

Agenda Item 7.f.

3/26/09 Meeting

# Implementing CHIPRA

## Mandates, State Options and Other Provisions

**Lesley Cummings**

**Executive Director**

**Managed Risk Medical Insurance Board**

**March 19, 2009**



# Mandates

<b>Requirement</b>	<b>Date Applicable</b>
<b>Application of DRA citizenship documentation and identification requirements to CHIP.</b>	<b>1/1/10 unless state law change needed. If so, 1/1/11.</b>
<b>Mental health and substance abuse parity.</b>	<b>1/1/11—assumes state law change needed.</b>

# Mandates (continued)

Requirement	Date Applicable
<p><b>State cannot prevent FQHC from contracting with a private dentist.</b></p> <p><b>Applies to Medicaid and CHIP.</b></p>	<p><b>4/1/09</b></p>
<p><b>Dental coverage required.</b></p> <ul style="list-style-type: none"><li>■ <b>State must select one of several specified benchmarks, one of which is state employee coverage.</b></li><li>■ <b>Believe HFP will need to develop encounter/claims based system to meet reporting requirements.</b></li></ul>	<p><b>10/1/09</b></p> <p><b>unless state law change needed. If so, 1/ 1/11.</b></p>

# Mandates (continued)

<b>Requirement</b>	<b>Date Applicable</b>
<b>FQHC's and RHC's must be paid as they are in Medicaid (prospective payments).</b>	<b>1/1/11—assumes state law change needed.</b>
<b>Medicaid Managed Care Standards applied to CHIP. (enrollee protections, anti-discrimination, conflict of interest, sanctions, etc.)</b>	<b>7/1/09 unless state law change needed. If so, 1/ 1/11.</b>

# Mandates (continued)

Requirement	Date Applicable
<p data-bbox="79 349 1155 592"><b><u>Quality Requirements.</u> CMS to establish mandatory indicators.</b></p> <ul data-bbox="79 635 1155 1249" style="list-style-type: none"><li data-bbox="79 635 1155 878">■ IOM and GAO to assess indicators for future modification.</li><li data-bbox="79 921 1155 1249">■ Promise of enhanced administrative funding for collecting and reporting child health measures.</li></ul>	<p data-bbox="1155 349 1812 763"><b>HHS will establish Quality Measurement Program by 1/1/10.</b></p> <p data-bbox="1155 921 1812 1249"><b>CA must submit its Child Health Quality Report by 2/11.</b></p>

# State Options

Option	Date Applicable
<b>Expand coverage up to 300% at CHIP funding ratios. Above 300% at Medicaid funding ratios.</b>	<b>4/1/09. If state expands coverage and needs additional funding (above allotment), SPA needs to be submitted by 8/31/09 for FFY 2010.</b>
<b>Cover pregnant women with CHIP funds. Unborn option left undisturbed with statement that no congressional intent expressed on legality or illegality of unborn option.</b>	<b>4/1/09</b>

# State Options (continued)

<b>Option</b>	<b>Date Applicable</b>
<b>Draw down FFP for “recent legal immigrant” children and pregnant women in both Medicaid and CHIP. In some cases, must obtain verification during eligibility re-determination that person is lawfully residing in U.S.</b>	<b>4/1/09</b>
<b>Express Lane option to use findings from school lunch, WIC and other “public agencies” when determining eligibility for MC or CHIP.</b>	<b>2/4/09</b>

# State Options (continued)

Option	Date Applicable
<b>Dental Only Coverage. To use option, must cover children up to highest income eligibility standard as of January 1, 2009, not impose limitations or waiting lists, and provide benefits to all eligible children.</b>	<b>4/1/09. Would require authorization in state statute.</b>
<b>Use an SSN match to meet citizenship documentation requirements.</b>	<b>4/1/ 09</b>

# State Options (continued)

<b>Option</b>	<b>Date Applicable</b>
<b>Purchasing pool for employers with fewer than 250 employees. One employee must be pregnant or have an eligible child. Pool must offer two CHIP benchmark products. No CHIP funds can be spent on administration.</b>	<b>4/1/09. Would require authorization in state statute.</b>

# State Options (continued)

Option	Date Applicable
<b>School Based Health Centers can receive funding for services.</b>	<b>4/1/09 unless state law change needed.</b>
<b>Premium assistance in both CHIP and Medicaid.</b> <b>Mandatory benefit wrap. Employer must contribute 40 percent of cost.</b>	<b>4/1/09. Would require authorization in state statute.</b>

