage of children up to age 21 under CHIP. Would expand the definition of child under CHIP to include persons under age 20 or 21, at state option. The effective date would be January 1, 2008 | No provision.            | No provision.      | Support the House language so as to allow states to eliminate “age cliffs” between Medicaid and SCHIP in a state. |

**PROVISION: OPTIONAL COVERAGE OF LEGAL IMMIGRANTS IN MEDICAID AND CHIP**

**CURRENT LAW:** States may provide full Medicaid coverage to legal immigrants who meet applicable categorical and financial eligibility requirements after such persons have been in the United States for a minimum of five years. Sponsors can be held liable for the costs of public benefits (such as Medicaid and SCHIP) provided to legal immigrants.

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| H§132 Optional coverage of legal immigrants under the Medicaid program and CHIP. Would allow states to cover legal immigrants who are pregnant women and/or children under age 21 (or such higher age as the state has elected) under Medicaid or CHIP before the five-year bar is met effective upon the date of enactment. Sponsors would not be held liable for the costs associated with providing benefits to such legal immigrants, and the cost of such assistance would not be considered an unreimbursed cost. | No provision.            | No provision.      | Support the House language to end the five-year waiting period for legal immigrant children and pregnant women. |

**PROVISION: PARENT COVERAGE UNDER CHIP**

**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 SCHIP programs including expanding eligibility to populations who are not otherwise eligible for Medicaid or SCHIP (e.g., childless adults). Approved SCHIP Section 1115 waivers are deemed to be part of a state's SCHIP state plan for purposes of federal reimbursement. Costs associated with waiver programs are subject to each state's enhanced-FMAP. Under SCHIP Section 1115 waivers, states must meet an "allotment neutrality test" where combined federal expenditures for the state's regular SCHIP program and for the state's SCHIP demonstration program are capped at the state's individual SCHIP allotment. The Deficit Reduction Act of 2005 prohibited the approval of new demonstration projects that allow federal SCHIP funds to be used to provide coverage to non-pregnant childless adults, but allowed for the continuation of such existing Medicaid or SCHIP waiver projects affecting federal SCHIP funds that were approved before February 8, 2008.

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| <p><b>H§134 Limitation on waiver authority to cover adults.</b> The provision would prohibit the Secretary from allowing federal CHIP allotments to be used to provide health care services (under the Section 1115 waiver authority) to individuals who are not targeted low-income children or pregnant women (e.g., non-pregnant childless adults or parents of Medicaid or CHIP-eligible children) unless the Secretary determines that no CHIP-eligible child in the state would be denied CHIP coverage because of such eligibility. To meet this requirement, states would have to assure that they have not instituted a waiting list for their CHIP program, and that they have an outreach program to reach all targeted low-income children in families with annual income less than 200% FPL.</p> | <p><b>S§106 Conditions for coverage of parents.</b> Would prohibit the approval or renewal of Section 1115 demonstration waivers that allow federal CHIP funds to be used to provide coverage to parent(s) of targeted low-income child(ren). The 11 states with CMS approval for such waivers would be permitted to use federal CHIP funds to continue such coverage during FY2008 and FY2009 as long as such funds are not used to cover individuals with annual income that exceeds the income eligibility in place as of the date of enactment. Beginning in FY2010, allowable spending under the waivers would be subject to a set aside amount from a separate allotment. In FY2010 only, costs associated with such parent coverage would be subject to each such state's CHIP enhanced FMAP for States that meet certain coverage benchmarks (related to performance in providing coverage to children) in FY2009, or each such state's Medicaid FMAP rate for all other states.</p> | <p>Same as Senate bill.</p> | <p>Urge a policy that would <b>allow parents to be covered</b> by states under the same program and policy as their low-income children. Policymakers should carefully consider how best to achieve the goal of allowing children and parents to remain together as part of national health reform.</p> |
| <p>For FY2011 or 2012, costs associated with such parent coverage would be subject to: (1) a state's REMAP percentage (i.e., a percentage which would be equal to the sum of (a) the state's FMAP percentage and (b) the number of percentage points equal to one-half of the difference between</p>  |  |                             |   |

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|  | <p>the state's FMAP rate and the state's E-FMAP rate) if the state meets certain coverage benchmarks (related to performance in providing coverage to children) for the preceding fiscal year, or (2) the state's regular Medicaid FMAP rate if the state failed to meet the specified coverage benchmarks for the preceding fiscal year.</p> <p>Would require a Government Accountability Office study regarding effects of adult coverage on the increase in child enrollment or quality of care.</p> |  |  |
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**PROVISION: MEDICAID TMA**

**CURRENT LAW:** States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation is called transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections, as well as those who lose eligibility due to an increase in earned income or hours of employment. Congress expanded work-related TMA under section 1925 of the Social Security Act in 1988, requiring states to provide TMA to families who lose Medicaid for work-related reasons for at least six, and up to 12, months. Since 2001, work-related TMA requirements under section 1925 have been funded by a series of short-term extensions, most recently through September 30, 2007.

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| <p><b>H§801. Modernizing transitional Medicaid.</b> The House bill would extend work-related TMA under section 1925 through September 30, 2011. States could opt to treat any reference to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months) for purposes of the initial eligibility period for work-related TMA, in which case the additional 6-month extension would not apply. States could opt to waive the requirement that a family have received Medicaid in at least three of the last six months in order to qualify. They would be required to collect and submit to the Secretary of HHS (and make publicly available) information on average monthly enrollment and participation rates for</p> | <p>No provision.</p>            | <p>No provision.</p>      | <p>Support language in the House bill.</p> |

adults and children under work-related TMA, and on the number and percentage of children who become ineligible for work-related TMA and whose eligibility is continued under another Medicaid eligibility category or who are enrolled in CHIP. The Secretary would submit annual reports to Congress concerning these rates. Except for the four-year extension of work-related TMA, which would be effective October 1, 2007, the provision would be effective upon enactment.

**PROVISION: STATE AUTHORITY TO EXPAND INCOME OR RESOURCE ELIGIBILITY FOR CHILDREN**

**CURRENT LAW:** States have the ability under current law to extend Medicaid coverage to children in families with income below 133% of FPL for children under age 6, or 7, or 8 and below 100% of FPL for children under age 19. States also are able to define income and resource counting methodologies. Part of this flexibility includes the ability to disregard certain amounts form income or resources for the purpose of determining Medicaid eligibility. A targeted low-income child qualifying for enhanced federal matching payments is one who is under the age of 19 years without health insurance, and who would not have been eligible for Medicaid under the rules in effect in the state on March 31, 1997. States can set the upper income level for targeted low-income children up to 200% of the federal poverty level (FPL), or 50 percentage points above the applicable pre-SCHIP Medicaid income level.

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| No provision.           | No provision.                   | A§115. <b>State Authority Under Medicaid.</b> The provision clarifies that nothing in the bill should be construed as limiting the flexibility of states to increase the income or resource eligibility levels for children under Medicaid state plans or under Medicaid waivers. In addition, the provision would protect the ability of states to extend Medicaid coverage beyond the Medicaid applicable income level effectively allowing a shift of children from a targeted low-income eligibility pathway to a traditional Medicaid eligibility pathway. | Support the conference agreement clarification language. |

