

CHIPRA Impacts and Implementation ~ MRMIB and DHCS
Updated 5/19/09 ~ Changes from 3/19/09 Legislative Briefing Document are Highlighted

Summary of Provision <i>Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)</i>	Impact on Healthy Families and Medi-Cal Programs	Important Dates and Action Items
FINANCING		
<ul style="list-style-type: none"> ■ Offsets (SEC 701). Increases federal tobacco tax by \$0.61. 		<p>Effective date is April 1, 2009.</p>
FUNDING FOR STATES		
<ul style="list-style-type: none"> ■ Capped Funding Levels (SEC 101 & 108). Increases the national CHIP allotment level over 4 ½ years and is expected to cover over 6 million children. <p>2009: \$10.562 billion 2010: \$12.520 billion 2011: \$13.459 billion 2012: \$14.982 billion 2013: \$17.406 billion</p> <p>If there is not enough CHIP funding to give each state its full allotment, the law requires proportionate reductions to each state's allotment to fit within the national cap.</p>	<p>In February 2009, Harbage Consulting reviewed California's CHIP funding requirements under a contract with the California Health Care Foundation, and concluded that this funding level will be sufficient for CA's projected needs.</p>	<p>Effective date is April 1, 2009.</p> <ul style="list-style-type: none"> ■ No action is needed.
<ul style="list-style-type: none"> ■ Fiscal Year 2009 Allotments (SEC 102). Bases state allocations on a state's actual use of and projected need for CHIP funds. <p>A state's allotment level for FFY 2009 is set at 110 percent of: 1) a state's fiscal year 2008 CHIP spending (adjusted for per capita health care growth and child population growth); or 2) its FFY 2008 CHIP allotment (adjusted for per capita</p>	<p>According to a January 2009 Congressional Research Services report, California's CHIP allotment for FFY 2009 is 85 percent larger than the prior law FFY 2009 allotment, growing from \$799.2 million to \$1.481 billion.</p> <p>Harbage Consulting concluded that the \$1.481 billion allotment will be sufficient</p>	<p>Effective date is April 1, 2009.</p> <ul style="list-style-type: none"> ■ MRMIB calculated expected FFY 2009 needs and submitted the estimate to CMS by March 10, 2009 as CMS requested.

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<p>health care growth and child population growth); or 3) its February 2009 projected need for funds in FFY 2009, whichever is greatest.</p>	<p>for FFY 2009.</p>	
<p>■ Allotments in Future Years (SEC 102). Rebases states' allotments to reflect state expenditures and specified adjustments (per capita health care growth and child population growth factors).</p> <p>In 2011, a state's actual use of CHIP funds will serve as the basis for its new allotment (adjusted for health care inflation and child population growth).</p> <p>The law allows states with approved plans to expand eligibility or benefits to receive an increase in their allotments beyond the automatic growth factors, but states can request the adjustments only for FFYs 2010 and 2012. A state must submit a State Plan Amendment (SPA) before August 31 preceding the beginning of the applicable fiscal year.</p> <p>In addition, if states receive additional federal funding from the "child enrollment contingency fund" (see below), these funds are built into their future allotments.</p>	<p>Harbage Consulting indicated that the growth factors are adequate to meet CA's need. If federal funds are not spent, the state will lose them in future years.</p> <p>The limitation on increasing the state allotment to FFYs 2010 and 2012 places constraints on future program expansion timelines if the automatic growth factors do not provide for a sufficient allotment.</p>	<p>Effective date is April 1, 2009.</p> <p>■ A SPA would need to be submitted by Aug. 31, 2009 and Aug. 31, 2011 if an increase in the allotment beyond the automatic growth factors is needed to fund an expansion for FFYs 2010 or 2012.</p>
<p>■ Child Enrollment Contingency Fund (SEC 103). Provides (through a separate appropriation of 20% of total allotment) states with additional</p>	<p>There is no expectation that CA will need additional funding for FFY 2009.</p>	<p>Effective date is April 1, 2009.</p> <p>■ No action is needed.</p>

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<p>funds when they face a CHIP funding shortfall and their enrollment of children exceeds a target level.</p>		
<p>■ Allotment Availability and Redistribution of Unused CHIP Funds (SEC 105 & 106). Reduces the period during which a state can use an annual CHIP allotment from three to two years, beginning with the FFY 2009 allotment. The law outlines a system for redistributing funds to states facing a CHIP funding shortfall.</p>	<p>CA can spend its allotment within two years.</p>	<p>Effective date is April 1, 2009.</p> <p>■ No action is needed.</p>
MANDATES		
<p>■ Elimination of Counting Medicaid Child Presumptive Eligibility Costs Against Title XXI Allotment (SEC 113). Strikes a current law provision requiring that federal reimbursement for Medicaid benefits received by children who appeared Medicaid-eligible during periods of PE be made out of the CHIP allotment.</p> <p>Strikes the Medicaid requirements for deemed newborns regarding living arrangements with the mother.</p>	<p>This section will leave more funds available in a state's CHIP allotment. CA estimates this is about \$80 million a year.</p> <p>It also lessens administrative burdens in reconciling claims for such expenditures between Titles XIX and XXI.</p>	<p>Effective date is April 1, 2009.</p> <p>■ The May Reviser provides that, effective April 1, DHCS will discontinue claiming Title XXI and will claim against Title XIX.</p> <p>■ ACWDL 09-17 was issued by DHCS on April 13, 2009, instructing counties on the new deeming rules regarding living arrangements of the infants.</p>
<p>■ Citizenship Documentation Requirement (SEC 211). Extends the Medicaid citizenship documentation requirements to CHIP.</p>	<p>Presently, HFP requires a copy of the child's birth certificate for enrollment. HFP is exploring an electronic data match with vital statistics birth records,</p>	<p>Effective date is January 1, 2010 OR January 1, 2011 if state statute change is needed.</p>