# Other Provisions

Requirement	Date Applicable
<b>Performance bonus for increased Medicaid enrollment of uninsured children. (Contingent on satisfying 5 “simplified” enrollment rules)</b>	<b>4/1/09</b>
<b>Outreach funding geared to rural areas and racial and ethnic populations. CMS to allocate funds.</b>	<b>4/1/09</b>
<b>Enhanced FMAP for translation and interpretation services for both Medicaid and SCHIP.</b>	<b>4/1/09</b>

# Other Provisions (continued)

<b>Requirement</b>	<b>Date Applicable</b>
<b>GAO Report on Medicaid Managed Care Rates.</b>	<b>8/10</b>
<b>New Commission on payment and access in Medicaid and CHIP. Reports due March 2010 and June 2010.</b>	<b>2/4/09</b>

# Other Provisions (continued)

<b>Requirement</b>	<b>Date Applicable</b>
<b>Small Employer Education and Outreach Task Force</b>	<b>4/1/09</b>
<b>PERM: CMS to issue final rule on PERM within 6 months.</b>	<b>8/09</b>

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<b>FINANCING</b>		
■ <b>Offsets (SEC 701) Effective after March 31, 2009.</b> Tobacco tax increase of \$.61.		■ No action required.
<b>SCHIP FUNDING FOR STATES</b>		
■ <b>Capped Funding Levels (SEC 101 &amp; 108) Effective April 1, 2009.</b> Increases the national SCHIP allotment level over 4 ½ years and is expected to cover over 6 million children.  2009: \$10.562 billion 2010: \$12.520 billion 2011: \$13.459 billion 2012: \$14.982 billion 2013: \$17.406 billion  If there is not enough SCHIP funding to give each state its full allotment, the law directs proportionate reductions to each state’s allotment to fit within the national cap.	Harbage Consulting, reviewing California SCHIP funding requirements under a contract with California Health Care Foundation indicates that this funding level will be quite sufficient for CA needs.	■ No action required.
■ <b>Fiscal Year 2009 Allotments (SEC 102) Effective April 1, 2009.</b> Bases state allocation on a state’s actual use of and projected need for SCHIP funds.  A state’s allotment level for federal 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.	According to Congressional Research Services, California’s allotment for 2009 is 85 percent larger than prior law for FFY '09 allotment growing from \$799.2 million to \$1,481.2 billion.  Harbage Consulting concludes the \$1,481.2 billion allotment will be sufficient for FFY 09.	■ Calculate expected FFY 2009 needs; identify expansion provisions and projected cost.  ■ CMS requests submission by March 10, 2009.

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<p>■ <b>Allotments in Future Years (SEC 102) Effective April 1, 2009.</b> The law “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 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>Allows 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. 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</p>	<p>Harbage Consulting indicates that the growth factors are adequate to meet CA need. If federal funds are not spent, state will lose them in future years.</p> <p>The limitation on increasing the state allotment to FFY 2010 and 2012 places constraints on future program expansion timelines if the automatic growth factors do not provide for a sufficient allotment.</p>	<p>■ No action needed.</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</p>

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“child enrollment contingency fund” (see below), these funds are built into their future allotments.		expansion for FFY 2010 or 2012.
<p>■ <b>Child Enrollment Contingency Fund (SEC 103) Effective April 1, 2009.</b> The fund (through a separate appropriation of 20% of total allotment) provides states with additional funds when they face an SCHIP funding shortfall <u>and</u> their enrollment of children exceeds a target level.</p> <p>Target level is based on federal fiscal year 2008 monthly average unduplicated enrollment in Medicaid and SCHIP increased by the population growth for children for year ending on June 30, 2007 plus 1 percentage point.</p> <p>Or</p> <p>Subsequent fiscal year is equal to the target average number of child enrollees for the previous fiscal year plus the child population growth factor.</p> <p>As noted above, any state expenditure from the fund will be considered in rebasing.</p>	There is no expectation that CA will need additional funding for federal fiscal year 2009.	■ No action required.
<p>■ <b>Allotment Availability and Redistribution of Unused SCHIP Funds (SEC 105 &amp; 106) Effective April 1, 2009.</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 law outlines a system for redistributing funds to states facing an SCHIP funding shortfall.</p>	HFP can spend its allotment within 2 years.	■ No action needed.