**PROVISION: "EXPRESS LANE" 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.

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| <p>H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. Beginning in January 2008, the bill would allow States to rely on an eligibility determination finding made within a State-defined period from an Express Lane Agency to determine whether a child under age 19 (or up to age 21 at state option) has met one or more of the eligibility requirements (e.g., income, assets or resources, citizenship, or other criteria) necessary to determine an individual's initial eligibility, eligibility redetermination, or renewal of eligibility for medical assistance under Medicaid or CHIP.</p> | <p>S§203. Demonstration project to permit States to rely on findings by an Express Lane agency to determine components of a child's eligibility for Medicaid or CHIP. Would create a three-year demonstration program that would allow up to ten states to use Express Lane eligibility determinations at Medicaid and CHIP enrollment and renewal. The demonstration would authorize and appropriate \$44 million for the period of FY2008 through FY2012 for systems upgrades and implementation. Of this amount, \$5 million would be dedicated to an independent evaluation of the demonstration for the Congress. Under the demonstration, states would be permitted to rely on a finding made by an Express Lane Agency within the preceding 12 months to determine whether a child has met one or more of the eligibility requirements (e.g., income, assets, citizenship or other criteria) necessary to determine an individual's eligibility for Medicaid or CHIP.</p> | <p>A§203. State option to rely on finding from an Express Lane agency to conduct simplified eligibility determinations. Like the House bill, beginning in January 2008, the agreement would allow states to rely on an eligibility determination finding made within a State-defined period from an Express Lane Agency to determine whether a child under age 19 (or up to age 21 at state option) has met one or more of the eligibility requirements (e.g., income, assets or resources, citizenship, or other criteria) necessary to determine an individual's initial eligibility, eligibility redetermination, or renewal of eligibility for medical assistance under Medicaid or CHIP. Under the agreement, however, states would be required to verify citizenship or nationality status, and such eligibility determinations would not be permitted after September 30, 2012.</p> | <p>Generally support the language in the House bill, which has no sunset date.</p> <p>Support providing federal grant funding to information technology development.</p> <p>Support directing the IRS, starting with tax year 2009, to modify basic income tax forms (140, 1040EZ, etc.) to give parents a chance to identify their uninsured children and to request use of tax data to determine eligibility for coverage. Further direct IRS to make pertinent data available to state Medicaid and SCHIP agencies, conditioned on satisfying data security and privacy requirements. Direct HHS to develop a menu of state responses ranging from sending the families an application form to granting Express Lane Eligibility based on income tax data.</p> <p>Support directing IRS to establish procedures for making income tax return information available to state health agencies, at the family's request, other than through the income tax form.</p> <p>Support including state and federal income tax data as a basis for Express Lane Eligibility.</p> |

**CURRENT LAW:** SCHIP 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 SCHIP be coordinated when States implement separate SCHIP programs. In these circumstances, applications for SCHIP coverage must first be screened for Medicaid eligibility.

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| <p>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 States would be required to determine Medicaid or CHIP eligibility using its regular procedures and to inform the family that they may qualify for lower premium payments if the family's income were directly evaluated for an eligibility determination by the State using its regular policies.</p> | <p>Like the House provision the Senate's provision would establish criteria for how a state would meet screen and enroll requirements, would not relieve states of their obligation to determine eligibility for Medicaid, and would require the state to inform families that they may qualify for lower premium payments or more comprehensive health coverage under Medicaid if the family's income were directly evaluated by the state Medicaid agency.</p> | <p>Same as House bill.</p>  | <p><b>Support conference language</b> while making sure legislative history authorizes the use of sampling to claim SCHIP FMAP for children who receive Medicaid based on these "screen and enroll" methods.</p>                             |
| <p>A child may receive health coverage based on Express Lane Enrollment or other third-party data without filing a formal Medicaid or CHIP application if the individual either provided advance consent to disclosure or has not objected to disclosure after receiving advance notice of disclosure and a reasonable opportunity</p>   | <p>A child may receive health coverage based on Express Lane Enrollment or other third-party data but if the child or the family affirmatively consents to being enrolled through affirmation and signature on an Express Lane agency application.</p>   | <p>Like the Senate bill, although the language allowing waiver of the signature requirement and allowance of an electronic signature was dropped.</p> | <p><b>Support the House language.</b></p> <p><u>Oppose</u> language requiring affirmation and a consent signature in order to receive health coverage, and instead, permit states to use other methods to obtain parental consent before</p> |

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| to object. | The State may waive any signature requirements for enrollment for a child who consents to, or on whose behalf consent is provided for, enrollment in the State Medicaid plan or the State CHIP plan and any signature may also allow an electronic signature. |  | children are enrolled. |
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**CURRENT LAW:** 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.

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| No provision.  | Error rates associated with incorrect eligibility determinations would be monitored.  | Same as Senate bill.      | <p><b>Support the House position.</b></p> <p>If the Senate language prevails, define error to mean that both of the following are true: (1) the Express Lane Eligibility agency reached an incorrect result in applying its own rules; and, (2) the child who received health coverage as a result was otherwise ineligible for Medicaid and for SCHIP.</p>   |
| Express Lane agencies would include public agencies determined by the State as capable of making eligibility determinations including public agencies that determine eligibility under the Food Stamp Act, the School Lunch Act, the Child Nutrition Act, or the Child Care Development Block Grant Act. | Express Lane agencies would include public agencies determined by the State as capable of making eligibility determinations and goes beyond list of agencies included in the House provisions to include additional public agencies such as those that determine eligibility under TANF, CHIP, Medicaid, Head Start, etc. Also included are state specified governmental agencies that have fiscal liability or legal responsibility for the accuracy of eligibility determination findings, and public agencies that are subject to an interagency agreement limiting the disclosure and use of such information for eligibility determination purposes. | Same as Senate bill.      | <p><b>Support adding public schools and federal and state income tax data as a basis for Express Lane Eligibility to the Senate and conference language.</b></p> <p><u>Oppose</u> efforts to prohibit allowing non-governmental agencies, including non-profit organizations, from sharing eligibility data with Medicaid and SCHIP, as it would limit and harm the ability for children to receive health coverage and create added and unnecessary bureaucracy for children to be enrolled.</p> |

The provision would explicitly exclude programs run through title XX (Social Services Block Grants) of the Social Security Act, and private for-profit organizations as agencies that would qualify as an Express Lane agency.

**CURRENT LAW:** Medicaid applicants must attest to the accuracy of the information submitted on their applications, and sign application forms under penalty of perjury.

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| <p>Signatures under penalty of perjury would not be required on a Medicaid application form attesting to any element of the application for which eligibility is based on information received from an Express Lane Agency or from another public agency. The provision would authorize federal or State agencies or private entities in possession of potentially pertinent data relevant for the determination of eligibility under Medicaid to share such information with the Medicaid agency for the purposes of child enrollment in Medicaid, and would impose criminal penalties for entities who engage in unauthorized activities with such data.</p> | <p>Like the House provision, the Senate bill 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 and would monitor error rates associated with incorrect eligibility determinations. Like the House bill, the provision would authorize entities in possession of potentially pertinent data relevant for the determination of eligibility under CHIP or Medicaid</p> | <p>Same as House bill, however, like the Senate bill the agreement would authorize entities in possession of potentially pertinent data relevant for the determination of eligibility under CHIP <i>or</i> Medicaid (e.g., the National Directory of New Hires database) to share such information with the CHIP <i>or</i> Medicaid agency (e.g., the National Directory of New Hires database) to share such information with the CHIP or Medicaid agency.</p> | <p>Support the conference language, but make sure that any option permitted under the “e-signature” statute can be used to meet the Medicaid signature requirement.</p> |
| <p>No provision.</p>   | <p>The Senate bill would authorize and appropriate \$5 million in new federal funds for fiscal years 2008 through FY2011 for the purpose of conducting an evaluation of the effectiveness of these demonstration programs. The Secretary would be required to submit a report to Congress with regard to the evaluation findings no later than September 30, 2011.</p>   | <p>Like the Senate bill, the agreement would authorize and appropriate \$5 million in new federal funds for fiscal years 2008 through FY2011 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, 2011.</p>  |   |

**PROVISION: OUT-STATIONED ELIGIBILITY DETERMINATIONS**

**CURRENT LAW:** Under current law, a Medicaid state plan must provide for the receipt and initial processing of applications for medical assistance for low-income pregnant women, infants, and children under age 19 at outstation locations other than Temporary Funding for Needy Assistance (TANF) offices such as, disproportionate share hospitals, and Federally-qualified health centers. State eligibility workers assigned to outstation locations perform initial processing of Medicaid applications including taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete processing of the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews.

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| <p><b>H§113 Application of Medicaid outreach procedures to all children and pregnant women.</b> Effective January 1, 2008, the House bill would provide for the receipt and initial processing of applications for medical assistance for children and pregnant women under any provision of this title, and would allow for such application forms to vary across outstation locations.</p> | <p>No provision.</p>     | <p>No provision.</p> | <p>Support the House language.</p> |

**PROVISION: FUNDING FOR OUTREACH AND ENROLLMENT**

**CURRENT LAW:** Under current law, title XXI specifies that federal SCHIP funds can be used for SCHIP health insurance coverage which meets certain requirements. Apart from these benefit payments, SCHIP payments for four other specific health care activities can be made, including (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of SCHIP children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, payments for other specific health care activities cannot exceed 10% of the total amount of expenditures for SCHIP benefits and other specific health care activities combined. The federal and state governments share in the costs of both Medicaid and SCHIP, 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%, but certain administrative functions have a higher federal matching rate.

