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Medicaid and SCHIP Provisions in H.R. 3162 and S. 1893/H.R. 976

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Medicaid and SCHIP Provisions in H.R. 3162 and S. 1893/H.R. 976

Summary

Medicaid, authorized under Title XIX of the Social Security Act, is a federal-state program providing medical assistance for low-income individuals who are aged, blind, disabled, members of families with dependent children, or who have one of a few specified medical conditions.

The Balanced Budget Act of 1997 (BBA 1997) established the State Children's Health Insurance Program (SCHIP) under a new Title XXI of the Social Security Act. SCHIP builds on Medicaid by providing health insurance to uninsured children in families with incomes above applicable Medicaid income standards. States provide children with health insurance that meets specific standards for benefits and cost-sharing through separate SCHIP programs, or through their Medicaid programs, or through a combination of both. SCHIP has federal appropriations for the current fiscal year, but none are slated for FY2008 and beyond.

Two bills under consideration in the House and the Senate would make important changes to Medicaid and SCHIP. On August 1, 2007, the House passed H.R. 3162, the Children's Health and Medicare Protection (CHAMP) Act of 2007. The bill would reauthorize and increase funding levels and state grant distributions for SCHIP and make changes to the Medicare and Medicaid programs. The major SCHIP provisions would enhance outreach and enrollment efforts to increase the number of children covered by the program, modify the program's citizenship verification process, change minimum benefit requirements, establish a five-year demonstration project for certain children (and their families) to buy into SCHIP coverage, and make other changes.

On July 19, 2007, the Senate Finance Committee marked up the Children's Health Insurance Program Reauthorization Act of 2007 (S. 1893/H.R. 976). The Senate struck the language in an unrelated House-passed tax measure (H.R. 976) and replaced it with the language contained in S. 1893, as approved by the Senate Finance Committee. A total of 92 amendments were offered, with 9 adopted. The bill passed the Senate on August 2, 2007. The Senate bill provides authorized appropriations to SCHIP through FY2012 and changes how federal SCHIP funds are allotted to states. Other key provisions would enhance the program's outreach and enrollment efforts, extend coverage to pregnant women, and alter the citizenship verification process for program eligibility.

The following side-by-side comparison provides a brief description of current law and the changes that would be made to Medicaid and SCHIP under H.R. 3162 and S. 1893/H.R. 976. Medicare provisions in Titles II through VII of H.R. 3162 are not described here. This report will be updated as legislative activity warrants.

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Background

Medicaid, authorized under Title XIX of the Social Security Act, is a federal-state program providing medical assistance for low-income individuals who are aged, blind, disabled, members of families with dependent children, or who have one of a few specified medical conditions.

The Balanced Budget Act of 1997 (BBA 1997) established SCHIP under a new Title XXI of the Social Security Act. SCHIP builds on Medicaid by providing health insurance to uninsured children in families with incomes above applicable Medicaid income standards. States provide SCHIP children with health insurance that meets specific standards for benefits and cost-sharing, or through their Medicaid programs, or through a combination of both.

SCHIP has federal appropriations for the current fiscal year, but none are slated for FY2008 and beyond.[1]

Recent Legislative Activity

Two bills under consideration in the House and the Senate would make important changes to Medicaid and SCHIP. On August 1, 2007, the House passed H.R. 3162, the Children's Health and Medicare Protection (CHAMP) Act of 2007. The bill would reauthorize and increase funding levels and state grant distributions for the State Children's Health Insurance Program (SCHIP) and make changes to the Medicare and Medicaid programs.

An August 1 estimate from the Congressional Budget Office (CBO) indicates that the SCHIP title of H.R. 3162 would increase outlays by $47.4 billion over 5 years and by $128.7 billion over 10 years, and that the Medicaid title of the bill would increase outlays by $4.4 billion over 5 years and by $4.6 billion over 10 years. Including Medicare and miscellaneous provisions, the CBO estimates that the entire bill would increase outlays by $25.6 billion over 5 years and by $58.0 billion over 10 years. These costs would be offset by an increase in the federal tobacco tax and other

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[1] Although no SCHIP appropriations are currently slated for FY2008 forward, both OMB and CBO assume that the program continues at the FY2007 appropriation level of $5.04 billion.

changes, which the CBO estimates would increase revenue by $28.1 billion over 5 years and by $58.1 billion over 10 years.[2]

On July 19, 2007, the Senate Finance Committee marked up the Children's Health Insurance Program Reauthorization Act of 2007 (S. 1893/H.R. 976). The Senate struck the language in an unrelated House-passed tax measure (H.R. 976) and replaced it with the language contained in S. 1893, as approved by the Senate Finance Committee. A total of 92 amendments were offered, with 9 adopted. The bill passed the Senate on August 2, 2007.

The Senate bill contains eight titles, six dealing with SCHIP and Medicaid. Recent CBO estimates indicate that the Senate bill would increase SCHIP outlays by $28.6 billion over the five-year period of FY2008- FY2012. Additional outlay increases would occur as a result of effects on Medicaid (e.g., changes in citizenship documentation). In sum, the CBO estimates total spending increases of $35.2 billion over the five-year window. The proposal also contains provisions that offset this direct spending increase with changes in the excise taxes associated with tobacco products.[3]

Medicaid and SCHIP Provisions in H.R. 3162 and S. 1893/H.R. 976

Table 1 provides a brief description of current law and a side-by-side comparison of the changes that would be made to Medicaid and SCHIP under H.R. 3162 and S. 1893/H.R. 976.[4] A comparison of some of the key provisions across both bills is described below.

Funding/Financing. Under current law, the SCHIP appropriation for FY2007 (the last year for which there is an appropriation) was just over $5 billion, with states' allotments available for three years. Under the House bill, allotments from FY2008 onward would be available for only two years. Appropriations for FY2008 onward would be provided without a national amount specified. The annual appropriation would be determined automatically as the sum total of the allotments calculated for all the states and territories. For FY2009 onward, states' allotments would be based on either prior-year allotments or prior-year spending. States would not be limited in the amount of prior-year balances they could carry forward.

Under the Senate legislation, allotments from FY2007 onward would be available for only two years. The FY2008 appropriation would be $9.125 billion, rising to $16.0 billion in FY2012, with no appropriations provided thereafter. As

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[2] CBO, Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children's Health and Medicare Protection Act, for the Rules Committee (August 1, 2007), available at [http://www.cbo.gov/ftpdocs/85xx/doc8519/HR3162.pdf].

[3] "Cost estimate for the legislative language (ERN07632) provided by the Committee on Finance on July 26, 2007, Congressional Budget Office, available at [http://www.cbo.gov/ftpdocs/84xx/doc8489/BaucusSCHIP7-26-07.pdf].

[4] Medicare provisions in Titles II through VII of H.R. 3162 are not described here.

long as those amounts were adequate, states would be allotted in FY2009-FY2011 what they project to spend for the year in federal SCHIP expenditures plus 10%, with the funds not used for states' allotments going into a bonus pool. States would be limited in the amount of prior-year balances they could carry forward.

The House legislation calls for bonus payments to states that increase their enrollment of children in Medicaid or SCHIP above certain levels. Qualifying states would receive cash payments as a percentage of the state share of their Medicaid/SCHIP expenditures, though setting a higher bar and paying a lower percentage in SCHIP as compared to Medicaid. The Senate bill would also provide bonus payments, but the payments would be for increasing child enrollment in Medicaid, not in SCHIP. The payments would be based on fixed-dollar amounts specified in the legislation.

Limitations on SCHIP Matching Rate. Under current law, states can set their upper income eligibility level for SCHIP at the higher of 200% of the federal poverty level (FPL) or 50 percentage points above their income eligibility level for Medicaid children prior to SCHIP's enactment. However, by using existing flexibility to define what "counts" as income, any state can raise its effective SCHIP income eligibility level above 200% FPL through the use of income disregards. Neither the House nor the Senate bill would affect states' ability to use income disregards. However, the Senate bill would reduce the federal reimbursement rate for costs associated with SCHIP enrollees whose income would exceed 300% FPL without the use of certain disregards. An exception would be provided for states that, on the date of enactment, have federal approval or have enacted a state law to cover SCHIP enrollees above 300% FPL.

Eligibility. With respect to eligibility, the House bill (as amended) would allow states to cover individuals up to age 21 (rather than age 19) in their SCHIP programs. Although some differences apply, both the House and Senate bills would allow broader coverage of pregnant women under SCHIP, in terms of eligibility and benefits, when certain conditions are met. The House bill would allow states to cover certain legal immigrants who meet applicable categorical and financial eligibility requirements (i.e., pregnant women and/or children under age 21) before such persons have been in the United States for a minimum of five years as required under current law. The Senate bill does not include a comparable provision.

Section 1115 of the Social Security Act allows the Secretary of HHS to waive certain statutory requirements to modify virtually all aspects of Medicaid and SCHIP as long as such changes further the goals of Titles XIX (Medicaid) and/or XXI (SCHIP). States and the federal government have used the Section 1115 waiver authority to cover non-Medicaid and SCHIP services, limit benefit packages for certain groups, cap program enrollment, cover groups such as non-pregnant childless adults that are not otherwise eligible, among other purposes.