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<p>Gives states the option of meeting the citizenship documentation requirement by submitting the names and Social Security Numbers (SSNs) of individuals enrolled in Medicaid and CHIP to the Social Security Administration (SSA) at least monthly. If SSA finds that the name and SSN do not match, the state must make a reasonable effort to address the discrepancy while providing coverage to the otherwise eligible individual. If the issue is not resolved, individuals have 90 days to establish citizenship or fix the problem with their SSN after which they are disenrolled within 30 days.</p> <p>The HHS Secretary may impose penalties on states if more than three percent of the names and SSNs they submit to the SSA are deemed "invalid" and not corrected. The law provides for a federal match of 90 percent for the design, development or installation of the SSN matching system and 75 percent match for costs attributed to the operation of the system.</p> <p>Another provision specifies the acceptance of documentation from Federally Recognized Indian tribes.</p> <p>The law clarifies that children born in the U.S. to mothers on Medicaid shall be deemed to have provided satisfactory documentation of citizenship and shall not be required to provide further documentation.</p>	<p>since 92% of HFP enrollees are born in California.</p> <p>Presently CHIP does not require children's SSN's. Such a requirement would require HFP to change the application, program regulations and operations.</p> <p>The SSA match may ameliorate the problems created by the citizenship documentation requirements. DHCS believes the SSN match with SSA would be more cost effective than the current cost of counties processing the citizenship documents.</p> <p>CA currently has a 5% error rate in validating new applicants' SSNs. After initial implementation of the SSN match with SSA, DHCS believes this error rate could be lowered, eliminating the potential penalties for exceeding the 3% threshold requirement. DHCS has not received federal guidance confirming whether or not a successful match will be acceptable evidence of <i>citizenship and identity or citizenship only</i>.</p> <p>Under California's rules, immigrants requesting full scope status have 30 days or the time it takes to determine eligibility (whichever is longer) to provide documents. Full scope</p>	<ul style="list-style-type: none"> ■ At this time, MRMIB assumes state statute changes are not needed to comply with this requirement. ■ MRMIB is working with DHCS to implement a process that complies with the citizenship and identity requirements. This process will include the following steps: <ol style="list-style-type: none"> 1) Continue to accept copies of birth certificates; 2) Implement an HF19 transaction that would query the vital statistics database maintained by DHCS for Medicaid purposes to electronically validate CA born children (92% of HFP enrollment). This process will streamline enrollment by electronically verifying citizenship before requiring families to submit birth certificates. Also, CA will begin linking to the national EVVE database that will allow MRMIB to electronically verify citizenship from other states. 3) Change the joint HFP/Medi-Cal application to include a new declaration whereby the applicant attests to the identity of the children for whom they are applying for coverage (to comply with the identity requirements). This mirrors the

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	<p>eligibility is granted during that time and while status is being verified if otherwise eligible. Currently, citizens may be given more time to provide documents if they are making a good faith effort, but full scope eligibility does not begin for citizen applicants until citizenship documents are provided. DHCS has interpreted this section as allowing full scope coverage of citizens while they are obtaining documents, which provides equitable treatment of citizen and immigrant applicants.</p> <p>Currently, Medi-Cal issues a new identification card for children born in the US to mothers on Medi-Cal upon notification of the child's birth by the facility at which delivery occurred.</p>	<p>current process used by Medi-Cal to comply with the DRA requirements.</p> <ul style="list-style-type: none"> ■ To the extent the current eligibility verification procedures must change, it will probably require emergency regulations and modifications to the joint HFP/Medi-Cal application. ■ DHCS: intends to implement an electronic exchange with SSA to match SSNs of U.S. citizens and U.S. nationals for verification of citizenship/identity. The SSN verification, correction process for invalid SSNs will require a state law change. ■ DHCS is awaiting CMS guidance on this issue.
<ul style="list-style-type: none"> ■ Medicaid Managed Care Standards Applied to CHIP (SEC 403). Requires states to apply Medicaid managed care standards to CHIP, specifically related to the following: 1) enrollment; 2) provision of information; 3) beneficiary protections; 4) quality assurance standards; 5) protection from fraud and abuse; and 6) sanctions for non-compliance. 	<p>This requirement appears to require the collection of encounter and claims data as of July 1, 2009, as is required under the Medicaid law now applicable to CHIP programs. MRMIB has been developing but does not yet have an encounter and claims data system.</p> <p>CMS has held one all-state conference call on this subject but has indicated that it is not yet ready to opine on many of the detailed</p>	<p>Effective date of this provision is July 1, 2009 OR January 1, 2011 if state statute change is needed.</p> <ul style="list-style-type: none"> ■ MRMIB is evaluating whether implementation requires state statute changes. ■ MRMIB has sought confirmation from CMS that collection of encounter and claims data is required under this section but has not yet received a