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| <p><b>H§114 Encouraging culturally appropriate enrollment and retention practices.</b> The provision would permit states to receive Medicaid federal matching payments for translation or interpretation services in connection with the enrollment and use of services by individuals for whom English is not their primary language. Payments for this activity would be matched at 75% FMAP rate.</p> | <p><b>S§201 Grants for outreach and enrollment.</b> The provision would set aside \$100 million (during the period of fiscal years 2008 through 2012) for a grant program under CHIP to finance outreach and enrollment efforts that increase participation of Medicaid and CHIP-eligible children. Such amounts would not be subject to current law restrictions on expenditures for outreach activities. For such period, 10% of the funding would be dedicated to a national enrollment campaign, and 10% would be</p> | <p><b>A§201. Grants and enhanced administrative funding for outreach and enrollment.</b> Same as Senate bill with the following changes: (1) the agreement is silent as to whether grant funds would be subject to current law restrictions on expenditures for outreach activities, (2) in addition to the enhanced matching rate available for translation and interpretation services under CHIP, the agreement would also provide a 75% FMAP rate for translation and interpretation services</p> | <p>Support the conference language, as two-thirds of this nation's uninsured children are eligible but unenrolled in Medicaid or CHIP.</p> |

set-aside for grants for outreach to, and enrollment of, children who are Indians. Remaining funds would be distributed to specified entities to conduct outreach campaigns that target geographic areas with high rates of eligible but not enrolled children who reside in rural areas, or racial and ethnic minorities and health disparity populations. Grant funds would also be targeted at proposals that address cultural and linguistic barriers to enrollment. Finally it would provide the greater of 75%, or the sum of the enhanced FMAP for the state plus five percentage points for translation and interpretation services under CHIP by individuals for whom English is not their primary language.

under Medicaid, and (3) the agreement would allow for the use of Community Health Workers for outreach activities.

**PROVISION: CONTINUOUS ELIGIBILITY UNDER CHIP**

**CURRENT LAW:** States are required to redetermine Medicaid and SCHIP eligibility at least every 12 months with respect to circumstances that may change and affect eligibility. Continuous eligibility allows a child to remain enrolled for a set period of time regardless of whether the child's circumstances change (e.g., the family's income rises above the eligibility threshold), thus making it easier for a child to stay enrolled. Not all states offer it, but among those that do the period of continuous eligibility ranges from 6 months to 12 months.

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| H§115 continuous eligibility under CHIP The House bill would require separate CHIP programs (or CHIP programs operating under the Section 1115 waiver authority) to implement 12 months of continuous eligibility for targeted low-income children whose annual family income is less than 200% FPL. | No provision.            | No provision.      | Support the House language. |

**PROVISION: COMMISSION TO MONITOR ACCESS AND OTHER MATTERS**

**CURRENT LAW:** In accordance with P.L. 92-263, in May of 2005, the Secretary of HHS established a Medicaid Commission, to provide advice on ways to modernize Medicaid so that it could provide high quality health care to its beneficiaries in a financially sustainable way. The charter for this Commission included rules regarding voting and non-voting members, meetings, compensation, estimated costs, and two reports. The Commission terminated 30 days after submission of its final report to the Secretary of HHS

(dated December 29, 2006). No ongoing Commission has ever existed for the program.

| <b>HOUSE: H.R. 3162</b>  | <b>SENATE: S. 1893/H.R. 976</b> | <b>AGREEMENT H.R. 976</b> | <b>JOINT POLICY RECOMMENDATION</b> |
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| <p><b>H§141. Children's Access, Payment and Equality Commission.</b> Would establish a new federal commission. Among many tasks, this new Commission would review (1) factors affecting expenditures for services in different sectors, payment methodologies, and their relationship to access and quality of care for Medicaid and CHIP beneficiaries, (2) the impact of Medicaid and CHIP policies on the overall financial stability of safety net providers (e.g., FQHCs, school-based clinics, disproportionate share hospitals), and (3) the extent to which the operation of Medicaid and CHIP ensures access comparable to access under employer-sponsored or other private health insurance. Commission recommendations would be required to consider budget consequences, be voted on by all members, and the voting results would be included in Commission reports. Certain MEDPAC provisions would apply to this new commission (i.e., relating to membership with the addition of Medicaid and CHIP beneficiary representatives, staff and consultants, and powers). The provision would authorize to be appropriated such sums as necessary to carry out the duties of the new commission.</p> | <p>No provision.</p>            | <p>No provision.</p>      | <p>Support the House language.</p> |

**PROVISION: MODEL ENROLLMENT PRACTICES**

**CURRENT LAW:** No provision.

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| <p><b>H§142 Model of interstate coordinated enrollment and coverage process.</b> The House bill would require the Comptroller</p> | <p>No provision.</p>            | <p><b>A§213. Model of interstate coordinated enrollment and coverage process.</b> Like the House bill, except the agreement</p> | <p>Support either the House or conference language.</p> |

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| <p>General, 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.</p> |  | <p>would require <i>the Secretary of HHS</i>, 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.</p> |  |
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**PROVISION: CITIZENSHIP DOCUMENTATION**

**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 SCHIP. However, since some states use the same enrollment procedures for all Medicaid and SCHIP applicants, it is possible that some SCHIP enrollees would be asked to present evidence of citizenship.

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| <p><b>H§143. Medicaid citizenship documentation requirements.</b> The House bill would make Medicaid citizenship documentation for children under age 21 a state option, using criteria that are no more stringent than the existing documentation specified in section 1903(x)(3) of the Social Security Act. See <b>H§136</b> (under Miscellaneous) for auditing requirements. See <b>H§112(a)</b> for ability of “Express Lane” agencies to determine eligibility without citizenship documentation.</p> | <p><b>S§301. Verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP.</b> The Senate bill 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</p> | <p><b>A§211. Verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP.</b> Same as the Senate bill regarding a new option for meeting citizenship documentation requirements, except that 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</p> | <p>Support repeal of documentation language from the Deficit Reduction Act (DRA).</p> <p>If not, support citizenship documentation to be a state option rather than a mandate.</p> <p>If conference language proceeds, allow for changes to strict documentation requirements required by CMS regulations, such as allowing copies of documents and allow for coverage pending verification of citizenship and allow for use of SAVE for non-citizens and naturalized citizens.</p> |

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|  | <p>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, notifying the individual, providing 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 disenrolling the individual within 30 days after the end of the 90-day period if evidence is not provided.</p> | <p>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.</p>  |  |
|  | <p>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 that has attained the age of 1 before the date of the enrollment.</p>  | <p>Same as the Senate bill, except that states would only submit the name and SSN of newly enrolled individuals who are not exempt from the citizenship documentation requirement.</p>  |  |
|  | <p>In establishing the program, the state would be allowed to enter into an agreement with the Commissioner to provide for the electronic submission and verification of the name and SSN of an individual before the individual is enrolled.</p>   | <p>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; (2) to submit to the Commissioner the names and SSNs of such individuals on a batch basis, provided that such batches are submitted at least on a monthly basis; or (3) 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</p> |  |

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|  |   | <p>such method is no more burdensome for individuals to comply with than any burdens that may apply under a method described in (1) or (2). The program would be required to provide that, in the case of any individual who is required to submit an 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.</p>  |  |
|  | <p>States would be required 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 7%.</p> <p>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.</p> | <p>States would be required 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%. 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.</p> |  |