With respect to SCHIP coverage of adult populations (e.g., nonpregnant childless adults and parents of Medicaid and SCHIP-eligible children), the House bill (as amended) would allow for such coverage as long as states ensure that they have not instituted a waiting list for their SCHIP program, and that they have an outreach program to reach all targeted low-income children in families with annual incomes

less than 200% FPL. By contrast, the Senate bill phases out SCHIP coverage of non-pregnant childless adults after two years, and in FY2009, federal reimbursement for such coverage would be reduced to the Medicaid federal medical assistance percentage (FMAP) rate. Coverage of parents would still be allowed, but beginning in FY2010, allowable spending under the waivers would be subject to a set aside amount from a separate allotment and would be matched at the state's regular Medicaid FMAP rate unless the state is able to prove that it met certain coverage benchmarks (related to performance in providing coverage to children). Finally, in FY2011 and FY2012, the federal matching rate for costs associated with such parent coverage would be reduced to a rate between the Medicaid and SCHIP rates for states that meet certain coverage benchmarks, and to the state's regular Medicaid FMAP for all other states.

Enrollment/Access. Both bills include provisions to facilitate access and enrollment in Medicaid and SCHIP. Among the major provisions, the House bill would create a state option to rely on a finding from specified agencies to determine whether a child under age 19 (or an age specified by the state not to exceed 21 years of age) has met one or more of the eligibility requirements (e.g., income, assets or resources, citizenship, or other criteria) necessary to determine an individual's initial eligibility, eligibility redetermination, or renewal of eligibility for medical assistance under Medicaid. The Senate bill, by contrast, would allow up to 10 states to use Express Lane[5] eligibility determinations for Medicaid and SCHIP enrollment and renewal through a three-year demonstration program. Like the House bill, the Senate bill does not relieve states of their obligation to determine eligibility for Medicaid, and would require the state to inform families that they may qualify for lower premium payments or more comprehensive health coverage under Medicaid if the family's income were directly evaluated by the state Medicaid agency. Both bills would drop the requirement for signatures on a Medicaid application form under penalty of perjury.

Citizenship Documentation Rules. Both the House and Senate bills would make some similar modifications of existing Medicaid citizenship documentation rules (e.g., by requiring additional documentation options for federally recognized Indian tribes, specifying the reasonable opportunity period for individuals who are required to present documentation). However, the Senate bill would allow states to meet Medicaid citizenship documentation requirements through name and Social Security number validation, make citizenship documentation a requirement for SCHIP, provide an enhanced match for certain administrative costs, and require separate identification numbers for children born to women on emergency Medicaid. In contrast, the House bill would make Medicaid citizenship documentation for children under age 21 a state option, allow "Express Lane" agencies to determine eligibility without citizenship documentation, and require eligibility audits to ensure that federal funds are not spent on individuals who are not legal residents.

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[5] *Express Lane eligibility* refers to specified agencies that would be permitted to a streamline the Medicaid and SCHIP eligibility determination and intake process to make it easier for individuals to qualify for coverage.

Premium Assistance/Employer Buy-In. The House bill would allow the Secretary of Health and Human Services to establish a five-year demonstration project under which up to 10 states would be permitted to provide SCHIP child health assistance to children (and their families) to individuals who are beneficiaries under a group health plan. The Senate bill would allow states to offer a premium assistance subsidy for qualified employer sponsored coverage to all targeted low-income children who are eligible for child health assistance and have access to such coverage, or to parents of targeted low-income children.

Benefits. Both the House and Senate bills would make other changes to covered benefits under SCHIP. Under the House bill, dental care and services provided by federally qualified health centers (FQHCs) and rural health clinics (RHCs) would become mandatory benefits. With respect to dental services, the House bill would also require the Secretary of HHS to implement a program to educate new parents about the importance of oral health care for infants, and would require states to report data on the receipt of dental services for SCHIP children. In the Senate bill, a new grant would be authorized to improve the availability of dental services and strengthen dental coverage for children under SCHIP. GAO would be required to evaluate access to dental care under both the House and Senate bills. In addition, the Senate bill includes a new mental health parity provision for SCHIP, while the House bill would broaden the scope of coverage for mental health services under certain SCHIP benefit plans. Provisions to reduce diabetes in children are included in both the House and Senate bills. The House bill would extend funding for existing diabetes programs authorized under the Public Health Services Act, while the Senate bill would create a new demonstration project to promote screening and improvements in diet and physical activity. Finally, for the benchmark package option under Medicaid, established in the Deficit Reduction Act of 2005 (P.L. 109-171), both the House and Senate bills would require coverage of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT), benefit for individuals under 21 (rather than under age 19).

Monitoring Quality. There are other new initiatives to improve access and quality of care for children under Medicaid and SCHIP, including a new federal commission (House bill only), child health care quality measurement programs (both the House and Senate bills), and a second federal SCHIP evaluation (House bill only).

Payments. With respect to payment policies, both the House and Senate bills would require that payments for FQHCs and RHCs under SCHIP follow the prospective payment system for such services under Medicaid. The House bill would prohibit the Secretary of HHS from taking actions to further restrict Medicaid coverage or payments for rehabilitation services or for certain school-based services beyond policies in effect as of July 1, 2007. This prohibition would continue for one year after the date of enactment of this provision. Finally, the federal and state governments are required to monitor and take actions to reduce erroneous payments under both Medicaid and SCHIP. The two systems for conducting these evaluations are the Medicaid Eligibility Quality Control (MEQC) program and the newer Payment Error Rate Measurement (PERM) program. The Senate bill stipulates several requirements for a final rule on PERM and requires the Secretary of HHS to coordinate these two systems and reduce redundancies.

Table 1. Medicaid and SCHIP Provisions

	Current Law	House: H.R. 3162	Senate: H.R. 976
References to Title XXI; Elimination of Confusing Program References	A provision in P.L. 106-113 directed the Secretary of HHS or any other federal officer or employee, with respect to references to the program under Title XXI, in any publication or official communication to use the term "SCHIP" instead of "CHIP" and to use the term "State children's health insurance program" instead of "children's health insurance program."	**H§155. References to title XXI.** The provision would repeal this section in P.L. 106-113. Thus, for official publication and communication purposes, the provision would reinstate "CHIP" and "children's health insurance program," as applicable, when referencing Title XXI.	**S§606. Elimination of confusing program references.** Identical to the House bill.
Funding/Financing			
CHIP appropriations	Section 2104(a) of the Social Security Act specifies the following SCHIP appropriation amounts (of which the territories receive 0.25%): $4.3 billion annually from FY1998 to FY2001; $3.15 billion annually from FY2002 to FY2004; $4.05 billion in FY2005 and FY2006; and $5.0 billion in FY2007. No amounts are specified for FY2008 onward.	**H§101. Establishment of new base CHIP allotments.** Appropriations for FY2008 onward would be provided without a national amount specified. The annual appropriation would be determined automatically as the sum total of the allotments calculated for all the states and territories. No end year would be specified; the program could receive annual appropriations in perpetuity.	**S§101. Extension of CHIP.** The following national appropriation amounts would be specified for CHIP in §2104(a): $9.125 billion in FY2008; $10.675 billion in FY2009; $11.85 billion in FY2010; $13.75 billion in FY2011; and two semiannual installments of $1.75 billion each in FY2012. **S§103. One-time appropriation.** A separate appropriation of $12.5 billion would be provided for CHIP allotments in the first half of FY2012.

	Current Law	House: H.R. 3162	Senate: H.R. 976
Allotment of federal CHIP funds to states	The national SCHIP amount available to states is allotted primarily on the basis of estimates of each state's number of children who are low income (that is, with family income below 200% of the federal poverty theshold) and the number of such children who are uninsured. The source of data is the average of the number of such children based on the three most recent Annual Social and Economic (ASEC) Supplements (formerly known as the March supplements) to the Census Bureau's Current Population Survey (CPS) before the beginning of the calendar year in which the applicable fiscal year begins. The estimates are adjusted to account for geographic variations in health costs (calculated as 85% of each state's variation from the national average in its average wages in the health services industry). A ceiling is in place to ensure that a state's portion of the total available appropriation does not exceed 145% of its share of funds in FY1999. In addition, there are three floors to ensure a state's share does not fall below certain levels.	**H§101. Establishment of new base CHIP allotments.** *FY2008.* Generally, a state's FY2008 allotment would be the greater of (1) its own projection of federal CHIP expenditures in FY2008, based on the state's May 2007 submission to CMS, and (2) the state's FY2007 CHIP allotment multiplied by the allotment increase factor (described below). If the state enacted legislation during 2007 that would expand eligibility or improve benefits, the state may use its August 2007 submission of expenditure projections instead.	**S§102. Allotments for the 50 states and the District of Columbia.** *FY2008.* For FY2008, a state's allotment would be calculated as 110% of the greatest of the following four amounts: (1) the state's FY2007 federal CHIP *spending* multiplied by the annual adjustment (described below); (2) the state's FY2007 federal CHIP *allotment* multiplied by the annual adjustment; (3) for states that receive federal CHIP funds in FY2007 because of their shortfalls, or states that were projected to be in shortfall based on their November 2006 submission of projected expenditures, the state's FY2007 projected federal spending as of November 2006 (or as of May 2006, for a state whose May 2006 projection was $95 million to $96 million higher than its November 2006 projection, a provision that affects only North Carolina) multiplied by the annual adjustment; and (4) the state's *FY 2008 federal CHIP projected spending* as of August 2007 and certified by the state not later than September 30, 2007.