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	<p>implementation issues. CMS expects to issue a State Health Official (SHO) letter on this subject in the near future.</p>	<p>response from CMS.</p> <ul style="list-style-type: none"> ■ MRMIB is evaluating the other legal and practical issues related to implementation of this provision.
<ul style="list-style-type: none"> ■ Dental Coverage (SEC 501). Requires CHIP plans to include coverage of dental services. <p>Coverage must meet articulated standards or be equivalent to specified benchmark dental benefit standards. Possible benchmarks include federal employee dependent coverage, state employee dependent coverage, or commercial dental coverage with largest enrollment.</p> <p>The law also requires the federal HHS Secretary to implement dental education for parents of newborns and strategies for increasing access to dental services, including the creation of online provider lists.</p> <p>The law requires reports on type of dental coverage provided by age.</p>	<p>HFP provides dental coverage to subscribers now, based on coverage available to the dependents of state employees, but without orthodontia. State employee orthodontia coverage has a high deductible, something that would not fall within CHIP cost-sharing rules.</p> <p>Complying with the reporting requirements would necessitate an encounter and claims-based data system for dental coverage. MRMIB does not currently have such a system and was planning on developing a system for health coverage first. Developing such a system will be a cost to the state and require staffing. The reporting requirement may require MRMIB to revise the measures dental plans report to ensure that the measures conform to the statute.</p>	<p>Effective date is January 1, 2011 assuming state statute change is needed.</p> <ul style="list-style-type: none"> ■ At this time, MRMIB assumes state statute changes are needed to comply with this requirement. ■ MRMIB has sought guidance from CMS on exactly what benefits are required, whether orthodontia coverage is required, and if so, what the scope of benefits for orthodontia is. ■ MRMIB has sought confirmation from CMS that encounter and claims data is required under this section. ■ <i>Note:</i> MRMIB regulations implement the dental benefit cap of \$1,500 a year (from 2008 health TBL) on July 1, 2009. ■ MRMIB recently received a "Stop-the-Clock" letter from CMS that includes a comment that the SPA

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		<p>MRMIB submitted implementing the dental cap may be short-lived if it conflicts with the dental coverage provisions under CHIPRA.</p>
<p>■ Provision of Dental Services Through FQHCs (SEC 501). Prohibits states from preventing a FQHC from entering into a contractual relationship with private practice dental providers in the provision of FQHC services.</p>	<p>MRMIB is working to understand this section and its impact.</p> <p>DHCS is analyzing this section and its impact on the Medi-Cal program. Medi-Cal provides dental coverage under its current program and it is a requirement under EPSDT.</p>	<p>Effective date of this provision is April 1, 2009 OR January 1, 2011 if state statute change is needed.</p> <p>■ CMS is developing formal guidance on this item; this guidance will assist MRMIB and DHCS in determining if a state law change and/or a SPA is needed for implementation.</p>
<p>■ Mental Health and Substance Abuse Parity (SEC 502). By making recently-enacted federal mental health parity laws applicable to CHIP, requires that, if a state provides mental health or substance abuse services through CHIP, the financial requirements and treatment limitations for those benefits cannot be more restrictive than those for medical and surgical benefits.</p>	<p>This section requires an expansion of HFP mental health and substance abuse services. Such an expansion will result in increased state costs beginning in state FY 2010-11.</p> <p>The requirement for mental health parity raises the question of whether it is possible for HFP to assure parity given the current county SED carve-out.</p>	<p>Effective date is July 1, 2010 OR January 1, 2011 if state statute change is needed.</p> <p>■ At this time, MRMIB is assessing whether state statute changes are needed to comply with this requirement.</p> <p>■ MRMIB is seeking CMS guidance on parity requirements.</p> <p>■ MRMIB is preparing an analysis and will present an Issue Brief on options for serving children with SED to the MRMIB Board at its May 20, 2009 meeting.</p>

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<p>■ Application of Prospective Payment System to CHIP Services Provided by FQHCs and RHCs (SEC 503). Requires the application of Medicaid's prospective payment system (PPS) to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for CHIP services provided after October 1, 2009.</p> <p>The federal HHS Secretary will award \$5 million in grants to CHIP states for expenditures related to the transition to PPS rates for services provided by FQHCs and RHCs.</p>	<p>MRMIB contracts solely with managed care organizations. Complying with this section will increase state costs and could have serious implications for HFP rate negotiations.</p> <p>MRMIB may adopt the same approach used by DHCS.</p> <p>DHCS complies with this requirement in Medi-Cal by auditing the rates managed care organizations pay to clinics and then separately funding the difference between plan rates and the (PPS) rates.</p>	<p>Effective date is January 1, 2011 because state statute change is needed.</p> <ul style="list-style-type: none"> ■ MRMIB assumes state statute changes are needed to comply with this requirement since HFP statute currently authorizes a managed care approach only. ■ MRMIB is conducting an analysis of and will present an Issue Brief on options for transitioning to PPS for FQHCs and RHCs to the MRMIB Board at its June 2009 meeting. ■ MRMIB will obtain CMS guidance on how to apply for the grant funding and decide whether to apply.
OPTIONS		
<p>■ Performance Bonuses (SEC 104). Includes new performance bonuses to encourage states to enroll more of the uninsured children who are already eligible for Medicaid.</p> <p>States that have simplified their enrollment procedures and increase enrollment of these children above a target level receive a federal payment for each extra child enrolled to help</p>	<p>In order to determine some of the calculations for the performance bonuses, information must come from the federal HHS Secretary. Once this information is available, DHCS will assess its eligibility for the performance bonuses. Eligibility for the bonuses requires states to have the simplified enrollment procedures in place for a full</p>	<p>Effective date is April 1, 2009.</p> <ul style="list-style-type: none"> ■ Action is contingent upon receipt of guidance from CMS. DHCS is evaluating its options in order to meet 5 out of the 8 requirements and is awaiting guidance from CMS on Express Lane Eligibility requirements.