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|   | <p>States would receive 90% reimbursement for costs attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement name and SSN validation, and 75% for the operation of such systems.</p>  | <p>Same as the Senate bill.</p>   |   |
| <p>Groups that are exempt from the citizenship documentation requirement would remain the same as under current law, except for 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 (note that H§131(b)(1) is also relevant because it would explicitly allow one year of deemed eligibility for all children born to women on Medicaid, including emergency Medicaid, by removing 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) of the Social Security Act). The provision would require additional documentation options for federally recognized Indian tribes. It would also specify that states must provide citizens with 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 and must not deny medical assistance on the basis of failure to provide such documentation until the individual has had such an opportunity.</p> | <p>The Senate provision would also clarify requirements under the existing section 1903(x). It is similar to the House provision regarding 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 to be issued by regulations, and the reasonable opportunity to present evidence. However, the Senate provision would not include additional language to reiterate that states must not deny medical assistance on the basis of failure to provide documentation until an individual has had a reasonable opportunity. In addition, although the Senate 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 bill would not 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).</p> | <p>Same as the Senate bill, except that A§113(b)(1) would remove the requirement that a newborn remain in his or her Medicaid-eligible mother's household in order to qualify for deemed eligibility.</p> | <p><b>Support the House language</b>, especially with respect to the deemed eligibility provision, the added documentation options for Native Americans, and the adding of the reasonable opportunity period.</p> |
|   | <p>The Senate provision would make citizenship documentation a requirement</p>   | <p>Same as the Senate bill.</p>   | <p><b>Oppose the Senate and conference language of imposing citizenship</b></p>   |

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|  | <p>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% and 75% reimbursement for name and SSN validation would be available under CHIP, and would not count towards a state's CHIP administrative expenditures cap.</p> |                                 | <p>documentation requirements to CHIP when there is no evidence it prevents coverage by undocumented immigrants but instead limits coverage by U.S. citizen children.</p> |
| <p>These changes would be effective as if included in the Deficit Reduction Act of 2005. States would be allowed to provide retroactive eligibility for certain individuals who had been determined ineligible under previous citizenship documentation rules.</p> | <p>Except for clarifications made to the existing citizenship documentation requirement, which would be retroactive, the provision would be effective on October 1, 2008. States would be allowed to provide retroactive eligibility for certain individuals who had been determined ineligible under previous citizenship documentation rules.</p>   | <p>Same as the Senate bill.</p> |   |

**PROVISION: ELIMINATION OF NEW HEALTH OPPORTUNITY ACCOUNTS**

**CURRENT LAW:** The Deficit Reduction Act of 2005 allowed the Secretary of HHS to establish no more than 10 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. As of July 2007, South Carolina was the only state to receive CMS approval for a Health Opportunity Account Demonstration.

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| <p>H§145 Prohibiting initiation of new health opportunity account demonstration programs. The House bill would prohibit the Secretary of HHS from approving any new Health Opportunity Account demonstrations as of the date of enactment of this Act.</p> | <p>No provision.</p>            | <p>A§613. Prohibiting initiation of new health opportunity account demonstration programs. Same as House bill.</p> | <p>Support the House and conference language.</p> |

**PROVISION: OUTREACH AND ENROLLMENT OF INDIANS**

**CURRENT LAW:** State SCHIP 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 SCHIP (e.g., for other child health assistance, health service initiatives, outreach, and program administration) cannot exceed 10%

of the total amount of expenditures for benefits and these non-benefit payments combined.

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| No provision.    | S§202. Increased outreach and enrollment of Indians. Would encourage states to take steps to enroll Indians residing in or near reservations in Medicaid and CHIP. These steps may include outstationing of eligibility workers [at certain hospitals and Federally Qualified Health Centers]; 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. This provision would also exclude costs for outreach to potentially eligible Indian children and families from the 10% cap on non-benefit expenditures under CHIP. | A§202. Increased outreach and enrollment of Indians. Same as the Senate bill. | Support the Senate and conference language. |

**PROVISION: ELIGIBILITY INFORMATION DISCLOSURE**

**CURRENT LAW:** Under current law, each State must have an income and eligibility verification system under which (1) applicants for Medicaid and several other specified government programs must furnish their Social Security numbers to the state as a condition for eligibility, and (2) wage information from various specified government agencies is used to verify eligibility and to determine the amount of the available benefits. 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, unearned income, unemployment information, etc.

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| No provision.    | S§204 Authorization of certain information disclosures to simplify health coverage determinations. The Senate bill 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 | A§203. State option to rely on finding from an Express Lane agency to conduct simplified eligibility determinations. Same as Senate bill, but included in the "Express Lane" eligibility provision. | Support the Senate bill or the conference language. |

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 (1) the National New Hires Database, (2) the National Income Data collected by the Commissioner of Social Security, or (3) data about enrollment in insurance that may help to facilitate outreach and enrollment under Medicaid, CHIP, and certain other programs.

**PROVISION: REDUCING ADMINISTRATIVE BARRIERS TO ENROLLMENT**

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

| <b>HOUSE: H.R. 3162</b> | <b>SENATE: S. 1893/H.R. 976</b>  | <b>AGREEMENT H.R. 976</b>  | <b>JOINT POLICY RECOMMENDATION</b>               |
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| No provision.           | §§302 <b>Reducing administrative barriers to enrollment.</b> The Senate bill 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. | A§212. <b>Reducing administrative barriers to enrollment.</b> Same as Senate bill. | Support the Senate bill and conference language. |

**PROVISION: PREVENTING CROWD-OUT**

**CURRENT LAW:** Current law and regulations require that state SCHIP plans include procedures to ensure that SCHIP coverage does not substitute for coverage provided in group health plans (also know as “crowd out”). State SCHIP plans must also include procedures for outreach and coordination with other public and private health insurance

programs. On August 17, 2007, the Bush Administration released a letter to state health officials to explain how CMS would apply these existing requirements in reviewing state requests to extend SCHIP eligibility to children in families with income exceeding 250% FPL. Such states will now be required to implement specific crowd-out prevention strategies, including some already adopted by many states (e.g., imposing waiting periods, requiring cost-sharing similar to policies for private coverage, verifying family insurance status). Such states must also provide certain assurances regarding policies targeting the “core” low-income child population (e.g., enrollment of at least 95% of children below 200% FPL in either Medicaid or SCHIP) and policies expected to minimize crowdout (e.g., monitoring changes in private insurance coverage for the target population). While all states will be monitored for adherence to these policies, states covering children above 250% FPL are expected to amend their state SCHIP plans (and/or waivers as applicable) in accordance with this review strategy within 12 months, or CMS may pursue corrective action.

| HOUSE: H.R. 3162 | SENATE: S. 1893/H.R. 976 | AGREEMENT H.R. 976   | JOINT POLICY RECOMMENDATION   |
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| No provision.    | No provision.            | <p><b>A§116. Preventing substitution of CHIP coverage for private coverage.</b> The agreement defines “CHIP crowdout” as the substitution of CHIP coverage for health benefits coverage other than Medicaid or CHIP. The agreement would require that states already covering children with income exceeding 300% FPL (and beginning in 2010, new states that propose to do so) to describe how they will address crowd-out and implement “best practices” to avoid crowd-out (to be developed by the Secretary in consultation with state). Beginning in 2010, these “higher income eligibility states” cannot have a rate of public and private coverage for low-income children that is statistically significantly less than the “target rate of coverage of low-income children” (i.e., the average rate of both private and public health benefits coverage as of 1/1/10, among the 10 states and DC with the highest percentage of such coverage, to be calculated by the Secretary). States that fail to meet this requirement in a given fiscal year would not receive any federal CHIP payments for higher income children until they are able to establish that they are in compliance with this rule. States would have an opportunity to submit and implement a corrective action plan prior to the start of the affected fiscal year. The Secretary would not be</p> | <p><b>Support no provision</b> as it may discourage states from undertaking expansions of coverage that would provide coverage to all of our nation’s children. Also, Congress can ask for a GAO report without having to seek one through legislation.</p> |

permitted to deny payments before the beginning of such a fiscal year and must not deny payments if there is a reasonable likelihood that the corrective action plan would bring the state into compliance with the target rate of coverage for low-income children. Not later than 18 months after the date of enactment of this Act, GAO would be required to submit to the Congressional committees with jurisdiction over CHIP and the Secretary of HHS, a report describing the best practices of states in addressing CHIP crowd-out. Analyses must address several issues, including (1) the impact of different geographic areas (urban versus rural) and different labor markets on CHIP crowd-out, (2) the impact of different strategies for addressing CHIP crowd-out, (3) the incidence of crowd-out at different income levels, and (4) the relationship between changes in the availability and affordability of dependent coverage under employer-sponsored health insurance and CHIP crowd-out. In addition, not later than 18 months after the date of enactment of this Act, the IOM would be required to submit to the Congressional committees with jurisdiction over CHIP and the Secretary, a report on the most accurate, reliable and timely way to measure (1) state-specific rates of public and private health benefits coverage among children with income below 200% FPL, (2) CHIP crowd-out, including for children with income exceeding 200% FPL, and (3) the least burdensome way to obtain the necessary data to conduct these measurements. The agreement appropriates \$2 million for this IOM study for the period ending September 30, 2009.