	Current Law	House: H.R. 3162	Senate: H.R. 976
		Adjustment for cost and child population growth. The allotment increase factor would be the product of (1) the per capita health care growth factor, and (2) the child population growth factor. The per capita health care growth factor would be 1 plus the percentage increase in the projected per capita amount of National Health Expenditures over the prior year's. The child population growth factor would be 1.01 plus the percentage increase (if any) in the population of children under 19 years of age in the state, based on the most recent published estimates from the Census Bureau.	*Adjustment for cost and child population growth.* The annual adjustment for health care cost growth and child population growth is the product of (1) 1 plus the percentage increase (if any) in the nominal projected per capita spending in National Health Expenditures for the year over the prior year, and (2) 1.01 plus the percentage change in the child population (under age 19) in each state, based on the most timely and accurate published estimates from the Census Bureau.
		FY2009 onward. For FY2009 and every future odd-numbered fiscal year, a state's federal CHIP allotment would be equal to the prior year's *allotment* multiplied by the allotment increase factor.	*FY2009 onward.* For FY2009 to FY2011, a state's allotment would be calculated as 110% of its projected spending for that year.

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		For FY2010 and every future even-numbered fiscal year, a state's federal CHIP allotment would be "rebased." In these years, the state's allotment would be the prior year's federal CHIP *expenditures* multiplied by the allotment increase factor.	The regular CHIP appropriations available to states in FY2012 (that is, the $1.75 billion provided semi-annually reduced by payments to the territories) would be calculated using states' projected federal CHIP spending allocable to each semi-annual period. The one-time appropriation of $12.5 billion in §103 of the legislation is to be treated in the same manner as the $1.75 billion appropriation for the first semi-annual allotment. If the available national allotment for a semi-annual period in FY2012 exceeds the amount to be allotted in that period based on states' projected CHIP expenditures, the remaining amount would be allotted proportionally based on each state's share of the allotment calculated for that FY2012 period.
			If national appropriation is inadequate. For FY2008, if the state allotments as calculated exceed the available national allotment, states' allotments would be reduced proportionally.

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			For FY2009 to FY2012, if the state allotments as calculated exceed the available national allotment, then the available national allotment would be distributed among states using a different formula. It would calculate each state's share (percentage) of the available national allotment primarily based on states' own projected CHIP expenditures for that fiscal year.
			Additional provisions. If a state's projected CHIP expenditures for FY2009 to FY2012 are at least 10% more than the allotment calculated for the preceding fiscal year (regardless of the computation used if the national appropriation was inadequate) and, during the preceding fiscal year, the state did not receive approval for a CHIP state plan amendment or waiver to expand CHIP coverage or did not receive a CHIP Contingency Fund payment, then the state would be required to submit to the Secretary by August 31 of the preceding fiscal year information relating to the factors that contributed to the increase as well as any additional information requested by the Secretary. The Secretary would be required

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			to review the information and provide a response in writing within 60 days as to whether the states' projections of CHIP expenditures are approved or disapproved (and if disapproved, reasons for disapproval), or specified additional information. If disapproved or requested to provide additional information, the state would be provided with reasonable opportunity to submit additional information. If the Secretary has not determined by September 30 whether the state has demonstrated the need for the increase in the succeeding fiscal year's allotment, a provisional allotment would be provided based on 110% of the allotment calculated for the preceding fiscal year (regardless of the computation used if the national appropriation was inadequate) and may adjust the allotment by not later than November 30.
			For calculating the FY2008 allotments to states and territories, the Secretary would be required to use the most recent data available before the start of the fiscal year but may adjust the allotments as necessary on the basis of actual expenditure data for FY2007

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			submitted no later than November 30, 2007. The Secretary could make no adjustments for FY2008 after December 31, 2007.
Allotment of federal CHIP funds to territories	In addition to receiving 0.25% of the national SCHIP appropriation in Section 2104(a) of the Social Security Act, the following SCHIP appropriation amounts were specified for the territories: The territories are also allotted the following appropriation amounts in §2104(c)(4)(B): $32 million in FY1999; $34.2 million in FY2000 and FY2001; $25.2 million in FY2002 to FY2004; $32.4 million in FY2005 and FY2006; and $40 million in FY2007. The amounts set aside for the territories are distributed according to the percentages specified in statute: Puerto Rico, 91.6%; Guam, 3.5%; the Virgin Islands, 2.6%; American Samoa, 1.2%; and the Northern Mariana Islands, 1.1%.	**H§101. Establishment of new base CHIP allotments.** There would be no separate CHIP appropriation for the territories. Beginning with FY2008, the allotment to a territory or commonwealth would be equal to its prior year federal CHIP expenditures multiplied by the per capita health care growth factor (described above) and by 1.01 plus the percentage increase (if any) in the population of children under 19 years of age in the United States.	**S§104. Improving funding for the territories under CHIP and Medicaid.** There would be no separate CHIP appropriation for the territories. For FY2008, each territory's allotment would be its highest annual federal CHIP spending between FY1998 and FY2007, plus the annual adjustment for health care cost growth and national child population growth described above. For FY2009 through FY2012, each territory's allotment would be the prior year's allotment, plus the annual adjustment for health care cost growth and national child population growth. In FY2012, 89% of the amount to be allotted to the territories would be allotted in the first half of the fiscal year, with the remaining 11% allotted in the second half of the fiscal year.
Period of availability of CHIP allotments	SCHIP allotments are available for three years.	**H§102. 2-year initial availability of CHIP allotments.** Beginning with the FY2008 allotment, CHIP allotments would be available for two years.	**S§109. Two-year availability of allotments; expenditures counted against oldest allotments.** Beginning with the FY2007 allotment, CHIP allotments would be available for two years. Notwithstanding the

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			period of availability, states would forgo from their unspent FY2006 and FY2007 allotments the amount by which those allotments not expended by September 30, 2007, exceeded 50% of the FY2008 allotment. On October 1 of fiscal years 2009 to 2012, states would also forgo the amount by which the unspent funds from the prior year's allotment exceeded a particular percentage of that allotment (that is, 20% in FY2009, and 10% in FY2010, FY2011, and FY2012).
CHIP funds for shortfall states	Allotments unspent after three years are available for redistribution to states that had exhausted that particular allotment by the end of the three-year period of availability. The HHS Secretary determines how the funds are redistributed to those states. In the past couple of years, redistributed funds have gone exclusively to shortfall states (i.e., states that were projected to exhaust all their available SCHIP allotments during the year) and sometimes the territories.	**H§101. Establishment of new base CHIP allotments.** A state's allotment could be be increased through a "performance-based shortfall adjustment" if (1) its federal CHIP expenditures in a fiscal year (beginning with FY2008) exceed the amount of federal CHIP allotments available to the state in the previous fiscal year (not including any available CHIP funds redistributed from other states), and (2) its average monthly enrollment of children in CHIP exceeded the target enrollment number for the year, which is	**S§105. Incentive bonuses for states.** FY2005 allotments unspent after their three-year period of availability would be redistributed only to states that met the third criteria used in calculating the base allotment for FY2008 (that is, states that received federal CHIP funds in FY2007 because of their shortfalls, states that were projected to be in shortfall in FY2007 based on their November 2006 submission of projected expenditures, or states whose May 2006 projection was $95 million to $96 million higher than its November 2006 projection). For these states, the unspent FY2005 funds

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		the prior year's average monthly CHIP enrollment increased by 1% and by the state's child population growth.	would be redistributed in proportion to their FY2007 allotment.
		For the states that qualify, the adjustment would be added to the state's allotment at the start of the subsequent fiscal year, except that the Secretary would also be required to "develop a process to administer the performance-based shortfall adjustment in a manner so it is applied to (and before the end of) the fiscal year (rather than the subsequent fiscal year)." The adjustment would be calculated as the product of (1) the amount by which the actual average monthly caseload exceeded the target number of enrollees, and (2) the state's projected per capita CHIP expenditures (state and federal) multiplied by the enhanced FMAP for the state for the fiscal year involved. The adjustment would only be available in the fiscal year in which it was provided and would not be available for redistribution if unspent. The Comptroller General would be required to periodically audit the	**S§108. CHIP contingency fund.** A CHIP Contingency Fund would be established in the U.S. Treasury. The Contingency Fund would receive deposits through a separate appropriation. For FY2009, its appropriation would be 12.5% of the CHIP available national allotment. For FY2010 through FY2012, the appropriation would be such sums as are necessary for making payments to eligible states for the fiscal year, as long as the annual payments did not exceed 12.5% of that fiscal year's CHIP available national allotment. Balances that are not immediately required for payments from the Fund would be invested in U.S. securities that provide additional income to the Fund. Amounts in excess of the 12.5% limit shall be deposited into the Incentive Pool. For purposes of the CHIP Contingency Fund, amounts set aside for block grant payments for transitional coverage of childless adults shall not count as part of the available national allotment.