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<p>defray the added cost of successful outreach efforts. The size of the payment can vary from 15 to 62.5 percent of the per capita state Medicaid expenditures for children.</p> <p>Target levels are adjusted over time by growth in a state's child population plus 4 percentage points through 2009; 3.5 percentage points for 2010, 2011, and 2012; 3 percentage points for 2013, 2014 and 2015; and 2.5 percentage points in future years.</p> <p>Payment of the bonus during a child's presumptive eligibility period is contingent on the child's subsequent enrollment in Medicaid and will not include children covered at the state's option under the newly qualified immigrant expansion provisions.</p> <p>Beginning in federal fiscal year 2009, \$3.2 billion will be made available through a separate appropriation.</p>	<p>fiscal year. The state must meet 5 of 8 requirements in order to qualify for the performance bonus. DHCS may not meet the joint application requirement because it does not include a joint renewal; however, the state is evaluating the Express Lane requirements.</p>	
<p>■ Pregnant Women (SEC 111). Gives states the new option of covering pregnant women with CHIP funds by submitting a state plan amendment (SPA). States choosing this option must cover pregnant women up to at least 185 percent of the federal poverty level (FPL) in Medicaid (or higher if the state already covers pregnant women in Medicaid at a higher income level). States also cannot impose any enrollment caps or waiting list in CHIP.</p>	<p>There does not appear to be a reason to change to the new option from the current FFP provisions for pregnant women in Medi-Cal and the Access for Infants and Mothers (AIM) Program. See Unborn Option below.</p> <p>CA already does auto enrollment into the HFP for AIM-linked infants under the Unborn Option.</p>	<p>Effective date is April 1, 2009.</p> <p>■ CA has no plans to implement this option.</p>

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<p>Establishes auto enrollment for children born to women under this section. The child remains eligible until age one in either CHIP or Medicaid.</p>		
<p>■ Pregnant Women – Unborn Option (SEC 111) Leaves undisturbed, but explicitly expresses no congressional intent concerning the legality or illegality of, present CMS “unborn child” regulation permitting CHIP reimbursement for prenatal care.</p>	<p>This provision allows CA to continue to receive federal matching funds for pregnant women in the Access for Infants and Mothers (AIM) Program under the “unborn child” approach.</p>	<p>Effective date is April 1, 2009.</p> <p>■ No action is needed.</p>
<p>■ Limitation on Matching Rate for Expansions (SEC 114) Imposes new constraints if a state decides in the future to cover children with family incomes above 300 percent of the federal poverty level (FPL). The state may receive only the lower Medicaid matching rate effective FFY 2009.</p>	<p>To the extent CA wants to expand HFP eligibility above 300% FPL, federal matching rate would be 50/50 rather than 65/35.</p>	<p>Effective date is April 1, 2009.</p> <p>■ CA has no plans to implement this option.</p>
<p>■ Enhanced FMAP for Translation or Interpretation Services (SEC 201). Provides an enhanced matching rate in CHIP (the higher of 75 percent or the sum of the enhanced FMAP plus 5 percent) and Medicaid (75 percent of the sum expended) for translation and interpretation services in connection with enrollment of, retention of, and use of services for families whose primary language is not English.</p>	<p>This section could result in an unknown amount of state funds freed up for other purposes when implemented. However, there are also administrative costs to implementing this section.</p>	<p>Effective date is April 1, 2009.</p> <p>■ MRMIB is pursuing two potential options for implementing this section so that MRMIB receives the enhanced FMAP for translation/interpretive services. They are as follows:</p> <p>1) Implement a new monthly (or quarterly) translation and interpretive services report from Maximus that details expenditures on those services including how CA pays for those costs</p>

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		<p>(through the PMPM or pass through costs); or</p> <p>2) Establish a percentage of the PMPM that is attributable to expenditures for translation and interpretive services.</p> <p>■ DHCS is assessing the feasibility of changing health plan contracts to separate out these services. DHCS is also assessing the feasibility of separating out these services from the current Health Care Options contract for managed care and the contractor used for fee-for-service translations.</p>
<p>■ Express Lane Option (SEC 203). Gives states the option of using relevant findings within a “reasonable” period as determined by the state from school lunch programs, WIC, and other public agencies when determining children’s eligibility for CHIP and Medicaid during initial determination of eligibility, re-determination, or both.</p> <p>To assist states with implementation, the law outlines enrollment procedures states can use to meet “screen and enroll” rules under the Express Lane option. The law also lays out evaluation and error rate procedures states must meet when implementing the Express Lane option; specifically, the error rate will not be applied to the</p>	<p>Express Lane agencies currently serve children at 185% of FPL or below. Current express lane eligibility through the school lunch program is conducted only for new applications, not renewals. Other alternative Express Lane entities include the Food Stamp Program, the Women, Infants and Children (WIC) Program, and the Franchise Tax Board.</p>	<p>Effective date is February 4, 2009</p> <p>■ DHCS will conduct a cost benefit analysis to see if the potential high administrative costs for implementing the Express Lane option would be an effective avenue for increasing the enrollment of eligible uninsured children and increasing the retention of existing subscribers. The administrative costs include any forms redesign to explain Express Lane eligibility to applicants and beneficiaries and provide for an opt-out of Medicaid consideration; system redesign to track which applicants and</p>