**PROVISION: MEDICAL CHILD SUPPORT UNDER SCHIP**

**CURRENT LAW:** The Child Support Enforcement Program, within the Administration for Children and Families, provides assistance in obtaining support (both financial and medical) to children through locating parents, establishing paternity and support obligations, and enforcing those obligations. The federal government has a major role in determining the main components of state programs, funding, monitoring, and providing technical assistance, but the basic responsibility of administering the Child Support Enforcement Program is left to the states. Provisions for health insurance coverage, called medical support, are required to be included in support orders and may affect a child's eligibility for SCHIP.

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| No provision.    | No provision.            | <p><b>A§116(f). Treatment of medical support order.</b> The agreement would specify that nothing in title XXI of the Social Security Act (CHIP) shall be construed to allow the Secretary to require that a state deny CHIP eligibility for a targeted low-income child on the basis of the existence of a valid medical support order being in effect. A state could elect to limit eligibility on the basis of the existence of a valid medical support order, but only if the state does not deny eligibility in cases where the child asserts that the order is not being complied with for specified reasons (failure of the custodial parent to comply with the order; failure of an employer, group health plan or health insurance issuer to comply with such an order; or the child resides in a geographic area in which benefits under the health benefits coverage are generally unavailable), unless the state demonstrates that none of the reasons apply.</p> | <p>Concerned that medical support creates barriers to enrollment so <b>urge a review of this language before its adoption in order to minimize harm.</b></p> |

**PROVISION: SPECIAL ENROLLMENT PERIOD**

**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 fulltime 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.

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| No provision.    | S§411 Special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage or eligibility for assistance in purchase of employment-based coverage; coordination of care. The bill 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. The bill would also require employers to: share information about their benefit packages with states so states can evaluate the need to provide “wraparound” coverage, and notify families of their potential eligibility for premium assistance. | A§311. Special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage or eligibility for assistance in purchase of employment-based coverage; coordination of coverage. Same as Senate bill. | Support the Senate bill and conference language. |

## PROVISION: DENTAL SERVICES

**CURRENT LAW:** Under SCHIP, states may provide coverage under their Medicaid programs, create a new separate SCHIP program, or both. Under separate SCHIP programs, 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 (called 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% 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 SCHIP 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 receive comprehensive basic screening services (i.e., well-child visits including age-appropriate immunizations) as well as dental, vision and hearing services. In addition, EPSDT guarantees access to all federally coverable services necessary to treat a problem or condition among eligible individuals. 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.

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| H§121. Ensuring child-centered coverage. The provision would make | S§608. Dental health grants. As amended, would provide authority for | A§501. Dental benefits. The provision regarding dental benefits under CHIP in | Support the conference language, but should also include an option for states |

dental services a required benefit under CHIP. States would also be required to assure access to these services. The effective date would be October 1, 2008.

**H§144. Access to dental care for children.** The provision would require the Secretary of HHS to develop and implement a program to deliver oral health education materials that inform new parents about risks for, and prevention of, early childhood caries and the need for a dental visit within a newborn's first year of life. States could not prevent an FQHC from entering into contractual relationships with private practice dental providers under both Medicaid and CHIP (effective January 1, 2008). The data that states submit to the federal government documenting receipt of EPSDT services each fiscal year would be required to include parallel information on receipt of dental services among CHIP children. This reporting requirement would also apply to annual state CHIP reports. Such reporting would be required to include information on children enrolled in managed care plans, other private health plans, and contracts with such plans under CHIP (effective for annual state CHIP reports submitted for years beginning after the date of enactment of this Act). In addition, GAO would be required to conduct a study examining access to dental services by children in underserved areas, and the feasibility and appropriateness of using qualified mid-level dental providers to improve access. A report on this GAO study would be due not later than one year after the date of enactment of this Act.

new dental health grants to improve the availability of dental services and strengthen dental coverage for children under CHIP. To be awarded such a grant, states would describe quality and outcomes performance measures to be used to evaluate the effectiveness of grant activities, and must assure that they will cooperate with the collection and reporting of data to the Secretary of HHS, among several requirements. Grantees would be required to maintain state funding of dental services under CHIP at the level of expenditures in the fiscal year preceding the first fiscal year for which the new grant is awarded. Such states would not be required to provide any state matching funds for the new dental grant program. The Secretary would be required to submit to Congress an annual report on state activities and performances assessments under the new dental grant program. For the period FY2008 through FY2012, \$200 million would be appropriated for this grant program, to remain available until expended. The provision would also require the Secretary of HHS to include on the *Insure Kids Now* website and hotline a current and accurate list of all dentists and other dental providers in each state that provide such services to Medicaid and CHIP children, and must update this listing at least on a quarterly basis. The Secretary would also be required to work with states to include a description of covered dental services for children under both programs (including under applicable waivers) for each state, and must post this information on the *Insure Kids Now* website. The provision would require GAO to conduct a study on children's access to oral health care, including preventive and restorative

the agreement includes selected provisions in both the Senate and House bills, as well as new provisions. Under the agreement, 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 benefit packages." These 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 2 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. As in the House bill (Sec. 121), states would be required to assure access to dental services under CHIP. The effective date of these provisions would be October 1, 2008. The agreement also includes provisions from the House bill (Sec. 144) for (1) dental education for parents of newborns, (2) dental services through Federally Qualified Health Care Centers (FQHCs), and (3) reporting information on dental services for children. The agreement includes the provision in the Senate bill (with some modifications) regarding information on dental providers and descriptions of covered dental services

to provide wrap-around coverage for dental and mental health services through CHIP to augment private coverage so that families do not have to drop private insurance to get dental and mental health benefits through CHIP (also see mental health coverage below).

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 would be due not later than two years after the date of enactment of this Act). Also the provision would add an assessment of the quality of dental care provided to Medicaid and CHIP children to the Secretary's annual reports to Congress under the new child health quality improvement activities authorized in the Senate-passed bill.

under Medicaid and CHIP, to be made available to the public via the *Insure Kids Now* website and hotline. The agreement 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 (Sec. 501 of the Senate bill). Finally, the GAO study of dental services for children in the agreement follows the Senate bill with some additional provisions taken from the House bill (e.g., regarding the availability of mid-level dental providers). In addition, this GAO study would be due within 18 months of the date of enactment of this Act, rather than within 2 years as under the Senate bill.

**PROVISION: SERVICES PROVIDED BY FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) AND RURAL HEALTH CENTERS (RHCS)**

**CURRENT LAW:** In SCHIP statute, a number of coverable benefits are listed such as “clinic services (including health center services) and other ambulatory health care services.” Services provided by FQHCs and RHCs are a mandatory benefit for most beneficiaries under Medicaid.

| HOUSE: H.R. 3162   | SENATE: S. 1893/H.R. 976 | AGREEMENT H.R. 976 | JOINT POLICY RECOMMENDATION |
|--|--------------------------|--------------------|-----------------------------|
| H§121. Ensuring child-centered coverage. The provision would make the services provided by FQHCs and RHCs required benefits under CHIP. States would also be required to assure access to these services. The effective date would be October 1, 2008. | No provision.            | No provision.      | Support the House language. |

**PROVISION: MENTAL HEALTH SERVICES**

**CURRENT LAW:** For an explanation of the benchmark coverage options under SCHIP, see the current law description in the “dental services” row above. Under the Mental Health Parity Act (MHPA), Medicaid and SCHIP plans may define what constitutes mental health benefits (if any). The MHPA prohibits group plans from imposing annual and lifetime dollar limits on mental health coverage that are more restrictive than those applicable to medical and surgical coverage. Full parity is not required, that is, group plans may still impose more restrictive treatment limits (e.g., with respect to total number of outpatient visits or inpatient days) or cost-sharing requirements on mental health coverage compared to their medical and surgical services.

| HOUSE: H.R. 3162               | SENATE: S. 1893/H.R. 976            | AGREEMENT H.R. 976                  | JOINT POLICY RECOMMENDATION      |
|--------------------------------|-------------------------------------|-------------------------------------|----------------------------------|
| H§121. Ensuring child-centered | S§607. Mental health parity in CHIP | A§502. Mental health parity in CHIP | Support the House language and a |

**coverage.** The provision would increase the minimum actuarial value for mental health services from 75% to 100% for benchmark-equivalent coverage under CHIP. The effective date would be October 1, 2008.