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		accuracy of the data used for the allotment adjustment and make recommendations to Congress and the Secretary as the Comptroller General deems appropriate.	
		H§102. 2-year initial availability of CHIP allotments. H§103. Redistribution of unused allotments to address state funding shortfalls. Only a shortfall state (that is, a state that the Secretary estimates will have federal CHIP expenditures that exceed its available prior-year allotment balances, its performance-based shortfall adjustment, and its allotment for the fiscal year) would be eligible to receive redistributed funds. If the funds redistributed to a state based on its projected shortfall are not spent by the end of the fiscal year, they would be available for redistribution to other states in the next fiscal year. If the total amount available for redistribution exceeds the projected shortfalls, the remaining amounts would be available for redistribution in the next fiscal year.	Payments from the Fund are to be used only to eliminate any eligible state's shortfall (that is, the amount by which a state's available federal CHIP allotments are not adequate to cover the state's federal CHIP expenditures).

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		If the total amount available for redistribution is less than the projected shortfalls, the amounts provided to shortfall states would be reduced proportionally. The Secretary could adjust the amounts redistributed based on actual expenditure data as submitted not later than November 30 of the succeeding fiscal year.	
			The Secretary shall separately compute the shortfalls attributable to children and pregnant women, to childless adults, and to parents of low-income children. No payment from the Contingency Fund shall be made for nonpregnant childless adults. Any payments for shortfalls attributable to parents shall be made from the Fund at the relevant matching rate.
			Eligible states, which cannot be territories, for any month in FY2009 to FY2012 are those that meet any of the following criteria:
			(1) The state's available federal CHIP allotments are at least 95% but less than 100% of its projected federal CHIP expenditures for the fiscal year (i.e., less than

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			5% shortfall in federal funds), without regard to any payments provided from the Incentive Pool; or
			(2) The state's available federal CHIP allotments are less than 95% of its projected federal CHIP expenditures for the fiscal year (i.e., more than 5% shortfall in federal funds) and that such shortfall is attributable to one or more of the following: (a) One or more parishes or counties has been declared a major disaster and the President has determined individual and public assistance has been warranted from the federal government pursuant to the Stafford Act, or a public health emergency was declared by the Secretary pursuant to the Public Health Service Act; (b) the state unemployment rate is at least 5.5% during any consecutive 13 week period during the fiscal year and such rate is at least 120% of the state unemployment rate for the same period as averaged over the last three fiscal years; (c) the state experienced a recent event that resulted in an increase in the percentage of low-income children in the state without health insurance that was outside the control

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			of the state and warrants granting the state access to the Fund, as determined by the Secretary.
			The Secretary shall make monthly payments from the Fund to all states determined eligible for a month. If the sum of the payments from the Fund exceeds the amount available, the Secretary shall reduce each payment proportionally.
Extension of option for qualifying states	For qualifying states, federal SCHIP funds may be used to pay the difference between SCHIP's enhanced Federal Medical Assistance Percentage (FMAP) and the Medicaid FMAP that the state is already receiving for children above 150% of poverty who are enrolled in Medicaid. Qualifying states are limited in the amount they can claim for this purpose to the lesser of(1) 20% of the state's original SCHIP allotment amounts (if available) from FY1998-FY2001 and FY2004-FY2007; and (2) the state's available balances of those allotments. The statutory definitions for qualifying states capture most of those that had expanded their upper-income eligibility levels for children in their Medicaid programs to 185% of poverty prior to the enactment of	**H§104. Extension of option for qualifying states.** In addition to the current-law provisions, qualifying states would also be able to use the entirety of any allotment from FY2008 onward for CHIP spending under §2105(g).	**S§111. Option for qualifying states to receive the enhanced portion of the CHIP matching rate for Medicaid coverage of certain children.** Qualifying states under §2105(g) may also use available balances from their CHIP allotments from FY2008 to FY2012 to pay the difference between the regular Medicaid FMAP and the CHIP enhanced FMAP for Medicaid enrollees under age 19 (or age 20 or 21, if the state has so elected in its Medicaid plan) whose family income exceeds 133% of poverty.

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	SCHIP. Based on statutory definitions, 11 states were determined to be qualifying states: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington and Wisconsin.		
Bonuses for increasing enrollment of children	No provision.	**H§111. CHIP performance bonus payment to offset additional enrollment costs resulting from enrollment and retention efforts.** From FY2009 to FY2013, performance bonus payments would be paid to states implementing specified enrollment and retention efforts and enrolling eligible children above specified target levels.	**S§105. Incentive bonuses for states.** A CHIP Incentive Bonuses Pool would be established in the U.S. Treasury, to be used for any purpose the state determines is likely to reduce the percentage of low-income children in the state without health insurance.

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		Source of funds. No source of appropriations specified.	*Source of funds.* The Incentive Pool would receive deposits from an initial appropriation in FY2008 of $3 billion, along with transfers from six different potential sources, with currently available but not immediately required funds invested in interest-bearing U.S. securities that provide additional income into the Incentive Pool.
			The six additional sources for deposits would be as follows: (1) On December 31, 2007, the amount by which states' FY2006 and FY2007 allotments not expended by September 30, 2007, exceed 50% of the FY2008 allotment; (2) from 2008 to 2012, any of the national CHIP appropriation not allotted to the states; (3) on October 1 of fiscal years 2009 to 2012, the amount by which the unspent funds from the prior year's allotment exceeds a particular percentage of that allotment (that is, 20% in FY2009, and 10% in FY2010, FY2011, and FY2012); (4) any original allotment amounts not expended by the end of their second year of availability (beginning with the FY2007 allotment); (5) on October 1, 2009, any amounts set aside for transition off of CHIP coverage for childless

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			adults that are not expended by September 30, 2009; and (6) on October 1 of FY2009 through FY2012, any amounts in the CHIP Contingency Fund in excess of the fund's aggregate cap, as well as any Contingency Fund payments provided to a state that are unspent at the end of the fiscal year following the one in which the funds were provided.
		Payments to states. States that implement at least 4 out of 7 specified enrollment and retention efforts (that is, continuous eligibility, liberalization of asset requirements, elimination of in-person interview requirement, use of joint application for Medicaid and CHIP, automatic renewal, presumptive eligibility for children, and express lane) would be eligible to receive a bonus payment not later than the last day of the first calendar quarter of the following fiscal year. The amount would be the sum of payments calculated for the number of child enrollees in each of two "tiers" in Medicaid as well as in CHIP (reflecting certain levels of enrollment growth) multiplied by a percentage of the	*Payments to states.* Funds from the Incentive Pool would be payable in FY2009 to FY2012 to states that have increased their average monthly Medicaid enrollment among low-income children (with children defined as those under age 19 — or under age 20 or 21 if a state has so elected in its Medicaid program) during a coverage period above a baseline monthly average for the state.

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		state's share of projected Medicaid and CHIP per capita expenditures.	
		For such calculations, projected per capita state expenditures would be defined as projected average per capita federal and state Medicaid and CHIP expenditures for children for the most recent fiscal year, increased by the annual percentage increase in per capita amounts of National Health Expenditures for the respective subsequent fiscal year, and multiplied by the state's share of such expenditures required for the fiscal year involved.	The coverage period for FY2009 would be the first two quarters of FY2009. The baseline monthly average would be the average monthly enrollment of low-income children in Medicaid in the first two quarters of FY2007 multiplied by the sum of 1.02 and percentage population growth among low-income children in the state from FY2007 to FY2009.
		The baseline number of child enrollees for FY2008 would be equal to the monthly average number of child enrollees during FY2007 increased by child population growth for the year ending on June 30, 2006 (as estimated by the Census Bureau) plus one percentage point. For a subsequent fiscal year, the baseline number would be equal to the prior year's baseline number plus child population growth in that state plus one percentage point.	For FY2010 to FY2012, the coverage period would consist of the last two quarters of the preceding fiscal year and the first two quarters of the fiscal year. For FY2010 to FY2012, the baseline monthly average would be the baseline monthly average for the preceding fiscal year multiplied by the sum of 1.01 and percentage population growth among low-income children in the state over the prior year.

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		The first tier of child enrollment would be the amount by which the monthly average of children enrolled during the fiscal year exceeded the baseline number, but by no more than 3% for Medicaid or 7.5% for CHIP.	Average monthly enrollment and the baseline averages would not include children who do not meet the income eligibility criteria in effect on July 19, 2007.
		The second tier of child enrollment would be the amount by which the monthly average of children enrolled during the fiscal year exceeded the baseline number by 3% for Medicaid or 7.5% for CHIP.	A state eligible for a bonus would receive in the last quarter of FY2009 the following amounts, depending on the "excess" of the state's enrollment of children in Medicaid above the baseline monthly average during the coverage period: (i) If the excess does not exceed 2%, the product of $75 and the number of individuals in such excess; (ii) if the excess is more than 2% but less than 5%, the product of $300 and the number of individuals in such excess, less the amount in (i); and (iii) if the excess exceeds 5%, the product of $625 and the number of individuals in such excess, less the sum of the amounts in (i) and (ii).
		For the first tier above baseline child Medicaid enrollment, the state would receive 35% of the state share of those projected expenditures. For the first tier above baseline child CHIP enrollment,	For FY2010 onward, these dollar amounts would be increased by the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for the calendar year beginning on January 1

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		the state would receive 5% of the state share of those projected expenditures.	of the coverage period over that of the preceding coverage period.
		For the second tier above baseline child Medicaid enrollment, the state would receive 90% of the state share of those projected expenditures. For the second tier above baseline child CHIP enrollment, the state would receive 75% of the state share of those projected expenditures.	If the funds in the Incentive Pool were inadequate to cover the amounts calculated for all the eligible states, the amount would be reduced proportionally.
		The Government Accountability Office (GAO) would be required to submit a report for Congress not later than January 1, 2013, regarding the effectiveness of the performance bonus payment program in enrolling and retaining uninsured children in Medicaid and CHIP.	
No federal funding for illegal aliens	Under the Medicaid program, unauthorized aliens who meet all other program criteria are only eligible for emergency coverage. Under SCHIP, states may opt to cover unauthorized aliens who are pregnant, but covered services must be related to the pregnancy or to conditions that could complicate the pregnancy	**H§135. No federal funding for illegal aliens.** The House bill would specify that nothing in the bill allows federal payment for individuals who are not legal residents.	No provision.