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<p>■ <b>Elimination of Counting Medicaid Child Presumptive Eligibility Costs Against Title XXI Allotment (SEC 113) Effective April 1, 2009.</b> Strikes a current law provision that requires that federal reimbursement for Medicaid benefits received by Medicaid children during periods of PE be made out of the SCHIP allotment.</p> <p>Strikes the Medicaid requirements for deemed newborns regarding living arrangements with the mother.</p>	<p>This will leave more funds available in a state’s SCHIP allotment. CA estimates this is about \$80 million.</p> <p><i>DHCS COMMENT:</i>                      Lessens administrative burdens in reconciling claims for such expenditures between titles XIX and XXI.</p> <p>Guidance to be developed for the counties regarding the new provisions on the living arrangements for deemed newborns.</p>	<p>■ MRMIB communicated with DHCS in February 2009 requesting that DHCS change its claiming method for the May Revise.</p> <p>■ DHCS to develop guidance for counties with input from stakeholders.</p>
<p>■ <b>Limitation on Matching Rate (SEC 114) Effective April 1, 2009.</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 (FPL). The state may receive only the lower Medicaid matching rate effective federal fiscal year 2009.</p>	<p>To the extent CA wants to expand above 300% FPL, matching rate would be 50/50 rather than 65/35.</p>	<p>■ No action required.</p>
<b>COVERAGE OF ADULTS</b>		
<p>■ <b>Pregnant Women (SEC 111) Effective April 1, 2009.</b> Gives states the new 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>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 Program. See Unborn Provision below.</p>	<p>■ No action required.</p>

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<p>Allows states the option to provide presumptive eligibility for pregnant women.</p> <p>Establishes auto enrollment for children born to women under this section. The child remains eligible until age one in either SCHIP or Medicaid.</p>	<p>State already does auto enrollment into HFP for AIM-linked infants under the Unborn option.</p>	
<p>■ <b>Pregnant Women – Unborn Option (SEC 111) Effective April 1, 2009.</b> The law leaves undisturbed, but explicitly expresses no congressional intent concerning the legality or illegality of, present CMS “unborn child” regulation permitting SCHIP reimbursement for prenatal care.</p>	<p>This provision allows CA to continue to receive federal matching funds for pregnant women in Medi-Cal and the Access for Infants and Mothers Program under the “unborn” approach.</p>	<p>■ No action required.</p>
<p>■ <b>Parents (SEC 112) Effective April 1, 2009.</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 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 SCHIP enhanced matching rate for parent coverage.</p>	<p>None.</p>	<p>■ No action required.</p>
<p>■ <b>Childless Adults (SEC 112) Effective April 1, 2009.</b> Restates the existing ban on new waivers that allow SCHIP funds to be used for childless adults, and ends federal financial participation out of SCHIP for the four existing childless adult waivers after a one-year transition (federal fiscal year 2010).</p>	<p>None.</p>	<p>■ No action required.</p>

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<b>REACHING ELIGIBLE NOT ENROLLED CHILDREN</b>		
<p>■ <b>Simplifying Enrollment Procedures (SEC 104) Effective April 1, 2009.</b> To qualify for the performance bonus payments described below, a state must have adopted <u>at least five</u> of the following “best practice” methods for simplifying enrollment and renewal procedures. Most if not all of the following apply to SCHIP and Medicaid for children:</p> <ol style="list-style-type: none"> <li>1) Adopting continuous eligibility for a full 12 months;</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 eligibility;</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;</li> <li>6) Exercising the option to use presumptive eligibility determinations;</li> <li>7) Exercising the new option to use Express Lane (described below); and</li> <li>8) Implementation of premium assistance subsidies.</li> </ol>	<p><i>DHCS COMMENT:</i>                      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 what was 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 (#2, 3, 4, 6) and will be in compliance with 5 options (including #1), to the extent the midyear status reports and continuous eligibility provisions are suspended or rescinded.</p>	<p>■ To qualify for the enhanced Medicaid FMAP under ARRA, state law changes will be needed regarding midyear status reporting and continuous eligibility for 12 months for children.</p>
<p>■ <b>Performance Bonuses (SEC 104) Effective April 1, 2009.</b> Includes new performance bonuses to encourage states to enroll more of the uninsured children who are already eligible for <u>Medicaid</u>.</p> <p>States that have simplified their enrollment procedures (see above) and increase enrollment of these children above a target level receive a federal payment for each extra child enrolled to</p>	<p><i>DHCS COMMENT:</i>                      In order to determine some of the calculations for the performance bonuses, information must come from the HHS Secretary. Once this information is available, DHCS will assess its eligibility for the performance bonuses. Eligibility for</p>	<p>■ Action is contingent upon receipt of guidance from CMS.</p>

