

SCHIP Reauthorization 2009  
 Comparison of House (HR 2) Bill and Senate (S 275)  
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HR 2	S 275
<b>FINANCING</b>	
<p>■ <b>Offsets.</b> Tobacco tax increase of \$.61 and \$300 million over 5 years in Medicare savings generated by limiting the expansion of physician owned specialty hospitals and disqualifying new physician owned hospitals from billing Medicare.</p>	Tobacco tax increase of \$.61.
<b>SCHIP FUNDING FOR STATES</b>	
<p>■ <b>Capped Funding Levels.</b> Increases the national SCHIP allotment level over 4 ½ years and is expected to cover over 6 million children.</p> <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 SCHIP funding to give each state its full allotment, bills direct proportionate reductions to each state's allotment to fit within the national cap.</p>	Same
<p>■ <b>Fiscal Year 2009 Allotments.</b> Bases state allocation on a state's actual use of and projected need for SCHIP funds.</p> <p>A state's allotment level for fiscal year 2009 is set at 110 percent of: 1) a state's fiscal year 2008 SCHIP spending (adjusted for per capita health care growth and child population growth); or 2) its fiscal year 2008 allotment (adjusted for per capita health care growth and child population growth); or 3) its February 2009 projected need for funds in fiscal year 2009, whichever is greatest.</p>	Same
<p>■ <b>Allotments in Future Years.</b>          The bill "rebases" states' allotments to reflect state expenditures and specified adjustments.</p> <p>Allotments will be adjusted annually to reflect:</p> <p>1. PER CAPITA HEALTH CARE GROWTH</p>	Same

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<p>FACTOR. One plus the percentage increase in the projected per capita amount of National Health Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary before the beginning of the fiscal year; and</p> <p>2. CHILD POPULATION GROWTH FACTOR. One plus the percentage increase (if any) in the population of children in the State from July 1 in the previous fiscal year to July 1 in the fiscal year involved, as determined by the Secretary based on the most recent published estimates of the Bureau of the Census before the beginning of the fiscal year involved, plus one percentage point.</p> <p>In 2011 a state’s actual use of SCHIP funds will serve as the basis for its new allotment (adjusted for health care inflation and child population growth).</p> <p>Allow states with approved plans to expand eligibility or benefits to receive an increase in their allotments, but states can request the adjustments only for fiscal years 2010 and 2012.</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>■ <b>Child Enrollment Contingency Fund.</b> The fund provides states with additional funds when they face an SCHIP funding shortfall and their enrollment of children exceeds a target level.</p> <p>Target level is based on FY 2007 enrollment in Medicaid and SCHIP, 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,</p>	Same

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<p>and 2.5 percentage points in future years.</p> <p>As noted above, any state expenditure from the fund will be considered in rebasing.</p>	
<p>■ <b>Redistribution of Unused SCHIP Funds.</b> Reduces the period during which a state can use an annual SCHIP allotment from three to two years, beginning with the fiscal year 2009 allotment. The bills outline a system for redistributing funds to states facing an SCHIP funding shortfall.</p>	Same
<p>■ <b>Elimination of Counting Medicaid Child Presumptive Eligibility Costs Against Title XXI Allotment.</b> Strike a current law provision that requires the payment for Medicaid benefits received by Medicaid children during periods of PE out of the SCHIP allotment.</p>	Same
<p>■ <b>Limitation on Matching Rate.</b> Imposes new constraints if a state decides in the future to cover children with family incomes above 300 percent of the federal poverty level. The state may only receive the lower Medicaid matching rate effective fiscal year 2009.</p>	Same
<b>COVERAGE OF ADULTS</b>	
<p>■ <b>Pregnant Women.</b> The bill retains existing authority for states to cover pregnant women through the “unborn child” option and allows for providing post-partum services for 60 days</p> <p>Gives states the option to cover pregnant women with SCHIP funds by submitting a state plan amendment.</p> <p>To use the option, states must cover pregnant women up to at least 185 percent of the federal poverty level in Medicaid (or higher if the state already covers pregnant women in Medicaid at a higher income level). States cannot impose any enrollment caps or waiting list in SCHIP.</p> <p>Allows states the option to provide presumptive eligibility for pregnant women.</p>	Same