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	or threaten the health of the unborn child (who will be a U.S. citizen if he or she is born in the United States).		
Medicaid funding for the territories	Medicaid programs in the territories are subject to spending caps. For FY1999 and subsequent fiscal years, these caps are increased by the percentage change in the medical care component of the Consumer Price Index (CPI-U) for all Urban Consumers (as published by the Bureau of Labor Statistics). The Deficit Reduction Act of 2005 increased the federal Medicaid caps in each of FY2006 and FY2007. For FY2007 the Medicaid caps are equal to:	**H§811 Payments for Puerto Rico and territories.** Would increase the territory Medicaid caps by the following amounts:	No provision.
	• For Puerto Rico, $250,400,000.	• For Puerto Rico, $250,000,000 for FY2009; $350,000,000 for FY2010; $500,000,000 for FY2011; and $600,000,000 for FY2012.	
	• For the Virgin Islands, $12,520,000.	• For the Virgin Islands, $5,000,000 for each of fiscal years 2009 through 2012.	
	• For Guam, $12,270,000.	• For Guam, $5,000,000 for each of fiscal years 2009 through 2012.	

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	• For the Northern Mariana Islands, $4,580,000.	• For the Northern Mariana Islands, $4,000,000 for each of fiscal years 2009 through 2012.	
	• For American Samoa $8,290,000.	• For American Samoa, $4,000,000 for each of fiscal years 2009 through 2012.	
	For FY2008 and subsequent fiscal years, the total annual cap on federal funding for the Medicaid programs in the insular areas is calculated by increasing the FY2007 ceiling for inflation.		
Enhanced matching funds for certain data systems in the territories	The federal Medicaid matching rate, which determines the federal share of most Medicaid expenditures, is statutorily set at 50 percent in the territories (an enhanced match is also available for certain administrative costs). Therefore, the federal government generally pays 50% of the cost of Medicaid items and services in the territories up to the spending caps.	**H§811 Payments for Puerto Rico and territories.** Beginning with FY2008, if a territory qualifies for the enhanced federal match (90% or 75%) that is available under Medicaid for improvements in data reporting systems, such reimbursement would not count towards its Medicaid spending cap.	**S§104 Improving funding for the territories under CHIP and Medicaid.** Identical to the House bill.

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Medicaid FMAP	The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa). When state FMAPs are calculated by HHS for the upcoming fiscal year, the state and U.S. per capita income amounts used in the formula are equal to the average of the three most recent calendar years of data on per capita personal income available from the Department of Commerce's Bureau of Economic Analysis (BEA). BEA revises its most recent estimates of state per capita personal income on an annual basis to incorporate revised and newly available source data on population and income. It also undertakes a comprehensive data revision every few years that may result in upward and downward revisions to each of the component parts of personal income, one of which is employer contributions for employee pension and insurance funds. In describing its 2003 comprehensive revision, BEA reported that upward revisions to employer contributions for pensions beginning with 1989 were the	**H§813. Adjustment in computation of Medicaid FMAP to disregard an extraordinary employer pension contribution.** For purposes of computing Medicaid FMAPs beginning with FY2006, any significantly disproportionate employer pension contribution would be disregarded in computing state per capita income, but not U.S. per capita income. A significantly disproportionate employer pension contribution would be defined as an employer contribution towards pensions that is allocated to a state for a period if the aggregate amount so allocated exceeds 25 percent of the total increase in personal income in that state for the period involved.	No provision.

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	result of methodological improvements and more complete source data.		
CHIP E-FMAP	The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. The enhanced FMAP (E-FMAP) for SCHIP equals a state's Medicaid FMAP increased by the number of percentage points that is equal to 30% of the difference between a state's FMAP and 100%. For example, in states with an FMAP of 60%, the E-FMAP equals the FMAP increased by 12 percentage points (60% + [30% multiplied by 40 percentage points] = 72%). E-FMAPs can range from 65% to 85%.	No provision.	**S§110. Limitation on matching rate for states that propose to cover children with effective family income that exceeds 300 percent of the poverty line.** For child health assistance or health benefits coverage furnished in any fiscal year beginning with FY2008 to targeted low-income children whose effective family income would exceed 300% of the poverty line but for the application of a general exclusion of a block of income that is not determined by type of expense or type of income, states would be reimbursed using the FMAP instead of the E-FMAP. An exception would be provided for states that, on the date of enactment, have an approved state plan amendment or waiver, or have enacted a state law to submit a state plan amendment to cover targeted low-income children above 300% of the poverty line.
	There are two types of income disregards used by states. The first type is exclusions of particular dollar amounts or types of income (or certain expenses, such as child care expenses).		

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	Nearly every state uses such disregards in SCHIP. These disregards often mirror the disregards in states' Medicaid programs. Although an individual's *gross* family income may be above the state's income eligibility level for SCHIP, the person may qualify because his or her *net* family income (taking into account the state's disregards) falls below the income threshold. The SCHIP statute provides flexibility for states to use such disregards. The second type of income disregard is when a state excludes an entire block of percent-of-poverty income. For example, New Jersey's SCHIP program covers children with *net* family income up to 200% of poverty. The state excludes all family income between 200% and 350% of poverty. As a result, children with *gross* family income up to 350% of poverty may be eligible for the state's SCHIP program.		
Eligibility			
Premium grace period	No statutory provision specifies a grace period for payment of SCHIP premiums. The congressionally mandated evaluation of SCHIP in 10 states (required not later than December 31, 2001) was to include an "[e]valuation of	**H§123. Premium grace period.** States would have to provide CHIP enrollees with a grace period of at least 30 days from the beginning of a new coverage period to make premium payments	No provision.

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	disenrollment or other retention issues, such as … failure to pay premiums ….” Federal regulations require states’ SCHIP plans to describe the consequences for an enrollee or applicant who does not pay required premiums and the disenrollment protections adopted by the state. According to the federal regulations, the protections must include the following: (1) The state must give enrollees reasonable notice of and an opportunity to pay past due premiums prior to disenrollment; (2) the disenrollment process must give the individual the opportunity to show a decline in family income that may qualify the individual for lower or no cost-sharing; and (3) the state must provide the enrollee with an opportunity for an impartial review to address disenrollment from the program, during which time the individual will continue being enrolled.	before the individual’s coverage may be terminated. Within seven days after the first day of the grace period, the state would have to provide the individual with notice that failure to make a premium payment within the grace period will result in termination of coverage and that the individual has the right to challenge the proposed termination pursuant to the applicable federal regulations. This provision would be effective for new coverage periods beginning on or after January 1, 2009.	
Optional coverage of older children under CHIP	Generally, eligibility for children under Medicaid is limited to persons under age 19 (or in some cases, under age 18, 19, 20 or 21). Under SCHIP, children are defined as persons under age 19.	**H§131. Optional coverage of children up to age 21 under CHIP.** Would expand the definition of child under CHIP to include persons under age 20 or 21, at state option. The effective date would be January 1, 2008.	No provision.

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Optional coverage of legal immigrants in Medicaid and CHIP	States may provide full Medicaid coverage to legal immigrants who meet applicable categorical and financial eligibility requirements after such persons have been in the United States for a minimum of five years. Sponsors can be held liable for the costs of public benefits (such as Medicaid and SCHIP) provided to legal immigrants.	**H§132 Optional coverage of legal immigrants under the Medicaid program and CHIP.** Would allow states to cover legal immigrants who are pregnant women and/or children under age 21 (or such higher age as the state has elected) under Medicaid or CHIP before the five-year bar is met effective upon the date of enactment. Sponsors would not be held liable for the costs associated with providing benefits to such legal immigrants, and the cost of such assistance would not be considered an unreimbursed cost.	No provision.
Optional coverage of pregnant women under CHIP	Under SCHIP, states can cover pregnant women ages 19 and older through waiver authority or by providing coverage to unborn children as permitted through regulation. In the latter case, coverage includes prenatal and delivery services only.	**H§133. State option to expand or add coverage of certain pregnant women under CHIP.** The provision would allow states to cover pregnant women under CHIP through a state plan amendment only if: (1) the Medicaid income eligibility threshold for pregnant women is at least 185% FPL (but cannot be lower than the percentage in effect for certain groups of pregnant women as of July 1, 2007), (2) the income eligibility threshold is at least 200% FPL for	**S§107. State option to cover low-income pregnant women under CHIP through a state plan amendment.** Would allow states to provide optional coverage under CHIP to pregnant women when specific conditions are met, including, for example (1) the upper income eligibility level for certain pregnant women under traditional Medicaid must be at least 185% FPL, (2) states must not apply any pre-existing condition or waiting period restrictions under CHIP, and (3) states must provide the same cost-sharing protections