**plans.** The provision 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.

**plans.** Same as Senate bill.

**provision clarifying that the Paul Wellstone Mental Health and Addiction Parity Act (P.L. #110-343) applies to all CHIP plans.**

Also support making mental health a required benefit and for providing a state option to provide wrap-around coverage for dental and mental health services through CHIP to augment private coverage so that families do not have to drop private insurance to get dental and mental health benefits through CHIP (also see dental coverage above).

**PROVISION: EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) SERVICES**

**CURRENT LAW:** The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) gave states the option to provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage that is nearly identical to plans available under SCHIP (described above in the “dental services” row). 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. In traditional Medicaid, EPSDT is available to most individuals under age 21.

| <b>HOUSE: H.R. 3162</b>   | <b>SENATE: S. 1893/H.R. 976</b>   | <b>AGREEMENT H.R. 976</b>   | <b>JOINT POLICY RECOMMENDATION</b>      |
|---|---|---|---|
| <p><b>H§121. Ensuring child-centered coverage.</b> The provision would require coverage of the EPSDT benefit for individuals under age 21, whether such persons are enrolled in benchmark plans, benchmark-equivalent plans or otherwise under Medicaid. The effective date would be the same as the original DRA provision (i.e., March 31, 2006).</p> | <p><b>S§605. Deficit Reduction Act technical corrections.</b> The provision would require that EPSDT be covered for any individual under age 21 who is eligible for Medicaid through the state Medicaid plan under one of the major mandatory and optional coverage groups and is enrolled in benchmark or benchmark-equivalent plans authorized under DRA. The provision would also give states flexibility in providing coverage of EPSDT services through the issuer of benchmark or benchmark-equivalent coverage or otherwise. In addition, the Secretary would be required to publish in the <i>Federal Register</i> and on the internet website of CMS, a list of the provisions in Title XIX that the Secretary has determined do not apply in order to</p> | <p><b>A§611(a). Deficit Reduction Act technical corrections - Clarification of requirement to provide EPSDT services for all children in benchmark benefit packages under Medicaid.</b> Same as the Senate bill with some modifications. The agreement 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 includes language from the House bill that specifies that an individual’s entitlement to EPSDT services remains intact under the benchmark benefit package option under Medicaid.</p> | <p>Support the conference language.</p> |

enable a state to carry out a state plan amendment to provide benchmark or benchmark-equivalent coverage under Medicaid. In such publications, the Secretary must also provide the reason for each such determination. The effective date would be the same as the original DRA provision (i.e., March 31, 2006).

**PROVISION: EVIDENCE-BASED NURSE HOME VISITATION**

**CURRENT LAW:** Some limited nurse home visitation services are currently covered under Medicaid targeted case management and administrative case management services. However, coverage is inadequate and inconsistent to meet the needs of low-income children and families.

| HOUSE: H.R. 3162 | SENATE: S. 1893/H.R. 976 | AGREEMENT H.R. 976 | JOINT POLICY RECOMMENDATION  |
|------------------|--------------------------|--------------------|--|
| No provision.    | No provision.            | No provision.      | Support the inclusion of language from the Salazar-Specter and DeGette-Capps-Murphy bills (S. 1052/H.R. 3024) to re-categorize existing coverage under Medicaid into a new option for States to cover all appropriate nurse home visitation services, while leaving existing options intact. Creates a new option for nurse home visitation under SCHIP. |

**PROVISION: SCHOOL-BASED HEALTH CENTERS SERVICES**

**CURRENT LAW:** A number of coverable benefits are listed in the SCHIP statute, such as “clinic services (including health center services) and other ambulatory health care services.”

| HOUSE: H.R. 3162  | SENATE: S. 1893/H.R. 976 | AGREEMENT H.R. 976   | JOINT POLICY RECOMMENDATION  |
|---|--------------------------|--|--|
| H§121. Ensuring child-centered coverage. The provision would add to the “clinic services” benefit category in CHIP statute “school-based health center services” for which coverage is otherwise provided under this title. Such providers must be authorized to cover such CHIP services under state law. The effective date would be on or after the date of enactment of this Act. | No provision.            | A§506. Clarification of coverage of services provided through school-based health centers. The agreement provides 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. | Support the inclusion of language from the Stabenow and Towns bills on this issue. |

**PROVISION: BENCHMARK COVERAGE OPTIONS**

**CURRENT LAW:** Under SCHIP, states may provide coverage under their Medicaid programs, create a new separate SCHIP program, or both. Under separate SCHIP programs, 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 (called 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% 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). The DRA also allowed similar benchmark coverage options under Medicaid.

| HOUSE: H.R. 3162  | SENATE: S. 1893/H.R. 976 | AGREEMENT H.R. 976   | JOINT POLICY RECOMMENDATION        |
|---|--------------------------|----------------------|------------------------------------|
| <p><b>H§121. Ensuring child-centered coverage.</b> The provision would require that benchmark coverage under CHIP be at least equivalent to the benchmark benefit packages specified in statute. The effective date would be October 1, 2008.</p> <p><b>H§122. Improving benchmark coverage options.</b> The provision would continue to allow Secretary-approved coverage under both CHIP and the DRA option under Medicaid, but only if such coverage is at least equivalent to a benchmark benefit package. The provision would also more explicitly define state employees benchmark coverage for both CHIP and the DRA option for Medicaid to include the state employee plan that has been selected the most frequently, by employees seeking dependent coverage, among such plans that provide dependent coverage, in either of the previous two years. The effective date would be October 1, 2008.</p> | <p>No provision.</p>     | <p>No provision.</p> | <p>Support the House language.</p> |

**PROVISION: EXTENSION OF FAMILY PLANNING SERVICES AND SUPPLIES**

**CURRENT LAW:** State Medicaid programs must offer family planning services and supplies to categorically needy individuals of childbearing age, including minors considered to be sexually active. Family planning services must be available to eligible pregnant women through the 60th day following the end of the pregnancy. Coverage of the medically needy other than pregnant women may include family planning. States receive a 90% federal matching rate for expenditures attributable to the offering, arranging, and furnishing of family planning services and supplies.

| HOUSE: H.R. 3162  | SENATE: S. 1893/H.R. 976 | AGREEMENT H.R. 976   | JOINT POLICY RECOMMENDATION        |
|---|--------------------------|----------------------|------------------------------------|
| <p><b>H§802 Family planning services.</b> The House bill would create a state option to extend family planning services and supplies (at the 90% federal Medicaid match rate) to women who are not pregnant and whose annual income does not exceed the highest income eligibility level established under the Medicaid State plan (or under title XXI) for pregnant women. States would be permitted to include individuals eligible for Medicaid §1115 family planning waivers that were approved as of January 1, 2007.</p> <p>Federal financial participation for medical assistance made available to such individuals would be limited to family planning services and supplies including medical diagnosis or treatment services, and only for the duration of the woman's eligibility under this state option or during a period of presumptive eligibility.</p> <p>Finally, the House bill would prohibit the enrollment of such individuals in a Medicaid benchmark and benchmark equivalent state plan option, unless such coverage includes medical assistance for family planning services and supplies.</p> | <p>No provision.</p>     | <p>No provision.</p> | <p>Support the House language.</p> |

**PROVISION: QUALITY MEASUREMENT**

**CURRENT LAW:** The Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) are both actively involved in funding and implementing an array of quality improvement initiatives, though only AHRQ has engaged in activities specific to children. 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% and a maximum of 83%. All states receive a 90% match for family planning services. The federal matching rates for administrative expenses does not vary by state and is generally 50%, but certain administrative functions have a higher federal match. For example, a 75% 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%.