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<p>help 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>the bonuses requires states to have the enrollment procedures (as noted above) in place for a full fiscal year.</p>	
<p>■ <b>Outreach Funding (SEC 201) Effective April 1, 2009.</b> Allocates \$100 million for federal 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. No entity shall be required to provide any matching funds as a condition for receiving the grant. The campaigns are geared to rural areas and racial and ethnic populations.</p>	<p>Note that funds can go to states, local governments and “other organizations.”</p>	<p>■ Await direction from CMS on how to apply for the outreach funding and decide whether MRMIB or DHCS will apply. Traditionally, DHCS has conducted the state’s outreach efforts.</p>

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<p>■ <b>Increased Outreach and Enrollment of Indians (SEC 202) Effective April 1, 2009.</b> 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>■ <b>Enhanced FMAP for Translation or Interpretation Services (SEC 201) Effective April 1, 2009.</b> 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 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>■ MRMIB will assess the value of separating out the translation and interpretation services from the administrative vendor contract.</p> <p>■ MRMIB will have to assess the value of changing health plan contracts to separate out these services.</p> <p>■ DHCS will have to assess the feasibility of changing health plan contracts to separate out these services.</p> <p>■ DHCS will have to assess the feasibility of separating out the translation and interpretation services from the current Health</p>

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		Care Options contract for managed care and the contractor used for fee-for-service translations.
<p>■ <b>Express Lane Option (SEC 203) Effective February 4, 2009.</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 law outlines enrollment procedures states can take to meet “screen and enroll” rules under Express Lane, such as establishing a threshold as a percentage of FPL that exceeds highest SCHIP applicable threshold by a minimum of 30% (or higher as determined by a state) and it increases state access to various data sources directly relevant to eligibility determination. The law 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.</p> <p>The law allows temporary enrollment in SCHIP pending “screen and enroll” with SCHIP 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><i>DHCS COMMENT:</i>            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.</p>	<p>■ DHCS would have to conduct a cost benefit analysis to see if the potential high administrative costs for implementing the express lane options would be an effective avenue for increasing the enrollment of eligible uninsured children and increasing the retention of existing subscribers.</p>
<p>■ <b>Citizenship Documentation Requirement (SEC 211) Effective January 1, 2010 or January 1, 2011, if state statute change is needed.</b> Extends the Medicaid citizenship</p>	<p>Presently, HFP requires a copy of the child’s birth certificate for enrollment.</p>	<p>■ MRMIB will assess what changes will be needed to existing HFP</p>

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<p>documentation requirements to SCHIP.</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 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 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 cost attributed to the operation of the system.</p>	<p>Presently SCHIP does not require children’s SSN’s. To do so HFP would have to change the application, program regulations and operations.</p> <p><b>DHCS COMMENT:</b> The SSA match may ameliorate the problems created by the citizenship documentation requirements. DHCS is interested in pursuing the electronic SSN option (batch process, not real time exchange) and believes it would be more cost effective than the current cost of counties processing the citizenship/identity documents.</p>	<p>documentation rules and procedures and whether, and to what extent, compliance will require state legislation.</p> <ul style="list-style-type: none"><li>■ To the extent the procedures must change, it would probably require emergency regulations and modifications to the joint application.</li><li>■ DHCS intends to implement an electronic exchange with SSA to match children’s SSN. A state law change will be needed to undertake the data match process, implement the correction process for invalid SSNs, and for providing full scope eligibility while citizenship status is</li></ul>