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		children under CHIP or Medicaid, and (3) certain enrollment limitations for CHIP children are not imposed. For the new group of CHIP pregnant women, the lower income limit would exceed 185% FPL (or the applicable Medicaid threshold, if higher) and the upper income limit could be up to the level of coverage for CHIP children in the state. Other limitations on eligibility for CHIP children would also apply. No pre-existing condition exclusions or waiting periods would be permitted. All cost-sharing would be capped at 5% of annual income. States electing to cover pregnant women would receive an adjustment to their annual CHIP allotments to cover these additional costs. Pregnancy-related assistance would include all services provided to CHIP children in the state (excluding EPSDT), and the period of coverage would be during pregnancy through the end of the month in which the 60-day postpartum period ends. Additional provisions would: (1) deem infants born to CHIP pregnant women to be eligible	applicable to CHIP children, and all cost-sharing incurred by pregnant women must be capped at 5% of annual family income. No cost-sharing would apply to pregnancy-related services. States choosing this new option would also be allowed to temporarily enroll such women for up to two months until a formal determination of eligibility is made. The upper income limit for this new coverage group would be the upper income standard applicable to CHIP children in the state. Other eligibility restrictions for children under CHIP would also apply to this new group of pregnant women (i.e., must be uninsured, ineligible for state employee coverage, etc.). Pregnancy-related assistance would include all services covered under CHIP for children in a state as well as prenatal, delivery and postpartum care, including care provided to pregnant women under the state's Medicaid program. Also children born to these pregnant women would be deemed eligible for Medicaid or CHIP, as appropriate, and would be covered up to age one year.

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		for Medicaid or CHIP (as applicable) up to age one year (regardless of whether the infant lives with the mother or the mother remains eligible), (2) allow presumptive eligibility for pregnant women and children under CHIP, and (3) allow entities that make presumptive eligibility determinations for children under Medicaid to make such determinations for pregnant women under CHIP.	
Nonpregnant childless adult coverage under CHIP	Under current law, Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) broad authority to modify virtually all aspects of the Medicaid and SCHIP programs including expanding eligibility to populations who are not otherwise eligible for Medicaid or SCHIP (e.g., childless adults). Approved SCHIP Section 1115 waivers are deemed to be part of a state's SCHIP state plan for purposes of federal reimbursement. Costs associated with waiver programs are subject to each state's enhanced-FMAP. Under SCHIP Section 1115 waivers, states must meet an "allotment neutrality test" where combined federal expenditures for the	**H§134 Limitation on waiver authority to cover adults.** The provision would prohibit the Secretary from allowing federal CHIP allotments to be used to provide health care services (under the Section 1115 waiver authority) to individuals who are not targeted low-income children or pregnant women (e.g., non-pregnant childless adults or parents of Medicaid or CHIP-eligible children) unless the Secretary determines that no CHIP-eligible child in the state would be denied CHIP coverage because of such eligibility. To meet this requirement, states would have to assure	**S§106 Phase-out coverage for nonpregnant childless adults under CHIP.** Would prohibit the approval or renewal of Section 1115 demonstration waivers that allow federal CHIP funds to be used to provide coverage to nonpregnant childless adults. The six states with CMS approval for such waivers would be permitted to use federal CHIP funds to continue such coverage through FY2008, but in FY2009, such states would receive an amount (as part of a separate allotment) equal to the federal share of the State's projected FY2008 waiver expenditures increased by the annual adjustment for per capita health care growth,

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	state's regular SCHIP program and for the state's SCHIP demonstration program are capped at the state's individual SCHIP allotment. The Deficit Reduction Act of 2005 prohibited the approval of new demonstration projects that allow federal SCHIP funds to be used to provide coverage to nonpregnant childless adults, but allowed for the continuation of such existing Medicaid or SCHIP waiver projects affecting federal SCHIP funds that were approved before February 8, 2006.	that they have not instituted a waiting list for their CHIP program, and that they have an outreach program to reach all targeted low-income children in families with annual income less than 200% FPL	and such waiver expenditures would be matched at the regular Medicaid FMAP rate.
			States with nonpregnant childless adult CHIP waivers in effect during FY2007 would be permitted to seek approval for a Medicaid nonpregnant childless adult waiver, but allowable spending under the Medicaid waiver would be limited to waiver spending in the preceding fiscal year, increased by the percentage increase (if any) in the projected per capita spending in the National Health Expenditures for the calendar year that begins during the fiscal year involved over the prior calendar year.

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Parent coverage under CHIP	Same as above.	Same as above.	**S§106 Conditions for coverage of parents.** Would prohibit the approval or renewal of Section 1115 demonstration waivers that allow federal CHIP funds to be used to provide coverage to parent(s) of targeted low-income child(ren). The 11 states with CMS approval for such waivers would be permitted to use federal CHIP funds to continue such coverage during FY2008 and FY2009 as long as such funds are not used to cover individuals with annual income that exceeds the income eligibility in place as of the date of enactment. Beginning in FY2010, allowable spending under the waivers would be subject to a set aside amount from a separate allotment.
			In FY2010 only, costs associated with such parent coverage would be subject to each such state's CHIP enhanced FMAP for States that meet certain coverage benchmarks (related to performance in providing coverage to children) in FY2009, or each such state's Medicaid FMAP rate for all other states.

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			For FY2011 or 2012, costs associated with such parent coverage would be subject to: (1) a state's REMAP percentage (i.e., a percentage which would be equal to the sum of (a) the state's FMAP percentage and (b) the number of percentage points equal to one-half of the difference between the state's FMAP rate and the state's E-FMAP rate) if the state meets certain coverage benchmarks (related to performance in providing coverage to children) for the preceding fiscal year, or (2) the state's regular Medicaid FMAP rate if the state failed to meet the specified coverage benchmarks for the preceding fiscal year.
			Would require a Government Accountability Office study regarding effects of adult coverage on the increase in child enrollment or quality of care.
Medicaid TMA	States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation is called transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid	**H§801. Modernizing transitional Medicaid.** The House bill would extend work-related TMA under section 1925 through September 30, 2011. States could opt to treat any reference to a 6-month period (or 6 months) as a reference to a 12-month period (or 12	No provision.

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	eligibility due to increased child or spousal support collections, as well as those who lose eligibility due to an increase in earned income or hours of employment. Congress expanded work-related TMA under section 1925 of the Social Security Act in 1988, requiring states to provide TMA to families who lose Medicaid for work-related reasons for at least six, and up to 12, months. Since 2001, work-related TMA requirements under section 1925 have been funded by a series of short-term extensions, most recently through September 30, 2007.	months) for purposes of the initial eligibility period for work-related TMA, in which case the additional 6-month extension would not apply. States could opt to waive the requirement that a family have received Medicaid in at least three of the last six months in order to qualify. They would be required to collect and submit to the Secretary of HHS (and make publicly available) information on average monthly enrollment and participation rates for adults and children under work-related TMA, and on the number and percentage of children who become ineligible for work-related TMA and whose eligibility is continued under another Medicaid eligibility category or who are enrolled in CHIP. The Secretary would submit annual reports to Congress concerning these rates. Except for the four-year extension of work-related TMA, which would be effective October 1, 2007, the provision would be effective upon enactment.	

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Spousal impoverishment rules	Medicaid law grants states the option to apply spousal impoverishment rules to the counting of income and assets for a married person who applies to Medicaid as a medically needy individual under section 1915(c) and (d) home and community-based (HCBS) waivers. States may not, however, apply spousal impoverishment rules when determining eligibility for medically needy individuals under 1915(e) waivers. In addition, states may not apply spousal impoverishment rules to the post-eligibility treatment of income for medically needy persons enrolled in 1915(c), (d), and (e) waivers. Neither eligibility nor post-eligibility spousal impoverishment rules are applied to persons receiving section 1915(I) or 1915(j) benefits unless these persons qualify for Medicaid through an eligibility group for which spousal impoverishment rules apply. Medicaid law allows states to apply spousal impoverishment eligibility and post-eligibility rules to medically needy individuals, subject to the Secretary's approval.	**H§804. State option to protect community spouses of individuals with disabilities.** The provision would amend Medicaid law to allow states to apply spousal impoverishment rules to medically needy applicants and their spouses during the eligibility and post-eligibility determination of income process for applicants of HCBS waivers authorized under sections 1915(c), (d), or (e) as well as section 1115 of the Social Security Act. It would also apply to medically needy individuals who are receiving benefits under sections 1915(I) and (j).	No provision.