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Establishes auto enrollment for children born to women under this section. The child remains eligible until age one in either SCHIP or Medicaid.	
<ul style="list-style-type: none"> <li>■ <b>Parents.</b> Prohibits HHS SECRETARY from approving any new waivers to cover parents with SCHIP funds. Coverage of parents in the 11 states that already have such waivers can continue without change for a two-year transition period through federal fiscal year 2011. In 2012 the bill sets rules for payment for coverage to limited block grants funded from state allotments. A state must meet specified benchmarks in covering children to receive the SCHIP enhanced matching rate for parent coverage.</li> </ul>	Same
<ul style="list-style-type: none"> <li>■ <b>Childless Adults.</b> Restates the existing ban on new waivers that allow SCHIP funds to be used for childless adults, and it ends federal financial participation out of SCHIP for the four existing childless adult waivers after a one-year transition (fiscal year 2010).</li> </ul>	Same
<b>REACHING ELIGIBLE NOT ENROLLED CHILDREN</b>	
<ul style="list-style-type: none"> <li>■ <b>Performance Bonuses.</b> Includes new performance bonuses to encourage states to enroll more of the uninsured children who are already eligible for <u>Medicaid</u>.</li> </ul> <p>States that have simplified their enrollment procedures (see below) and increase enrollment of these children above a target level receive a federal payment for each extra child enrolled to help defray the added cost of successful outreach efforts. The size of the payment can vary from 15 to 62.5 percent of the average cost to a state of enrolling a child.</p> <p>Beginning in fiscal year 2009, \$3.2 billion will be made available through a separate appropriation.</p>	S. 275 also clarifies that a child qualifies for the bonus during their presumptive eligibility period only if the child is determined to be eligible for Medicaid.

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<p>■ <b>Simplifying Enrollment Procedures.</b> To qualify for the performance bonus payments described above, a state must have adopted at least four of the following “best practice” methods for simplifying enrollment and renewal procedures in SCHIP and Medicaid for children:</p> <ol style="list-style-type: none"> <li>1) Adopting continuous eligibility for a full 12 months in SCHIP and Medicaid;</li> <li>2) Eliminating the asset test for children;</li> <li>3) Eliminating in-person interview requirements at application and renewal;</li> <li>4) Using the same joint applications and information verification process for purposes of establishing and renewing SCHIP and Medicaid;</li> <li>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 in SCHIP and Medicaid;</li> <li>6) Exercising the option to use presumptive eligibility determinations; and</li> <li>7) Exercising the new option to use Express Lane (described below) in SCHIP and Medicaid.</li> </ol>	<p>Same except state must adopt <u>five</u> of the “best practices”.</p> <p>S. 275 adds: Implementation of premium assistance subsidies as another qualifying best practice.</p>
<p>■ <b>Outreach Funding.</b> Allocates \$100 million for fiscal years 2009 through 2013 for outreach and enrollment grants designed to increase enrollment in SCHIP and Medicaid.</p> <p>Ten percent of the funding will be dedicated to a national enrollment campaign and ten percent to outreach grants targeting Native American children. HHS SECRETARY will distribute the remaining (80%) of the funds to state and local governments and other organizations to conduct outreach campaigns. The campaigns are geared to rural areas and racial and ethnic populations.</p> <p>Provides an enhanced matching rate in SCHIP (the higher of 75 percent or the sum of the enhanced FMAP plus 5 percentage points) and Medicaid (75 percent of the sum</p>	<p>Same</p>