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<p>Another provision specifies the acceptance of documentation from Federally Recognized Indian tribes.</p>	<p>Based on current efforts of validating new applicant SSN’s, CA has an error rate of approximately 5 percent. It is believed that after initial implementation, this error rate can be lowered which would eliminate the penalties for invalid SSA numbers that exceed the 3 percent threshold. This would allow the state to no longer require the DRA citizenship and identity requirements for Medi-Cal.</p> <p>Under California’s rules, immigrants claiming a full scope status have 30 days or the time it takes to determine eligibility (whichever is longer) to provide documents. Full scope 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 applicants until citizenship documents are provided. DHCS has interpreted this new language to allow full scope coverage of citizens while they are obtaining documents which provides equitable treatment of citizens to that of</p>	<p>being verified.</p>

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<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. The law requires states to issue a separate identification card to a child born to an alien mother who is currently on Medicaid; the requirement is effective April 1, 2009.</p>	<p>immigrants under these provisions.</p> <p>Under Medi-Cal today, a new identification card is issued for these children. It is not clear whether this provision would require the Department to speed up that process.</p>	
<p><b>ELIGIBILITY RULES FOR CHILDREN</b></p>		
<p>■ <b>Legal Immigrants (SEC 214) Effective April 1, 2009.</b> The law allows for FFP for legal immigrant children and pregnant women in both Title XIX and Title XXI by giving states the option of filing a SPA to cover them without the 5 year coverage ban. State cannot claim for pregnant women and children under Title XXI unless also doing so under Title XIX.</p> <p>Children are defined as persons under age 21. Adds a provision specifying that no debt will accrue to sponsors for this assistance.</p>	<p>This option would reduce present state costs because California now provides for coverage of children and pregnant women with state only funds.</p> <p>HFP will spend \$18.8 million on coverage for legal immigrant children in FY 2009-10. HFP currently covers this group with state-only funds. If the state implements this option, \$12.2 million would be covered by SCHIP funds. Additional savings from Medi-Cal for current expenditures could be realized.</p> <p><i>DHCS COMMENT:</i>          Subject to budget negotiations, the Governor has proposed eliminating the state funded program for legal</p>	<p>■ If the state decides to implement the option, DHCS and MRMIB will file the necessary SPAs.</p> <p>■ DHCS and MRMIB must file their respective SPAs by June 30, 2009 to the extent the state seeks funding retroactive to April 1, 2009. MRMIB must file an SCHIP SPA by August 31, 2009 to the extent that an increased allotment to fund the expansion is needed for FFY 2010 beyond the automatic growth factors.</p>

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<p>Requires states, as part of the eligibility re-determination process, to verify that the individual still is lawfully residing in the U.S. in those circumstances where the initial documentation would not be sufficient to establish continuing lawful residence.</p>	<p>immigrants in Medi-Cal.</p> <p>Note: the state must cover such children and pregnant women under Medicaid to get funding in SCHIP.</p> <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><b>DHCS COMMENT:</b> This new law change allows states to provide Medicaid covered services with FFP to eligible pregnant women and children (as defined) who would otherwise be subject to the 5 year bar. Non-pregnant adult non qualified aliens are not covered. This should not affect PRUCOL aliens because they are not qualified aliens and only qualified aliens are subject to the 5 year bar.</p>	<ul style="list-style-type: none"><li>■ MRMIB will enact emergency regulations to change the AER process.</li><li>■ MRMIB will evaluate whether the state can claim for any time period prior to effective date of emergency regulations addressing AER verification requirements.</li><li>■ MRMIB will review administrative vendor costs for re-verifying status at AER.</li></ul>

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<b>PREMIUM ASSISTANCE</b>		
<p>■ <b>A New State Option For Providing Premium Assistance (SEC 301) Effective April 1, 2009.</b> Gives states the <u>option</u> to offer a premium assistance subsidy for qualified employer sponsored coverage to all targeted low income children who are eligible for SCHIP 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> <p>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.</p> <p>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.</p> <p>If a group health plan or health insurance coverage offered through an employer is certified by an actuary as providing 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 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</p>	<p>It is highly unlikely that any ESI coverage offer could meet an actuarial certification as being the equivalent to CA SCHIP Benchmark coverage (CalPERS) and the requirement that the employer contributes 40 percent of the cost for dependent coverage. SCHIP ten year history has shown that premium assistance programs have been ineffective and have not been a good strategy for covering uninsured children in SCHIP; most SCHIP/Medicaid children do not have access to a parent's ESI coverage (Urban Institute Study January 2009; 4.6 percent in Medicaid have access and 15.9 percent in SCHIP have access).</p> <p><b>DHCS COMMENT:</b> 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</p>	<p>■ State statute would be required to implement.</p>