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<p>entire CHIP or Medicaid population.</p> <p>The law allows temporary enrollment in CHIP pending "screen and enroll" with CHIP matching funds during this period. The law does not allow information from an Express Lane agency to be used to verify someone's citizenship status or nationality.</p>		<p>beneficiaries had an aspect of eligibility determined by an Express Lane process; data matching between DHCS and the Express Lane eligibility entity; and preparation and submission of reports to CMS on Express Lane eligibility results.</p> <p>■ MRMIB will coordinate with DHCS if DHCS decides to implement this option.</p>
<p>■ Legal Immigrant Children and Pregnant Women (SEC 214). Allows for federal financial participation (FFP) for coverage of legal immigrant children and pregnant women in both CHIP and Medicaid by giving states the option of filing a state plan amendment (SPA) to cover them without the 5 year coverage ban.</p> <p><i>Note:</i> The state cannot claim for pregnant women and children under CHIP unless also doing so under Medicaid. Children are defined as persons under age 21.</p> <p>Also adds a provision requiring states, as part of the eligibility re-determination process, to verify that the individual is still lawfully residing in the U.S. in those circumstances where the initial documentation is not sufficient to establish continuing lawful residence.</p>	<p>This option would reduce present state costs because CA now provides coverage for legal immigrant children and pregnant women with state only funds.</p> <p>HFP will spend \$18.8 million on coverage for legal immigrant children in state FY 2009-10. If the state implements this option, MRMIB estimates savings of \$12.2 million General Fund in FY 2009-10, with additional savings in the Medi-Cal program.</p> <p>Subject to budget negotiations, the Governor has proposed eliminating the state-funded program for legal immigrants in Medi-Cal.</p>	<p>Effective date is April 1, 2009.</p> <p>■ Pending the May Revise decision, MRMIB is working on a draft SPA for CMS to begin drawing down FFP as of 4/1/09 for CA recent legal immigrant program. The due date for the SPA is 6/30/09 in order to draw down FFP back to 4/1/09.</p> <p>■ MRMIB will enact emergency regulations to change the Annual Eligibility Review (AER) process.</p> <p>■ MRMIB will also evaluate whether the state can claim for any time period prior to the effective date of emergency regulations addressing AER verification requirements.</p>

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	<p>Some children might have to provide additional documentation at AER. Presently HFP requires a copy of children's legal status documents upon initial enrollment but no further documentation at AER. Implementing these provisions may result in lower retention and could result in increased administrative costs.</p> <p>This new law change allows states to provide non-emergency Medicaid covered services with FFP to eligible legal immigrant pregnant women and children (as defined) who would otherwise be subject to the 5 year bar.</p>	<ul style="list-style-type: none"> ■ MRMIB will review administrative vendor contract for re-verifying status at AER.
<ul style="list-style-type: none"> ■ Premium Assistance (SEC 301). Gives states the option of offering a premium assistance subsidy for qualified employer-sponsored coverage to all targeted low-income children who are eligible for CHIP or Medicaid and have access to such coverage. The subsidy is the amount equal to the difference between the employee-only contribution and employee-plus-child contribution. <p>Creditable coverage is defined as a group health plan under the Public Health Services Act, in which the employer contribution is at least 40 percent and the coverage is offered to all employees. A Health Flex Spending Account or a</p>	<p>It is highly unlikely that any employer-sponsored insurance (ESI) would pass an actuarial certification as being the equivalent to the benefits provided in HFP, and it is also unlikely that employers would be willing to contribute the required 40 percent of the cost for dependent coverage. CHIP's ten year history has shown that premium assistance programs have been ineffective as a strategy for covering uninsured children in CHIP. In addition, most CHIP/Medicaid children do not have access to a parent's ESI coverage; according to a January 2009</p>	<p>Effective date is April 1, 2009.</p> <ul style="list-style-type: none"> ■ This is a state option. To the extent CA decides to pursue this option, state statute would be required to implement this section.

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<p>High Deductible Health Plan does not qualify for the subsidy.</p> <p>A state is required to provide for supplemental coverage consisting of items or services not covered or only partially covered under the employer-sponsored coverage and cost-sharing protection.</p> <p>If a group health plan or employer-offered health coverage is certified by an actuary as providing benefits equivalent to the benefits provided in a benchmark package, the state may provide premium assistance subsidies for enrollment of targeted low-income children in such group health plans or employer-offered coverage without the requirement to provide supplemental coverage for benefits and cost-sharing protection.</p> <p>The law allows a child to disenroll from the premium-assisted employer-sponsored coverage and enroll in CHIP in a manner that ensures continuity of coverage for the child.</p> <p>Expenditures for outreach activities related to the premium assistance subsidy program are not limited to the 10% cap, however such expenditures may not exceed an amount equal to 1.25 percent of the maximum amount permitted.</p>	<p>Urban Institute Study, just 4.6 percent of children on Medicaid and 15.9 percent of children in CHIP have access).</p> <p>As the provision is written, this premium assistance program is optional for individuals to enroll into. It is unlikely that individuals would take advantage of this new program when faced with the choice between paying premiums or having no-cost/low cost Medicaid. This would make the administration of the program cost-prohibitive given the likelihood of a low number of enrollees. Historically, beneficiaries have been more likely to choose Medi-Cal as their primary coverage rather than retaining private insurance through participation in the existing Health Insurance Premium Payment (HIPP) program under Medi-Cal.</p>	
<p>■ A New Purchasing Pool Option (SEC 301). Gives states the option of establishing a purchasing pool for employers with fewer than 250</p>		<p>Effective date is April 1, 2009.</p> <p>■ This is a state option. To the extent</p>