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Medicaid asset verification	The Social Security Administration (SSA) is piloting a financial account verification system (in field offices located in New York and New Jersey) that uses an electronic asset verification system to help confirm that individuals who apply for Supplemental Security Income (SSI) benefits are eligible. The process permits automated paperless transmission of asset verification requests between SSA field offices and financial institutions. Part of this pilot involved a comprehensive study to measure the value of such a system for SSI applicants as well as recipients already on the payment rolls. This study identified a small percentage (about 5 percent) of applicants and recipients who were overpaid based on this financial account verification system.	**H§817. Extension of SSI web-based asset demonstration project to the Medicaid program.** Under the House bill, the Secretary of HHS would be required to provide for application of the current law SSI pilot to asset eligibility determinations under the Medicaid program. This application would only extend to states in which the SSI pilot is operating and only for the period in which the pilot is otherwise provided. For purposes of applying the SSI pilot to Medicaid, information obtained from a financial institution that is used for purposes of SSI eligibility determinations could also be shared and used by states for purposes of Medicaid eligibility determinations.	No provision.
Enrollment/Access			
"Express lane" eligibility determinations	Medicaid law and regulations contain requirements regarding determinations of eligibility and applications for assistance. In limited circumstances outside agencies are permitted to determine eligibility for Medicaid. For example, when a joint TANF-Medicaid application is used the state TANF	**H§112 State option to rely on finding from an express lane agency to conduct simplified eligibility determinations.** Beginning in January 2008, would allow States to rely on a eligibility determination finding made within a State-defined period from an	**S§203 Demonstration project to permit States to rely on findings by an Express Lane agency to determine components of a child's eligibility for Medicaid or CHIP.** Would create a three-year demonstration program that would allow up to ten states to use Express Lane eligibility determinations at

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	agency may make the Medicaid eligibility determination. Medicaid applicants must attest to the accuracy of the information submitted on their applications, and sign application forms under penalty of perjury.	Express Lane Agency to determine whether a child under age 19 (or up to age 21 at state option) has met one or more of the eligibility requirements (e.g., income, assets or resources, citizenship, or other criteria) necessary to determine an individual's initial eligibility, eligibility redetermination, or renewal of eligibility for medical assistance under Medicaid or CHIP.	Medicaid and CHIP enrollment and renewal. The demonstration would authorize and appropriate $44 million for the period of FY2008 through FY2012 for systems upgrades and implementation. Of this amount, $5 million would be dedicated to an independent evaluation of the demonstration for the Congress. Under the demonstration, states would be permitted to rely on a finding made by an Express Lane Agency within the preceding 12 months to determine whether a child has met one or more of the eligibility requirements (e.g., income, assets, citizenship or other criteria) necessary to determine an individual's eligibility for Medicaid or CHIP.
		If a finding from an Express Lane Agency results in a child not being found eligible for Medicaid or CHIP, the States would be required to determine Medicaid or CHIP eligibility using its regular procedures and to inform the family that they may qualify for lower premium payments if the family's income were directly evaluated for an eligibility determination by the State using its regular policies. States may initiate an	Like the House provision the Senate's provision does not relieve states of their obligation to determine eligibility for Medicaid, and would require the state to inform families that they may qualify for lower premium payments or more comprehensive health coverage under Medicaid if the family's income were directly evaluated by the state Medicaid agency.

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		eligibility determination (and determine program eligibility) without a program application based on finding from an Express Lane Agency and information from sources other than the child only if the family has affirmatively consented to being enrolled in Medicaid or CHIP.	
		Express Lane agencies would include public agencies determined by the State as capable of making eligibility determinations including public agencies that determine eligibility under the Food Stamp Act, the School Lunch Act, the Child Nutrition Act, or the Child Care Development Block Grant Act.	Express Lane agencies would include public agencies determined by the State as capable of making eligibility determinations and goes beyond list of agencies included in the House provisions to include additional public agencies such as those that determine eligibility under TANF, CHIP, Medicaid, Head Start, etc. Also included are state specified governmental agencies that have fiscal liability or legal responsibility for the accuracy of eligibility determination findings, and public agencies that are subject to an interagency agreement limiting the disclosure and use of such information for eligibility determination purposes. The provision would explicitly exclude programs run through title XX (Social Services Block Grants) of the Social Security Act, and private for-profit organizations as agencies that would qualify

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			as an Express Lane agency.
		Signatures under penalty of perjury would not be required on a Medicaid application form attesting to any element of the application for which eligibility is based on information received from an Express Lane Agency or from another public agency. The provision would authorize federal or State agencies or private entities in possession of potentially pertinent data relevant for the determination of eligibility under Medicaid to share such information with the Medicaid agency for the purposes of child enrollment in Medicaid, and would impose criminal penalties for entities who engage in unauthorized activities with such data.	Like the House provision, would drop the requirement for signatures under penalty of perjury. The provision would permit signature requirements for a Medicaid application to be satisfied through an electronic signature and would monitor error rates associated with incorrect eligibility determinations.
Out-Stationed Eligibility Determinations	Under current law, a Medicaid state plan must provide for the receipt and initial processing of applications for medical assistance for low-income pregnant women, infants, and children under age 19 at outstation locations other than Temporary Funding for Needy Assistance (TANF) offices such as, disproportionate share hospitals, and	**H§113 Application of Medicaid outreach procedures to all children and pregnant women.** Effective January 1, 2008, the House bill would provide for the receipt and initial processing of applications for medical assistance for children and pregnant women under any provision of this title, and would allow	No provision.

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	Federally-qualified health centers. State eligibility workers assigned to outstation locations perform initial processing of Medicaid applications including taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete processing of the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews.	for such application forms to vary across outstation locations.	
Funding for outreach and enrollment	Under current law, title XXI specifies that federal SCHIP funds can be used for SCHIP health insurance coverage which meets certain requirements. Apart from these benefit payments, SCHIP payments for four other specific health care activities can be made, including (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of SCHIP children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, payments for other specific health care activities cannot exceed 10% of the total amount of expenditures for SCHIP benefits and	**H§114 Encouraging culturally appropriate enrollment and retention practices.** The provision would permit states to receive Medicaid federal matching payments for translation or interpretation services in connection with the enrollment and use of services by individuals for whom English is not their primary language. Payments for this activity would be matched at 75% FMAP rate.	**S§201 Grants for outreach and enrollment.** The provision would set aside $100 million (during the period of fiscal years 2008 through 2012) for a grant program under CHIP to finance outreach and enrollment efforts that increase participation of Medicaid and CHIP-eligible children. Such amounts would not be subject to current law restrictions on expenditures for outreach activities. For such period, 10% of the funding would be dedicated to a national enrollment campaign, and 10% would be set-side for grants for outreach to, and enrollment of, children who are Indians. Remaining funds would be distributed to specified

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	other specific health care activities combined. The federal and state governments share in the costs of both Medicaid and SCHIP, based on formulas defining the federal contribution in federal law. The federal match for administrative expenditures does not vary by state and is generally 50%, but certain administrative functions have a higher federal matching rate.		entities to conduct outreach campaigns that target geographic areas with high rates of eligible but not enrolled children who reside in rural areas, or racial and ethnic minorities and health disparity populations. Grant funds would also be targeted at proposals that address cultural and linguistic barriers to enrollment. Finally it would provide the greater of 75%, or the sum of the enhanced FMAP for the state plus five percentage points for translation and interpretation services under CHIP by individuals for whom English is not their primary language.
Continuous eligibility under CHIP	States are required to redetermine Medicaid and SCHIP eligibility at least every 12 months with respect to circumstances that may change and affect eligibility. Continuous eligibility allows a child to remain enrolled for a set period of time regardless of whether the child's circumstances change (e.g., the family's income rises above the eligibility threshold), thus making it easier for a child to stay enrolled. Not all states offer it, but among those that do the period of continuous eligibility ranges from 6 months to 12 months.	**H§115 continuous eligibility under CHIP** The House bill would require separate CHIP programs (or CHIP programs operating under the Section 1115 waiver authority) to implement 12 months of continuous eligibility for targeted low-income children whose annual family income is less than 200% FPL.	No provision.

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Commission to monitor access and other matters	In accordance with P.L. 92-263, in May of 2005, the Secretary of HHS established a Medicaid Commission, to provide advice on ways to modernize Medicaid so that it could provide high quality health care to its beneficiaries in a financially sustainable way. The charter for this Commission included rules regarding voting and non-voting members, meetings, compensation, estimated costs, and two reports. The Commission terminated 30 days after submission of its final report to the Secretary of HHS (dated December 29, 2006). No ongoing Commission has ever existed for the program.	**H§141. Children's Access, Payment and Equality Commission.** Would establish a new federal commission. Among many tasks, this new Commission would review (1) factors affecting expenditures for services in different sectors, payment methodologies, and their relationship to access and quality of care for Medicaid and CHIP beneficiaries, (2) the impact of Medicaid and CHIP policies on the overall financial stability of safety net providers (e.g., FQHCs, school-based clinics, disproportionate share hospitals), and (3) the extent to which the operation of Medicaid and CHIP ensures access comparable to access under employer-sponsored or other private health insurance. Commission recommendations would be required to consider budget consequences, be voted on by all members, and the voting results would be included in Commission reports. Certain MEDPAC provisions would apply to this new commission (i.e., relating to membership with the addition of Medicaid and CHIP	No provision.