| HOUSE: H.R. 3162   | SENATE: S. 1893/H.R. 976  | AGREEMENT H.R. 976  | JOINT POLICY RECOMMENDATION   |
|--|---|---|---|
| <p><b>H§151. Pediatric health quality measurement program.</b> The provision</p> | <p><b>S§501. Child health quality improvement activities for children</b></p> | <p><b>A§401. Child health quality improvement activities for children</b></p> | <p>Supports the language and provisions in the conference report,</p> |

would require the Secretary to establish a child health care quality measurement program. The purpose would be to develop and implement pediatric quality measures, a system for reporting such measures, and measures of overall program performance that may be used by public and private health care purchasers. By September 30, 2009, the Secretary would be required to publish the recommended measures for years beginning with 2010. In developing and implementing this program, the Secretary would be required to consult with a number of entities. The Secretary could award grants and contracts to develop, validate and disseminate these measures, and would be required to provide technical assistance to states to establish such reporting under Medicaid and CHIP. By January 1, 2009, and annually thereafter, the Secretary would be required to make available in an on-line format a complete list of all measures in use by states to measure the quality of medical and dental services provided to Medicaid and CHIP children. By January 1, 2010, and every two years thereafter, the Secretary would be required to report to Congress on the quality of care for children enrolled in CHIP and Medicaid, and patterns of utilization by pediatric characteristics.

**enrolled in Medicaid or CHIP.** The provision 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 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 10 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 (\$5 per year). The Secretary would be required to submit a report to Congress on this demonstration.

**enrolled in Medicaid or CHIP.** Same as the Senate bill. Adds a construction specifying that nothing in this provision supports restricting coverage under Medicaid and CHIP to only those services that are evidence-based.

**Also recommend greater emphasis upon improving primary child health care services, with an expanded definition of child health quality measures in and outcomes for primary care and incentives to states to strengthen the provision of evidenced-based well child care.**

**First Focus also supports creating an Office within CMS focused specifically on improving child health, with an emphasis upon primary care and prevention and reducing health disparities.**

The Secretary would also be required to establish a program to encourage the creation and dissemination of a 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.

**PROVISION: INFORMATION ON ACCESS TO COVERAGE UNDER CHIP**

**CURRENT LAW:** Annually, states submit reports to the Secretary of HHS assessing the operation of their SCHIP 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 identified in the state plan, effectiveness of discouraging substitution of public coverage for private coverage, identification of expenditures by type of beneficiary (e.g., children versus adults), and current income standards and methodologies.

| <b>HOUSE: H.R. 3162</b> | <b>SENATE: S. 1893/H.R. 976</b>  | <b>AGREEMENT H.R. 976</b>   | <b>JOINT POLICY RECOMMENDATION</b> |
|-------------------------|--|---|------------------------------------|
| No provision.           | <b>S§502. Improved information regarding access to coverage under CHIP.</b> The provision would add several reporting requirements to states' annual CHIP reports that are submitted to the Secretary of HHS. Examples of these new reporting requirements include (1) data on eligibility criteria, enrollment and continuity of coverage, (2) use of self-declaration of income for applications and renewals, and presumptive eligibility, (3) data on denials of eligibility and redeterminations of eligibility, (4) data regarding access to primary and specialty | <b>A§402. Improved availability of public information regarding enrollment of children in CHIP and Medicaid.</b> Same as Senate bill. The agreement adds a requirement that the Secretary specify a standardized format for states to use to report the new data required by the bill within one year of the date of enactment of this Act. Applicable states would be given up to 3 reporting periods to transition to the reporting of these new data in accordance with this standardized format. In addition, the agreement requires the Secretary to | Support the conference language.   |

care, networks of care and care coordination, and (5) if the state provides premium assistance for employer-based insurance, data regarding the extent to which such coverage is available to CHIP children, the range of monthly premium amounts, the number of children/families receiving such assistance on a monthly basis, the income level of the children/families involved, the benefits and cost-sharing protections for such children/families, the strategies used to reduce administrative barriers to such coverage, and the effects of such premium assistance on preventing substitution of CHIP coverage for employer-based coverage. The provision would also require GAO 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.

improve the timeliness of the data reported and analyzed from the Medicaid Statistical Information System (MSIS) with respect to enrollment and eligibility for children under Medicaid and CHIP, and to provide guidance to states regarding any new reporting requirements related to such improvements. For this purpose, the agreement appropriates \$5 million to the Secretary in FY2008, to remain available until expended. Beginning no later than October 1, 2008, MSIS data on enrollment of low-income children in Medicaid or CHIP with respect to a fiscal year must be collected and analyzed by the Secretary within 6 months of submission.

**PROVISION: PAYMENTS FOR FQHCs AND RHCS UNDER CHIP**

**CURRENT LAW:** Under current Medicaid law, payments to FQHCs and RHCs are based on a prospective payment system. Beginning in FY2001, per visit payments were based on 100% 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.

| <b>HOUSE: H.R. 3162</b>  | <b>SENATE: S. 1893/H.R. 976</b>   | <b>AGREEMENT H.R. 976</b>  | <b>JOINT POLICY RECOMMENDATION</b>   |
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| <p>H§121. Ensuring child-centered coverage. The provision would require that payments for FQHC and RHC services provided under CHIP follow the prospective payment system for such services under Medicaid. The effective date would be October 1, 2008.</p> | <p>S§609. Application of prospective payment system for services provided by Federally qualified health centers and rural health clinics. The provision would require states that operate separate and/or combination CHIP programs to reimburse FQHCs and RHCs based on the Medicaid prospective payment system.</p> | <p>. A§503. Application of prospective payment system for services provided by federally-qualified health centers and rural health clinics. Same as Senate bill.</p> | <p>Support the Senate and conference language with a revised effective date.</p> |

This provision would apply to services provided on or after October 1, 2008. For FY2008, \$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.

**PROVISION: MANAGED CARE SAFEGUARDS**

**CURRENT LAW:** A number of sections of the Social Security Act apply to states under Title XXI (SCHIP) in the same manner as they apply to a state under Title XIX (Medicaid). These include section 1902(a)(4)(C) (relating to conflict of interest standards); paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment); section 1903(w) (relating to limitations on provider taxes and donations); and section 1920A (relating to presumptive eligibility for children).

| HOUSE: H.R. 3162   | SENATE: S. 1893/H.R. 976  | AGREEMENT H.R. 976   | JOINT POLICY RECOMMENDATION                     |
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| H§152. Application of certain managed care quality safeguards to CHIP. The House bill would add subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932, which relate to requirements for managed care, to the list of Title XIX provisions that apply under Title XXI. It would apply to contract years for health plans beginning on or after July 1, 2008. | S§503. Application of certain managed care quality safeguards to CHIP. Same as the House provision, but with no effective date specified. | A§403. Application of certain managed care quality safeguards to CHIP. Same as the House bill. | Support the House bill and conference language. |

**PROVISION: DIABETES GRANTS**

**CURRENT LAW:** Section 330B of the Public Health Service Act specifies that the Secretary, directly or through grants, must provide for research into the prevention and cure of Type I diabetes. Appropriations are set at \$150 million per year during the period FY2004 through FY2008. Section 330C of the Public Health Service Act specifies the Secretary must make grants for providing services for the prevention and treatment of diabetes among American Indian and Alaska Natives. Appropriations are set at \$150 million per year during the period FY2004 through FY2008.

| HOUSE: H.R. 3162   | SENATE: S. 1893/H.R. 976   | AGREEMENT H.R. 976   | JOINT POLICY RECOMMENDATION  |
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| H§822. Diabetes grants. The provision would provide \$150 million for FY2009 | S§613. Demonstration projects relating to diabetes prevention. The | A§505. Demonstration projects relating to diabetes prevention. Same as | Support the Senate bill and conference language, as the diabetes grants were |