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<p>employees and at least one employee who is pregnant or has a targeted low-income eligible child. The purchasing pool will offer at least two CHIP benchmark or benchmark-equivalent products. A state is not permitted to use CHIP funds to pay for the administrative costs of establishing or operating such a pool.</p>		<p>CA decides to pursue this option, state statute would be required to implement this section.</p>
<p>■ Dental Only Supplemental Coverage (SEC 501). Adds a state option to provide dental-only supplemental coverage. The coverage cannot be more favorable than the coverage in the base CHIP program.</p> <p>Implementation of this section is subject to the CHIP limitations on premium and cost sharing. In general, in CHIP the family's cost cannot exceed 5% of the family's annual income.</p> <p>To take advantage of this option, a state must cover children up to the highest income eligibility standard as of January 1, 2009, not impose any limitations or waiting lists in its CHIP Program, and provide benefits to all children who apply for and meet the eligibility standards.</p>	<p>Providing this coverage would likely be quite costly, particularly given the requirement to serve all children.</p>	<p>Effective date is April 1, 2009.</p> <p>■ MRMIB is seeking clarification from CMS about whether CA's waiting list regulations, even if not implemented, would make HFP ineligible for this option.</p> <p>■ MRMIB intends to assess the feasibility of implementing this section; likely analyzing the issue in the Fall of 2009.</p>
<p>■ Clarification of Coverage of Services Provided Through School-Based Health Centers (SEC 505). Gives states the option of providing child health assistance for covered items and services that are furnished through school-based health centers. The law defines school-</p>	<p>This option is consistent with the Governor's white paper on the expansion of school-based health centers. However, MRMIB has questions about how such payments are to be made under HFP.</p>	<p>Effective date is April 1, 2009.</p> <p>■ MRMIB needs to review how DHCS manages the coordination of care with Managed Care plans for school-based health center care provided to</p>

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based health centers and sponsoring facilities.	There is no formal policy on how services provided by school-based health centers are to be paid for under Medi-Cal. There are general provisions under Medi-Cal managed care contracts to ensure coordination of care when services are provided to individuals who obtain such services at school health centers.	eligible children.
OTHER PROVISIONS		
<p>■ Simplifying Enrollment Procedures (SEC 104). To qualify for the performance bonus payments in its Medicaid program, a state must have adopted <u>at least five</u> of the following “best practice” methods for simplifying enrollment and renewal procedures in Medicaid and CHIP for children:</p> <ol style="list-style-type: none"> 1) Adopting continuous eligibility for a full 12 months; 2) Eliminating the asset test for children; 3) Eliminating in-person interview requirements at application and renewal; 4) Using the same joint applications and information verification process for purposes of establishing and renewing eligibility; 5) Allowing for “administrative” renewal (i.e., pre-printed form and notice to parent that eligibility will be renewed based on such information unless the state is provided other information) of coverage; 	<p>The federal American Recovery and Reinvestment Act (ARRA, Public Law No. 111-5) of 2009 includes provisions for Medicaid FMAP increases. In order to be eligible for the increases, DHCS must not have Medicaid eligibility procedures, standards or processes in place that are more restrictive than those in place as of July 1, 2008.</p> <p>In accordance with the CHIPRA provisions for eligibility simplification, DHCS currently meets 4 of the 8 options (#1, 2, 3, and 6). DHCS needs additional guidance from CMS on #4, but may not be eligible. DHCS is evaluating options under #7.</p> <p>The HFP currently complies with #1, #2, #3, #4 and #6 of these “best practices”</p>	<p>Effective date is April 1, 2009.</p> <p>■ To qualify for the enhanced Medicaid FMAP under ARRA, state law has been enacted suspending midyear status reporting and providing for continuous eligibility for 12 months for children in the Medi-Cal program.</p> <p>DHCS may need to evaluate Express Lane eligibility as an alternative to the joint application, depending on CMS guidance regarding the scope of the joint application requirement.</p>

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6) Exercising the option to use presumptive eligibility determinations; 7) Exercising the new Express Lane option; and 8) Implementation of premium assistance subsidies.	methods.	
<p>■ Parents (SEC 112). Prohibits the federal HHS Secretary from approving any new waivers to cover parents with CHIP funds. Coverage of parents in the 11 states that already have such waivers can continue without change for a two-year transition period through FFY 2011. In 2012 the law sets rules for payment for coverage through limited block grants funded from state allotments. A state must meet specified benchmarks in covering children to receive the CHIP enhanced matching rate for parent coverage.</p>	CA did not implement a parental coverage waiver, so this section has no impact.	<p>Effective date is April 1, 2009.</p>
<p>■ Childless Adults (SEC 112). Restates the existing ban on new waivers that allow CHIP funds to be used for childless adults, and ends FFP from CHIP for the four existing childless adult waivers after a one-year transition (FFY 2010).</p>	CA did not implement a childless adult coverage waiver, so this section has no impact.	<p>Effective date is April 1, 2009.</p>
<p>■ Outreach Funding (SEC 201). Allocates \$100 million for FFYs 2009 through 2013 for outreach and enrollment grants designed to increase enrollment in CHIP and Medicaid. 10% is set aside for outreach to Indians.</p>	The outreach campaigns are to be geared to rural areas and racial and ethnic populations. Funds can go to states, local governments and "other organizations."	<p>Effective date is April 1, 2009.</p> <p>■ The state is awaiting direction from CMS on how to apply for the outreach funding and will then decide how to do so. Traditionally, DHCS has</p>