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<p>expended) for translation and interpretation services for families for whom English is not the primary language.</p>	
<p>■ <b>Express Lane Option.</b> Gives states the option to use 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 SCHIP and Medicaid during initial determination of eligibility, re-determination, or both.</p> <p>To assist states with implementation, the bill outlines enrollment procedures states can take to meet “screen and enroll” rules under Express Lane, and it increases state access to various data sources directly relevant to eligibility determination. The bill also lays out evaluation and error rate procedures states must meet when implementing Express Lane specifically, the error rate will not be applied to the entire SCHIP or Medicaid population. Bill does not allow information from an Express Lane agency to be used to verify someone’s citizenship status or nationality.</p>	Same
<p>■ <b>Citizenship Documentation Requirement.</b> Extends the Medicaid citizenship documentation requirement to SCHIP effective October 1, 2009.</p> <p>Gives states <u>the option</u> to meet the citizenship documentation requirement by submitting the names and Social Security Numbers (SSNs) of individuals enrolled in Medicaid and SCHIP to the Social Security Administration (SSA) 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 within 30 days they are disenrolled.</p> <p>HHS SECRETARY may impose penalties on</p>	Same

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<p>states if more than <u>three percent</u> of the names and SSNs that they submit to the SSA are deemed “invalid” and not corrected. The bill provides for a federal match of 90 percent for the design, development or installation of the SSN matching system and 75 percent match for cost attributed to the operation of the system.</p> <p>Another provision specifies the acceptance of documentation from Federally Recognized Indian tribes. The bills clarify 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. The bill requires states to issue a separate identification card to a child born to an alien mother on Medicaid.</p>	
<p>■ <b>Increased Outreach and Enrollment of Indians.</b> Encourages states to take steps to provide for enrollment on or near reservations. In addition the bill revises the ten percent limit on outreach and expenditures to exclude state expenditures to increase outreach and enrollment of Indian children in SCHIP and Medicaid.</p>	Same
<b>ELIGIBILITY RULES FOR CHILDREN</b>	
<p>■ <b>Legal Immigrants.</b> The bill allows for FFP for legal immigrants by permitting states the option to cover legal immigrant children and pregnant women without the 5 year coverage ban.</p>	S 275 adds a provision which requires states that provide coverage to new legal immigrants (less than five years) must re-validate lawful U.S. residence at annual renewal.
<p>■ <b>Undocumented Immigrants.</b> Includes language that restates current law that no federal funding will be allocated to immigrants who are not in the country legally.</p>	Same
<b>PREMIUM ASSISTANCE</b>	
<p>■ <b>A New State Option For Providing Premium Assistance.</b> Gives states the <u>option</u> to offer a premium assistance subsidy for qualified employer sponsored coverage to</p>	Same

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<p>all targeted low income children who are eligible for SCHIP or Medicaid and have access to such coverage. Creditable coverage is defined as group health plan under the Public Health Services Act, employer contribution is at least 40 percent and the coverage is offered to all employees. A Health Flex Spending Account or a High Deductible Health Plan does not qualify for the subsidy. A state shall provide for supplemental coverage consisting of items or services not covered or only partially covered under the employer sponsored coverage and cost-sharing protection. Both bills allow a child to disenroll from the premium assisted employer sponsored coverage and enroll in SCHIP in a manner that ensures continuity of coverage for the child.</p> <p>If a group health plan or health insurance coverage offered through an employer is certified by an actuary as health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package or benchmark-equivalent coverage the state may provide premium assistance subsidies for enrollment of targeted low-income children in such group health plan or health insurance coverage but without regard to the requirement to provide supplemental coverage for benefits and cost-sharing protection.</p> <p>Expenditures for outreach activities related to the premium assistance subsidy program are not limited to the 10% cap however; such expenditures shall not exceed an amount equal to 1.25 percent of the maximum amount permitted.</p>	
<p>■ <b>Coordination of Premium Assistance with Private Coverage.</b> Include 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</p>	<p>Same</p>