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<p>employer sponsored coverage and enroll in SCHIP 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 shall not exceed an amount equal to 1.25 percent of the maximum amount permitted.</p>	<p>prohibitive given the likelihood of a low number of enrollees. Historically, beneficiaries have been more likely to choose Medi-Cal as the primary coverage rather than retaining private insurance through participation in the existing Health Insurance Premium Payment (HIPP) program under Medi-Cal.</p>	
<p>■ <b>Coordination of Premium Assistance with Private Coverage (SEC 311) Effective April 1, 2009.</b> 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>Only relevant for states that choose the premium assistance option.</p>	<p>■ No Action Required.</p>
<p>■ <b>A New Purchasing Pool Option (SEC 301) Effective April 1, 2009.</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 or operation of such a pool.</p>		<p>■ State statute would be required to implement.</p>
<p>■ <b>Clarification of “Qualifying Event” (SEC 311) Effective April 1, 2009.</b> Provision makes gaining or losing eligibility for Medicaid or SCHIP a “qualifying event” for the purposes of</p>		<p>■ No Action Required.</p>

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eligibility for employer-sponsored coverage.		
<b>BENEFITS</b>		
<p>■ <b>Dental Coverage (SEC 501) Effective October 1, 2009 or January 1, 2011 if state statute change is needed.</b> Requires SCHIP plans 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>The law 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>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 (CalPERS), but without orthodontia. State employee orthodontia coverage has a high deductible, something CMS’s has disapproved for California in the past given the limitations on cost sharing.</p> <p>Complying with the reporting requirements would necessitate an encounter claims-based 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>■ MRMIB will obtain guidance from CMS on exactly what benefits are required; MRMIB may need a state statute change depending on CMS interpretation.</p> <p>■ MRMIB will analyze and select benchmark.</p> <p>■ MRMIB will confirm with CMS that an encounter and claims system is required and assess the time frame for implementing the system.</p> <p>■ Evaluate whether additional statutory authority to obtain dental encounter data is needed.</p>

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<p>■ <b>Dental Only Supplemental Coverage (SEC 501) Effective April 1, 2009.</b> Adds a state <u>option</u> to provide dental-only supplemental coverage. Dental coverage under the dental-only coverage cannot be more favorable than the coverage in the base SCHIP Program.</p> <p>Provision is subject to the SCHIP limitations on premium and cost sharing. In general, in SCHIP 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 SCHIP 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>■ MRMIB intends to assess the feasibility of the provision in the Fall of 2009.</p>
<p>■ <b>Provision of Dental Services Through FQHCs (SEC 501) Effective April 1, 2009 or January 1, 2011 if state statute change is needed.</b> The state will not prevent 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 provision and its impact.</p> <p><i>DHCS COMMENT:</i> DHCS is analyzing this provision and its impact on the program. Medi-Cal provides dental coverage under its current program and it is a requirement under EPSDT.</p>	<p>■ DHCS is seeking guidance from CMS on this provision; this guidance will assist DHCS in determining if a state law change and/or a SPA is needed for implementation.</p>
<p>■ <b>Mental Health and Substance Abuse Parity (SEC 502) Effective for plan years beginning after October 4, 2009; in CA this is July 1, 2010. However, CA assumes a state statute change is required; therefore the provision is effective January 1, 2011.</b> By making recently-enacted federal</p>	<p>This appears to require expansion of HFP mental health and substance abuse services. Such an expansion would increase state costs.</p>	<p>■ MRMIB will obtain CMS guidance on parity requirements.</p> <p>■ MRMIB will assess the</p>