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<p>Ten percent of the funding will be dedicated to a national enrollment campaign and ten percent to outreach grants targeting Native American children. The HHS Secretary will distribute the remaining (80%) of the funds to state and local governments and other organizations to conduct outreach campaigns. No entity shall be required to provide any matching funds as a condition for receiving the grant.</p> <p>■ Increased Outreach and Enrollment of Indians (SEC 202). Encourages states to take steps to provide for enrollment on or near Indian Reservations. Non-application of 10% limit on outreach and certain other expenditures.</p>		<p>conducted the state's outreach efforts for both Medi-Cal and HFP.</p> <p>■ MRMIB is monitoring CMS direction, so that staff can assess the work load for submitting an outreach proposal to CMS and whether it would be through MRMIB or DHCS.</p>
<p>■ Coordination of Premium Assistance with Private Coverage (SEC 311). Includes changes to other federal laws designed to improve coordination between public and private coverage, including requiring employers to share information about their benefits package with states so that states can assess cost-effectiveness and the need for "wraparound" services; and requiring employers to notify families of their potential eligibility for premium assistance.</p>	<p>This section is only relevant for states that choose the premium assistance option.</p>	<p>Effective date is April 1, 2009.</p>
<p>■ Clarification of "Qualifying Event" (SEC 311). Makes gaining or losing eligibility for Medicaid or CHIP a "qualifying event" for the purposes of eligibility for employer-sponsored coverage.</p>		<p>Effective date is April 1, 2009.</p> <p>■ No action is needed.</p>

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<p>■ Quality Initiative for Children (SEC 401). Not later than January 1, 2010, the federal HHS Secretary shall—among other things—identify and publish for comment an initial, recommended core set of child health quality measures addressing the quality and availability of care, and duration and stability, of children's coverage. States will receive enhanced administrative funding for collecting and reporting on child health quality measures.</p> <p>The federal HHS Secretary will disseminate best practice measurements and facilitate the adoption of these practices. HHS will develop a standardized format for reporting on quality of healthcare for children. HHS will also establish a Pediatric Quality Measures Program by January 2011 to identify gaps in existing pediatric quality measures and establish priorities for development and advancement of such measures.</p> <p>■ Studies (SEC 401 & 402). By July 2010, the Institute of Medicine will report to Congress on pediatric health and health quality measures. By March 2011, the GAO will issue a report on children's access to primary and specialty care under CHIP and Medicaid and make recommendations for improving such access.</p>	<p>Federal leadership in Quality Initiatives is a welcome development but will increase workload and increase other costs.</p>	<p>Various child health quality reports to be released by HHS, the Institutes of Medicine and the GAO beginning in January 1, 2010.</p> <p>Pediatric Quality Measures Program to be established by HHS by January 2011.</p> <p>■ Once the HHS Secretary issues recommendations, MRMIB will seek CMS guidance on how to claim enhanced administrative funding.</p> <p>■ Complying with new CMS performance measure reporting requirements may necessitate MRMIB having an encounter and claims data system.</p>
<p>■ Demonstration Project Grants (SEC 401). In FFYs 2009 through 2013, requires the HHS to award 10 grants (\$20 million total) to establish</p>		<p>Effective date is April 1, 2009.</p> <p>■ MRMIB is awaiting direction from</p>

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<p>demonstration projects for states and child health providers to use and test child health quality measures and to promote the use of health information technology for children. In addition, the demonstration projects will evaluate provider-based models and demonstrate the impact of electronic health record models.</p> <p>The law also includes \$25 million in demonstration project funding to combat obesity.</p>		<p>CMS on how to apply for the demonstration project grant funding and will then decide whether to apply</p>
<p>■ Information Required for Inclusion in State Annual Report (SEC 401 & 402). Requires a state to include in its annual report information on eligibility criteria, enrollment, retention, measures such as 12 month continuous eligibility, self-declaration, presumptive eligibility, denials, re-determination of eligibility, access to services and networks of care and care coordination using CAHPS survey, and premium assistance.</p> <p>The HHS Secretary will specify a standardized format. The law also provides \$5 million to improve "MSIS," the data system used by states to report on enrollment and eligibility in CHIP and Medicaid.</p> <p>Requires that states conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and report results in their annual report. Allows a transition period of up to 3 reporting periods to transition to the reporting of such information.</p>		<p>Effective date is April 1, 2009.</p> <p>■ MRMIB will submit the next annual report to CMS in January 2010. In preparing the report, MRMIB will assess and include the additional information in the format required by the HHS Secretary.</p>