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cost-effectiveness and the need for “wraparound” services; and requiring employers to notify families of their potential eligibility for premium assistance.	
<p>■ <b>Clarification of “Qualifying Event.”</b>            Provision makes gaining or losing eligibility for Medicaid or SCHIP a “qualifying event” for the purposes of eligibility for employer-sponsored coverage.</p>	Same
<p>■ <b>A New Purchasing Pool Option.</b> Gives states the <u>option</u> to establish a purchasing pool for employers with fewer than 250 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 SCHIP benchmark or benchmark-equivalent products. A state is not permitted to use SCHIP funds to pay for the administrative costs of establishing such a pool.</p>	Same
<b>BENEFITS</b>	
<p>■ <b>Dental Coverage.</b> Requires SCHIP plans, starting October 1, 2009, to include coverage of dental services.</p> <p>Coverage must be equivalent to specified benchmark dental benefit standards. Possible benchmarks include federal employee dependent coverage, state employee dependent coverage, commercial dental coverage with largest enrollment</p> <p>Section 501(a)(5)(A) contains a statement that dental coverage shall include services “necessary to...restore oral structures to health and function</p> <p>501 (d) Requires reports on type of dental coverage provided by age            The bill also requires 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>S. 275 adds a state option to provide dental-only supplemental coverage which is not present in HR 2. Dental coverage under SCHIP cannot be more favorable than the dental-only coverage</p> <p>States may not apply a waiting period for dental-only supplemental coverage.</p> <p>To take advantage of this option, a state must cover children up to the highest income eligibility standard, does not impose any limitations or waiting lists, and provides benefits to all children who apply for and meet the eligibility standards.</p>

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<p>■ <b>Mental Health Parity.</b> Requires that if a state provides mental health or substance abuse services through SCHIP that the financial requirements and treatment limitations for those benefits not be more restrictive than those for medical and surgical benefits.</p>	Same
<p>■ <b>EPSDT Services in Medicaid.</b> 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 SCHIP.</p>	Same
<b>CHILD HEALTH QUALITY</b>	
<p>■ <b>Quality Initiative for Children.</b> HHS SECRETARY to develop, test, and disseminate a set of core child health quality measures addressing the quality and availability of care, and duration and stability of children’s coverage.</p> <p>Core set is defined as a group of valid, reliable and evidence based quality measures. Part of the core set of measures will include treatments to <i>correct or ameliorate the effects of physical and mental conditions</i>. HHS will establish a Pediatric Quality Measures Program by January 2010.</p>	Same
<p>■ <b>Studies.</b> By July 2010, the Institute of Medicine will report to Congress on pediatric health and health quality measures. By March 2011, the GAO will also issue a report on children’s access to primary and specialty care under SCHIP and Medicaid and make recommendations for improving such access.</p>	Same
<p>■ <b>State Reporting.</b> Requires states to submit a child health quality report to HHS SECRETARY no later than 2 years after enactment. HHS will disseminate best</p>	Same

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<p>practice measurements and reporting on quality of healthcare for children and facilitate the adoption of these practices.</p> <p>States will be required to provide information in their SCHIP annual reports on state specific child health quality measures.</p> <p>Sections 401(a)(8) and (b)(2) set up a program and structure for developing a pediatric quality measures program that would likely require the collection of encounter and claims data in order to be able to meet the requirements. Section 401(b)(6) defines pediatric quality measure in such a way that collection of encounter and claims data would be essential.</p> <p>Section 402(a)(2)(e)(4) requires that states conduct CAHPS results in their annual report (presumably starting with the 2009-10 federal annual report).</p> <p>States will receive enhanced administrative funding for collecting and reporting on child health measures.</p>	
<p>■ <b>Demonstration Project Grants.</b> In FFY 2009 – 2013, HHS to award 10 grants and establish a demonstration project 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 grants will evaluate provider-based models and demonstrate the impact of electronic health record models. The bill also includes \$25 million in demonstration funding to combat obesity.</p>	<p>Same</p>
	<p>■ <b>GAO Report on Medicaid Managed Care Rates.</b> New Section 617 in S. 275 requires a GAO report on Medicaid Managed Care Payment Rates on the extent to which State payment rates for Medicaid MCOs are “actuarially sound.” There is no mention of studying payment rates in SCHIP.</p>