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<p>mental health parity laws applicable to SCHIP, requires that, if a state provides mental health or substance abuse services through SCHIP, the financial requirements and treatment limitations for those benefits can not be more restrictive than those for medical and surgical benefits.</p>	<p>The requirement for parity raises the question of whether it is possible to assure parity with the SED carve-out.</p>	<p>impact on HFP mental health and substance abuse coverage.</p> <ul style="list-style-type: none"> <li>■ Assumes state statute changes.</li> </ul>
<ul style="list-style-type: none"> <li>■ <b>EPSDT Services in Medicaid (SEC 611) Effective April 1, 2009.</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.</li> </ul>	<p><i>DHCS COMMENT:</i>            Currently, Medi-Cal has not exercised the option to use benchmark packages.</p>	<ul style="list-style-type: none"> <li>■ No Action Required.</li> </ul>
<h3 style="color: blue;">CHILD HEALTH QUALITY</h3>		
<ul style="list-style-type: none"> <li>■ <b>Quality Initiative for Children (SEC 401) Effective April 1, 2009.</b> Not later than January 1, 2010 the HHS SECRETARY shall 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.</li> </ul> <p>Core set of measures is defined as a group of valid, reliable and evidence based quality measures. Part of the core set of measures will include treatments to correct or ameliorate the effects of physical and mental conditions. States will receive enhanced administrative funding for collecting and reporting on child health measures.</p> <p>HHS SECRETARY will disseminate best practice measurements and facilitate the adoption of these practices. HHS will develop</p>	<p>Federal leadership in Quality Initiatives is a welcome development but will increase workload and increase other costs.</p>	<ul style="list-style-type: none"> <li>■ MRMIB to obtain CMS guidance on how to claim enhanced administrative funding.</li> </ul>

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<p>standardized format for reporting on quality of healthcare for children.</p> <p>HHS will 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>■ <b>Studies (SEC 401 &amp; 402) Effective April 1, 2009.</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 issue a report on children’s access to primary and specialty care under SCHIP and Medicaid and make recommendations for improving such access.</p>		
<p>■ <b>Demonstration Project Grants (SEC 401) Effective April 1, 2009.</b> In federal fiscal years 2009 – 2013, HHS to award 10 grants (\$20 million) 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.</p> <p>The law also includes \$25 million in demonstration funding to combat obesity.</p>		<p>■ MRMIB will be waiting for CMS direction on how to apply for the grant funding and decide whether to apply.</p>
<p>■ <b>Information Required for Inclusion in State Annual Report (SEC 402) Effective April 1, 2009.</b> Requires a state to include in their annual report information on eligibility criteria, enrollment, retention, measures such as 12 month continuous eligibility, self-</p>		<p>■ MRMIB and DHCS complete an annual report; and will assess the additional information</p>

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<p>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>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 SCHIP and Medicaid.</p> <p>Requires that states conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey 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>this provision is requesting.</p>
<p>■ <b>New Commission: Medicaid and CHIP Payment and Access (SEC 506) Effective February 4, 2009.</b> Law sets up a new 17-member Medicaid and CHIP Payment and Access Commission to review polices 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</li></ul>	<p>It’s not clear what the Commission might want from states and there are no specifics in the law, though the Commission has broad authority to obtain information.</p>	<p>■ No Action Required.</p>

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<p>barriers.</p> <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>		
<b>OTHER PROVISIONS</b>		
<p>■ <b>Managed Care Standards Applied to SCHIP (SEC 403) Applies to contract years for health plans beginning on or after July 1, 2009 or January 1, 2011 if state statute changed is needed.</b> The law applies Medicaid managed care standards to SCHIP specifically related to the following: 1) enrollment 2) provision of information 3) beneficiary protections 4) quality assurance standards 5) protection from fraud and abuse 6) sanctions for non-compliance.</p>	<p>Appears to require the collection of encounter and claims data in order to be able to meet the requirements. MRMIB has been developing but does not have an encounter and claims system yet.</p>	<p>■ If encounter and claims data is required, MRMIB will assess the time frame for implementing the encounter and claims system.</p> <p>■ MRMIB will evaluate whether implementation requires state statute changes.</p>
<p>■ <b>Premium Grace Period (SEC 504) Effective February 4, 2009.</b> Grants families a 30-day premium payment grace period under SCHIP before termination of a child’s coverage.</p>	<p>HFP statute and practice already comply.</p>	<p>■ No Action Required.</p>
<p>■ <b>Clarification of Coverage of Services Provided Through School-Based Health Centers (SEC 505) Effective April 1, 2009.</b> Gives states the option to provide child health assistance for covered items and services that is furnished through school-based health centers. The law defines school-based health centers and sponsoring facilities.</p>	<p><i>DHCS COMMENT:</i>          This optional provision is consistent with the Governor’s white paper on the expansion of school-based health centers by 500 for elementary school-based health centers however there is no formal policy on how payments are to be made for such services</p>	<p>■ MRMIB needs to review how DHCS manages the coordination of care with Managed Care plans.</p>