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<p>States will receive enhanced administrative funding for collecting and reporting on child health measures.</p>		
<p>■ Premium Grace Period (SEC 504). Grants families a 30-day premium payment grace period under CHIP before termination of a child's coverage.</p>	<p>HFP already has a 60 day grace period for premium payments before children are disenrolled.</p>	<p>Effective date is February 4, 2009</p> <p>■ No action is needed.</p>
<p>■ New Commission: Medicaid and CHIP Payment and Access (SEC 506). Sets up a new 17-member Medicaid and CHIP Payment and Access Commission to review policies of Medicaid and CHIP related to children's access to covered services; examine issues affecting Medicaid and CHIP; and report to Congress (reports due March 1, 2010 and June 1, 2010, and each year thereafter). Members are appointed by the Controller General and represent a broad array of constituencies including physicians, employers, third-party payers and health care delivery experts, as well as consumers and state agency administrators.</p> <p>The specific topics to be reviewed include:</p> <ul style="list-style-type: none"> • Payment policies of Medicaid and CHIP • How Medicaid and CHP payments affect the health care delivery system in general • Other policies including transportation and language barriers. 	<p>It is currently not clear what the Commission may request from states in terms of information or involvement.</p>	<p>Effective date is February 4, 2009.</p> <p>■ No action is needed.</p>

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<p>The Commission has the authority to obtain "information necessary to enable it to carry out [its duties]" from any department or agency of the US.</p>		
<p>■ Payment Error Rate Measurement (PERM) (SEC 601). Outlines requirements and timeline (within 6 months after CHIPRA enactment) for new Final Rule on PERM regulations (the regulations which require states to report on errors in claim payments and eligibility determinations). Also, the law states an enhanced FMAP rate of no less than 90% for PERM expenditures.</p> <p>States in the first application cycle under the interim Final Rule may elect to accept any PERM error rate already determined or instead be treated as if FFY 2010 or 2011 were the first fiscal year for which PERM requirements apply to the state.</p>	<p>CA was in the first cycle of audits and already received its results, which were exemplary.</p> <p>CA wants changes in PERM rules to establish different requirements for high performers.</p>	<p>Law requires CMS to release regulations in August 2009.</p> <p>■ MRMIB is monitoring for CMS release of draft regulations for PERM and has identified the following concerns:</p> <p>1) New PERM rules should allow states to utilize any existing state quality assurance programs in place as the mechanism to comply with PERM audits. This would provide an efficient, cost effective mechanism without having to develop duplicative services.</p> <p>2) High performing PERM states should be rewarded with longer intervals between the required PERM audits. Lower performing states should be audited more frequently than those that have demonstrated they have implemented strong program control mechanisms, as evidenced by their high PERM scores (low error rates).</p>

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<p>■ Improving Data Collection (SEC 602). Allocates to the federal HHS \$20 million for improving the state-specific estimates of the number of children enrolled in CHIP and Medicaid available under the Current Population Survey and for exploring using the American Community Survey for such estimates.</p>	<p>Impact is unknown.</p>	<p>Effective date is April 1, 2009.</p> <p>■ No action is needed.</p>
<p>■ Updated Federal Evaluation of CHIP (SEC 603). Requires a new federal evaluation of CHIP in 2011 and allocates \$10 million towards the effort.</p>	<p>Impact is unknown.</p>	<p>Federal evaluation is due in 2011.</p> <p>■ No action is needed.</p>
<p>■ EPSDT Services in Medicaid (SEC 611) Effective April 1, 2009. Makes a technical fix to the Deficit Reduction Act of 2005 to clarify that Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services must be provided as part of benchmark benefit packages for children under Medicaid. This is not a requirement for CHIP.</p>	<p>This section is only relevant for states that use benchmark packages. CA does not use such benefit packages in Medi-Cal at this time.</p>	<p>Effective date is April 1, 2009.</p> <p>■ No action is needed.</p>
<p>■ GAO Report on Medicaid Managed Care Rates (SEC 617). Requires a GAO report on Medicaid Managed Care Payment Rates, specifically on the extent to which state payment rates for Medicaid MCOs are "actuarially sound." There is no mention of studying payment rates in CHIP.</p>	<p>For purposes of Medi-Cal, the managed care rates are certified by actuaries for actuarial soundness. This study appears to be duplicative of existing efforts and therefore unnecessary.</p>	<p>Law requires the GAO to release the report in August 2010.</p> <p>■ No action is needed.</p>

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<p>■ Outreach Regarding Health Insurance Options Available to Children (SEC 621). Establishes a task force to conduct a nationwide campaign of education and outreach to small businesses regarding the availability of coverage for children through private insurance options, the Medicaid program, and CHIP.</p> <p>Task force includes the Small Business Administration, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury.</p>	<p>Increased outreach could result in increased enrollment.</p>	<p>Effective date is April 1, 2009.</p> <p>■ No action is needed.</p>
GENERAL EFFECTIVE DATES		
<p>■ Implementation Timeframes for Provisions That Do Not Require State Law Changes (SEC 3). Unless otherwise specified, provisions take effect on April 1, 2009. Some provisions specify a later date or an urgency implementation, which means upon the President's signature (February 4, 2009).</p>		
<p>■ Implementation Timeline for Provisions Requiring State Law Change (SEC 3). Any new provisions which CMS determines require a state law change will be effective on the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment.</p>		<p>■ For California, the effective date of any provisions that CMS determines require a state statute change is January 1, 2011.</p>

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For a complete copy of the Children's Health Insurance Program Reauthorization Act (CHIPRA):

1. Go to www.thomas.loc.gov
2. Search HR 2 (bill number)
3. Click on **Latest Major Action**: Became Public Law No: 111-3 [GPO: [Text](#), [PDF](#)]
4. Click on Continue to GPO site

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