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| <p>for each of these two diabetes grant programs under the Public Health Service Act, as part of the appropriation for CHIP under this bill.</p> | <p>Senate bill, as amended, would create a new demonstration project to fund up to 10 states over three years to promote children's receipt of screenings and improvements in healthy eating and physical activity to reduce the incidence of type 2 diabetes. Activities could include reductions in cost-sharing or premiums when children receive regular screenings and reach certain benchmarks in healthy eating and physical activity. States would be permitted to provide (1) financial bonuses for partnerships with entities (e.g., schools) that increase education and other activities to reduce the incidence of type 2 diabetes, and (2) incentives to providers serving Medicaid and CHIP children to perform screening and counseling regarding healthy eating and exercise. The Secretary of HHS would be required to provide a report to Congress on the degree to which funded activities improve health outcomes related to type 2 diabetes among children in participating states. The provision would authorize to be appropriated a total of \$15 million during FY2008 through FY2012 to fund this demonstration.</p> <p><b>S§501. Child health quality improvement activities for children enrolled in Medicaid and CHIP.</b> Would include a childhood obesity demonstration project that would also include activities designed to improve health eating and physical activity among children.</p> | <p>Senate bill.</p> | <p>passed in subsequent legislation.</p> |
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**PROVISION: ELIMINATION OF COUNTING OF MEDICAID CHILD PRESUMPTIVE ELIGIBILITY COSTS AGAINST CHIP ALLOTMENTS**

**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.

| HOUSE: H.R. 3162 | SENATE: S. 1893/H.R. 976  | AGREEMENT H.R. 976  | JOINT POLICY RECOMMENDATION                 |
|------------------|---|---|---|
| No provision.    | S§603. Elimination of counting Medicaid child presumptive eligibility costs against title XXI allotment. The provision would strike these current law provisions. | A§113. Elimination of counting Medicaid child presumptive eligibility costs against title XXI allotment. Same as Senate bill. | Support the Senate and conference language. |

**PROVISION: OUTREACH TO SMALL BUSINESSES**

**CURRENT LAW:** No provision.

| HOUSE: H.R. 3162 | SENATE: S. 1893/H.R. 976   | AGREEMENT H.R. 976   | JOINT POLICY RECOMMENDATION                 |
|------------------|--|--|---|
| No provision.    | S§614. Outreach regarding health insurance options available to children. The Senate bill 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 | A§623. Outreach regarding health insurance options available to children. Same as the Senate bill. | Support the Senate and conference language. |

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.

**PROVISION: ASSURE CHIP PAYMENT TO INDIAN HEALTH CARE PROVIDERS**  
*[S. 1200 AS ENGROSSED, P. 370, LINE 19-P. 371, LINE 2, AMENDING §2102(B)(3)(D)]*

**CURRENT LAW:** No provision

| HOUSE: H.R. 3162 | SENATE: S. 1893/H.R. 976 | AGREEMENT H.R. 976 | JOINT POLICY RECOMMENDATION  |
|------------------|--------------------------|--------------------|--|
| No provision     | No provision             | No provision       | Include provision from S. 1200 (Indian Health Care Improvement Act amendments bill) to require State to describe how it will ensure CHIP payments are made to Indian health care providers |

**PROVISION: INCLUDE OTHER INDIAN HEALTH PROGRAMS IN EXEMPTION FROM CERTAIN PAYMENTS**  
*[S. 1200 AS ENGROSSED, P. 371, LINES 3-12 AMENDING §2105(C)(6)(B)]*

**CURRENT LAW:** No provision

| HOUSE: H.R. 3162 | SENATE: S. 1893/H.R. 976 | AGREEMENT H.R. 976 | JOINT POLICY RECOMMENDATION   |
|------------------|--------------------------|--------------------|---|
| No provision     | No provision             | No provision       | Include provision from S. 1200 (Indian Health Care Improvement Act amendments bill) to enable tribal and urban Indian organization programs to have same exemption as the Indian Health Service |

**PROVISION: PREMIUM, COST SHARING PROTECTIONS FOR INDIANS UNDER MEDICAID AND CHIP**  
*[S. 1200 AS ENGROSSED, P. 374 -376, LINE 18]*

**CURRENT LAW:** No provision

| HOUSE: H.R. 3162 | SENATE: S. 1893/H.R. 976 | AGREEMENT H.R. 976 | JOINT POLICY RECOMMENDATION  |
|------------------|--------------------------|--------------------|--|
| No provision     | No provision             | No provision       | Prohibit imposition of premium, cost sharing, etc. against Indians served by |

|  |  |  |  |
|--|--|--|--|
|  |  |  | <p>Indian Health Service, Indian tribe, tribal organization, or urban Ind. organization, or by a health provider to whom Indian is referred by these entities. Intent is to remove barrier to eligible Indian enrolling in Medicaid or CHIP and to avoid copayment costs allowed by DRA to be shifted from Medicaid to Indian Health Service, tribes and urban Indian organizations.</p> |
|--|--|--|--|

**PROVISION: EXCLUDE CERTAIN INDIAN PROPERTY FOR MEDICAID AND CHIP ELIGIBILITY**  
*[S. 1200 AS ENGROSSED, P. 376, LINE 21 – P. 378, LINE23]*

**CURRENT LAW:** No provision

| HOUSE: H.R. 3162 | SENATE: S. 1893/H.R. 976 | AGREEMENT H.R. 976 | JOINT POLICY RECOMMENDATION  |
|------------------|--------------------------|--------------------|--|
| No provision     | No provision             | No provision       | <p>As certain Indian-owned property is connected to the political relationship between tribes and Federal government or has value only in a unique Indian context, <b>such property should be exempt from consideration for Medicaid and CHIP eligibility in order to eliminate barrier to enrollment.</b> The provision is modeled on exemption of the same property from Medicaid estate recovery.</p> |

**PROVISION: REQUIRE STATES TO CONSULT WITH INDIAN HEALTH PROGRAMS ON CHIP AND MEDICAID CHANGES**  
*[S. 1200 AS ENGROSSED, P. 383, LINE 23 – P.385, LINE 24]*

**CURRENT LAW:** No provision

| HOUSE: H.R. 3162 | SENATE: S. 1893/H.R. 976 | AGREEMENT H.R. 976 | JOINT POLICY RECOMMENDATION  |
|------------------|--------------------------|--------------------|--|
| No provision     | No provision             | No provision       | <p>As Medicaid and CHIP state plan amendments, waiver requests, etc., often impact Indian health programs, <b>State should be required to consult with Indian health programs in the State before submission of requests that are likely to have direct effect on these programs so as to prevent unintended harm.</b></p> |

**PROVISION:** ANNUAL CMS REPORT ON INDIANS SERVED BY SSA PROGRAMS [S. 1200 AS ENGROSSED, P. 406-407]

**CURRENT LAW:** No provision

| HOUSE: H.R. 3162 | SENATE: S. 1893/H.R. 976 | AGREEMENT H.R. 976 | JOINT POLICY RECOMMENDATION  |
|------------------|--------------------------|--------------------|--|
| No provision     | No provision             | No provision       | Congress needs reliable data on Indian enrollment in Medicare, Medicaid and CHIP to discharge its legislative duties. This provision would <b>require CMS and Indian Health Service to collect and report such data to Congress.</b> |

**PROVISION:** HHS STUDY OF INTERSTATE COORDINATION OF MEDICAID AND CHIP COVERAGE FOR INDIAN CHILDREN WHO LEAVE STATE OF RESIDENCY FOR EDUCATIONAL AND OTHER REASONS [S. 1200 AS ENGROSSED, P. 408-409, L. 7]

**CURRENT LAW:** No provision

| HOUSE: H.R. 3162 | SENATE: S. 1893/H.R. 976 | AGREEMENT H.R. 976 | JOINT POLICY RECOMMENDATION  |
|------------------|--------------------------|--------------------|--|
| No provision     | No provision             | No provision       | As Indian and other Medicaid or CHIP eligible children who move temporarily to another State (e.g., to attend Indian boarding school) face continuation of coverage issues, this provision would <b>require HHS Secretary to examine these issues with State Medicaid Directors and make recommendations to Congress on how to address these barriers.</b> |

## FOR MORE INFORMATION:



**First Focus** is a bipartisan advocacy organization that is committed to making children and families a priority in federal policy and budget decisions. Children's health, education, family economics, child welfare, and child safety are the core issue areas around which First Focus is working to promote bipartisan policy solutions.

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The **National Association of Community Health Centers (NACHC)** works to promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.

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The **Children's Health Fund** is committed to providing health care to the nation's most medically underserved children and their families through the development and support of innovative primary care medical programs, response to public health crises, and the promotion of guaranteed access to appropriate health care for all children.

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