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	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.	
<p>■ <b>GAO Report on Medicaid Managed Care Rates (SEC 617) Report released August 2010.</b> 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>	<p><i>DHCS COMMENT:</i> For purposes of Medi-Cal, the managed care rates are certified by actuaries for actuarial soundness thus this study appears to be duplicative of existing efforts and unnecessary.</p>	<p>■ No Action Required.</p>
<p>■ <b>Application of Prospective Payment System for Services Provided by FQHC and RHC (SEC 503) Effective October 1, 2009 or in CA where we assume state statute change is needed Effective January 1, 2011.</b> Requires the application of Medicaid’s prospective payment system (PPS) for Federal Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) to SCHIP and a state cannot bar FQHCs from contracting with private dentist.</p> <p>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>	<p>MRMIB contracts solely with managed care organizations and must assess how to comply.</p> <p><i>DHCS COMMENT:</i> 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 rate via payments made from Medi-Cal fee-for-service.</p>	<p>■ MRMIB must conduct an analysis of the issue and make a recommendation on the best approach to meeting the requirement.</p> <p>■ MRMIB will obtain CMS guidance on how to apply for the grant funding and decide whether to apply.</p>
<p>■ <b>Payment Error Rate Measurement (PERM) (SEC 601) Rules released August 2009.</b> Outlines requirements and timeline (within 6 months after enactment) for new final rule on PERM</p>	<p>CA was in the first cycle of audits and already received its results which were exemplary.</p>	<p>■ MRMIB and DHCS will be prepared to comment on the final PERM rules</p>

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<p>regulation (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 wants changes in PERM rules to acknowledge high performance.</p>	<p>which are due for release in August 2009.</p>
<p>■ <b>Improving Data Collection (SEC 602) Effective April 1, 2009.</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.</p>	<p>Impact unknown.</p>	<p>■ No action required.</p>
<p>■ <b>Updated Federal Evaluation of SCHIP (SEC 603) Effective April 1, 2009.</b> Requires a new federal evaluation of SCHIP in 2011 and allocates \$10 million towards the effort.</p>	<p>Impact unknown.</p>	<p>■ No action required.</p>
<p>■ <b>Undocumented Immigrants (SEC 605) Existing Law.</b> Includes language that restates current law that no federal funding will be allocated to immigrants who are not in the country legally.</p>	<p>None.</p>	<p>■ No action required.</p>
<p>■ <b>Outreach Regarding Health Insurance Options Available to Children (SEC 621) Effective April 1, 2009.</b> Establishes a task force to conduct a nationwide campaign of education and outreach for small businesses concerns regarding the availability of coverage for children through private insurance options, the</p>	<p>Increased outreach could result in increased enrollment.</p>	<p>■ No action required.</p>

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<p>Medicaid program, and SCHIP.</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>		
<b>GENERAL EFFECTIVE DATE</b>		
<p>■ <b>Implementation Timeframes for Provisions That Do Not Require State Law Changes (SEC 3).</b> Unless otherwise specified, provisions take effect April 1, 2009. Some provisions specify a later date or an urgency implementation which would mean upon signature, February 4, 2009. Any new provisions which CMS agrees require a state law change will be effective January 1, 2011.</p>		<p>■ Awaiting CMS policy guidance in a number of areas.</p>
<p>■ <b>State Timeline for Implementation of New Provisions (SEC 3).</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>		<p>■ This is Jan. 1, 2011 for CA. MRMIB has tentatively identified that the following provisions may require state law changes.</p> <ol style="list-style-type: none"><li>1. Mental Health and Substance Abuse Parity</li><li>2. Required Dental Coverage and FQHC Dental Provision</li><li>3. Managed Care Standards</li><li>4. FQHC Payment</li></ol>

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		<p>System</p> <p>5. Citizenship Documentation Requirement</p> <p><i>DHCS COMMENT:</i> DHCS may require legislation for the following provisions:</p> <ol style="list-style-type: none"><li>1. FQHCs and their contractual arrangements for dental services.</li><li>2. Eligibility changes for increased FMAP.</li><li>3. New citizenship verification provisions.</li></ol>

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