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<p>■ <b>Model Electronic Health Record.</b> The bill requires the HHS SECRETARY to establish a program to encourage the development of a model electronic health record format for children in Medicaid and SCHIP.</p>	<p>Same</p>
<p>■ <b>Managed Care Standards Applied to SCHIP.</b> The bill applies Medicaid managed care standards to SCHIP specifically related to the following, 1) protection of enrollee-provider communication 2) demonstration of adequate capacity and services 3) anti-discrimination 4) compliance with certain maternity and health requirements 5) external independent review 6) restrictions on marketing 7) conflict of interest safeguards 8) sanctions for non-compliance.</p>	<p>Same</p>
	<p>■ <b>New Commission: Medicaid and CHIP Payment and Access.</b> S. 275 adds a new Section 506 which sets up a new 17-member Medicaid and CHIP Payment and Access Commission to review policies of Medicaid and SCHIP related to children’s access to covered services and examine issues affecting Medicaid and SCHIP 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"> <li>• Payment policies of Medicaid and SCHIP</li> <li>• How Medicaid and SCHIP payments affect the health care delivery system in general</li> <li>• Other policies including transportation and language barriers.</li> </ul> <p>The Commission has the authority to obtain “information necessary to enable it to carry out [the duties]” from any department or agency of the US.</p>

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<b>OTHER PROVISIONS</b>	
<p>■ <b>Application of Prospective Payment System for Services Provided by FQHC and RHC.</b> <u>Requires</u> the application of Medicaid’s payment system for Federal Qualified Health Centers and Rural Health Clinics to SCHIP for services provided after October 1, 2009. HHS SECRETARY will award \$5 million in grants to SCHIP states for expenditures related to transitioning to compliance with requirements to apply the prospective payment system to Federally Qualified Health Centers and Rural Health Centers.</p>	Same
<p>■ <b>Payment Error Rate Measurement (PERM).</b> Outlines requirements for new final rule on PERM regulation (the regulations which require states to report on errors in claim payments and eligibility determinations). Also, the bills state an enhanced FMAP rate of no less than 90% for PERM expenditures.</p>	Same
<p>■ <b>Implementation Timeframes for Provisions that do not require state law changes</b></p> <p>Unless otherwise specified, provisions take effect April 1, 2009. Some provisions specify an urgency implementation which would mean on signature.</p>	Same
<p>■ <b>State Timeline for Implementation of New Provisions.</b> Any new provisions which require a state law change are given until 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. In the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.</p>	Same
<p>■ <b>Information Required for Inclusion in State Annual Report.</b> Requires states to include information on eligibility criteria,</p>	Same

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enrollment, retention, measures such as 12 month continuous eligibility, self-declaration, presumptive eligibility, denials, access to services, and premium assistance. HHS SECRETARY will specify a standardized format. The bill also provides \$5 million to improve “MSIS,” the data system used by states to report on enrollment and eligibility in SCHIP and Medicaid.	
■ <b>Premium Grace Period.</b> Grants families a 30-day premium payment grace period under SCHIP before termination of a child’s coverage.	Same
■ <b>Clarification of Coverage of Services Provided Through School-Based Health Centers.</b> Gives states the option to provide child health assistance for covered items and services that is furnished through school-based health centers.	Section 505 of S. 275 defines school-based health centers and sponsoring facilities.
■ <b>Improving Data Collection.</b> Allocates to HHS \$20 million to improve the state-specific estimates of the number of children enrolled in SCHIP and Medicaid available under the Current Population Survey and to explore using the American Community Survey for such estimates.	Same
■ <b>Updated Federal Evaluation of SCHIP.</b> Requires a new federal evaluation of SCHIP in 2011 and allocates \$10 million towards the effort.	Same