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		beneficiary representatives, staff and consultants, and powers). The provision would authorize to be appropriated such sums as necessary to carry out the duties of the new Commission.	
Model enrollment practices	No provision.	**H§142 Model of interstate coordinated enrollment and coverage process.** The House bill would require the Comptroller General, in consultation with State Medicaid, CHIP directors, and organizations representing program beneficiaries to develop a model process (and report for Congress) for the coordination of enrollment, retention, and coverage of children who frequently change their residency due to migration of families, emergency evacuations, educational needs, etc.	No provision.
Citizenship documentation	Under current law, noncitizens who apply for full Medicaid benefits have been required since 1986 to present documentation that indicates a "satisfactory immigration status." Due to recent changes, citizens and nationals also must present documentation that proves citizenship and documents personal identity in order for states to receive federal Medicaid	**H§143. Medicaid citizenship documentation requirements.** The House bill would make Medicaid citizenship documentation for children under age 21 a state option, using criteria that are no more stringent than the existing documentation specified in section 1903(x)(3) of the Social Security	**S§301. Verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP.** The Senate bill would provide a new option for meeting citizenship documentation requirements. As part of its Medicaid state plan and with respect to individuals declaring to be U.S. citizens or nationals for purposes

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	reimbursement for services provided to them. This citizenship documentation requirement was included in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and modified by the Tax Relief and Health Care Act of 2006 (P.L. 109-432). Before the DRA, states could accept self-declaration of citizenship for Medicaid, although some chose to require additional supporting evidence. The citizenship documentation requirement is outlined under section 1903(x) of the Social Security Act and applies to Medicaid eligibility determinations and redeterminations made on or after July 1, 2006. The law specifies documents that are acceptable for this purpose and exempts certain groups from the requirement. It does not apply to SCHIP. However, since some states use the same enrollment procedures for all Medicaid and SCHIP applicants, it is possible that some SCHIP enrollees would be asked to present evidence of citizenship.	Act. See **H§136** (under Miscellaneous) for auditing requirements. See **H§112(a)** for ability of "Express Lane" agencies to determine eligibility without citizenship documentation.	of establishing Medicaid eligibility, a state would be required to provide that it satisfies existing Medicaid citizenship documentation rules under section 1903(x) of the Social Security Act or new rules under section 1902(dd). Under section 1902(dd), a state could meet its Medicaid state plan requirement for citizenship documentation by: (1) submitting the name and Social Security number (SSN) of an individual to the Commissioner of Social Security as part of a plan established under specified rules and (2) in the case of an individual whose name or SSN is invalid, notifying the individual, providing him or her with a period of 90 days to either present evidence of citizenship as defined in section 1903(x) or cure the invalid determination with the Commissioner of Social Security, and disenrolling the individual within 30 days after the end of the 90-day period if evidence is not provided. States would be required to provide information to the Secretary on the percentage of invalid names and SSNs submitted each month, and could be subject to a penalty if the average monthly percentage for any fiscal year is greater than

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			7%. States would receive 90% reimbursement for costs attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement name and SSN validation, and 75% for the operation of such systems.
		Groups that are exempt from the citizenship documentation requirement would remain the same as under current law, except for the inclusion of an additional permanent exemption for children who are deemed eligible for Medicaid coverage by virtue of being born to a woman on Medicaid (note that **H§131(b)(1)** is also relevant because it would explicitly allow one year of deemed eligibility for all children born to women on Medicaid, including emergency Medicaid, by removing the requirement that a newborn remain in his or her Medicaid-eligible mother's household in order to qualify for deemed eligibility under 1902(e)(4) of the Social Security Act). The provision would	The Senate provision would also clarify requirements under the existing section 1903(x). It is similar to the House provision regarding the inclusion of an additional permanent exemption for children who are deemed eligible for Medicaid coverage by virtue of being born to a woman on Medicaid, additional documentation options for federally recognized Indian tribes, and the reasonable opportunity to present evidence. However, the Senate provision would not include additional language to reiterate that states must not deny medical assistance on the basis of failure to provide documentation until an individual has had a reasonable opportunity. In addition, although the Senate provision would clarify that deemed eligibility applies to children born to

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		require additional documentation options for federally recognized Indian tribes. It would also specify that states must provide citizens with the same reasonable opportunity to present evidence that is provided under section 1137(d)(4)(A) of the Social Security Act to noncitizens who are required to present evidence of satisfactory immigration status and must not deny medical assistance on the basis of failure to provide such documentation until the individual has had such an opportunity.	noncitizen women on emergency Medicaid and would require separate identification numbers for children born to these women, the bill would not remove the requirement that a newborn remain in his or her Medicaid-eligible mother's household in order to qualify for deemed eligibility under 1902(e)(4).
			The Senate provision would make citizenship documentation a requirement for CHIP. In order to receive reimbursement for an individual who has, or is, declared to be a U.S. citizen or national for purposes of establishing CHIP eligibility, a state would be required to meet the Medicaid state plan requirement for citizenship documentation described above. The 90% and 75% reimbursement for name and SSN validation would be available under CHIP, and would not count towards a state's CHIP administrative expenditures cap.

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		These changes would be effective as if included in the Deficit Reduction Act of 2005. States would be allowed to provide retroactive eligibility for certain individuals who had been determined ineligible under previous citizenship documentation rules.	Except for clarifications made to the existing citizenship documentation requirement, which would be retroactive, the provision would be effective on October 1, 2008. States would be allowed to provide retroactive eligibility for certain individuals who had been determined ineligible under previous citizenship documentation rules.
Elimination of new Health Opportunity Accounts	The Deficit Reduction Act of 2005 allowed the Secretary of HHS to establish no more then 10 demonstration programs within Medicaid for health opportunity accounts (HOAs). HOAs are used to pay (via electronic funds transfers) health care expenses specified by the state. As of July 2007, South Carolina was the only state to receive CMS approval for a Health Opportunity Account Demonstration.	**H§145 Prohibiting initiation of new health opportunity account demonstration programs.** The House bill would prohibit the Secretary of HHS from approving any new Health Opportunity Account demonstrations as of the date of enactment of this Act.	No provision.

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Outreach and enrollment of Indians	State SCHIP plans must include a description of procedures used to ensure the provision of child health assistance to American Indian and Alaskan Native children. Certain non-benefit payments under SCHIP (e.g., for other child health assistance, health service initiatives, outreach, and program administration) cannot exceed 10% of the total amount of expenditures for benefits and these non-benefit payments combined.	No provision.	**S§202. Increased outreach and enrollment of Indians.** Would encourage states to take steps to enroll Indians residing in or near reservations in Medicaid and CHIP. These steps may include outstationing of eligibility workers [at certain hospitals and Federally Qualified Health Centers]; entering into agreements with Indian entities (i.e., the IHS, tribes, tribal organizations) to provide outreach; education regarding eligibility, benefits, and enrollment; and translation services. The Secretary would be required to facilitate cooperation between states and Indian entities in providing benefits to Indians under Medicaid and CHIP. This provision would also exclude costs for outreach to potentially eligible Indian children and families from the 10% cap on non-benefit expenditures under CHIP.

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Eligibility information disclosure	Under current law, each State must have an income and eligibility verification system under which (1) applicants for Medicaid and several other specified government programs must furnish their Social Security numbers to the state as a condition for eligibility, and (2) wage information from various specified government agencies is used to verify eligibility and to determine the amount of the available benefits. Subsequent to initial application, States must request information from other federal and state agencies, to verify applicants' income, resources, citizenship status, and validity of Social Security number, unearned income, unemployment information, etc.	No provision.	**S§204 Authorization of certain information disclosures to simplify health coverage determinations.** The Senate bill would authorize federal or State agencies or private entities with data sources that are directly relevant for the determination of eligibility under Medicaid to share such information with the Medicaid agency if: (1) there is no family objection to such disclosure, (2) the data would be used solely for the purpose of determining Medicaid eligibility, and (3) there is an interagency agreement in place to prevent the unauthorized use or disclosure of such information. Individuals involved in such unauthorized use would be subject to criminal penalty. In addition, for the purposes of the Express Lane Demonstration states only, the provision would allow the Medicaid and CHIP programs to receive such data from (1) the National New Hires Database, (2) the National Income Data collected by the Commissioner of Social Security, or (3) data about enrollment in insurance that may help to facilitate outreach and enrollment under Medicaid, CHIP, and certain other programs.

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Reducing administrative barriers to enrollment	During the implementation of SCHIP states instituted a variety of enrollment facilitation and outreach strategies to bring eligible children into Medicaid and SCHIP. As a result, substantial progress was made at the state level to simplify the application and enrollment processes to find, enroll, and maintain eligibility among those eligible for the program.	No provision.	**S§302 Reducing administrative barriers to enrollment.** The Senate bill would require the State plan to describe the procedures used to reduce the administrative barriers to the enrollment of children and pregnant women in Medicaid and CHIP, and to ensure that such procedures are revised as often as the State determines is appropriate to reduce newly identified barriers to enrollment.
Premium Assistance/Employer Buy-In Programs			
Employer Buy-in to CHIP	An enrollee buy-in program is a program under which the family of a child that does not qualify for the SCHIP program (usually due to excess income) can enroll their children into the SCHIP program by paying for most or all of the cost of coverage. Under current law, states may not receive federal matching funds for the services provided to these children, or for the costs of administering the buy-in program.	**H§821 Demonstration project for employer buy-in**. The House bill would allow the Secretary of Health and Human Services to establish a five-year demonstration project under which up to 10 states would be permitted to provide CHIP child health assistance to children (and their families) who would be targeted low-income children except for the fact that they have group health coverage as allowed under this provision. To qualify, states must have a CHIP income eligibility that is at least 200% FPL. Under the demonstrations, CHIP federal financial participation would be permitted only for such costs attributable	No provision.

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		to eligible children.	
		The House bill would require coverage and benefits under a demonstration project to be the same as the coverage and benefits provided under the state's CHIP plan for targeted low-income children with the highest family income level provided.	
		Families would be responsible for payments towards the premium for such assistance in an amount specified by the state as long as no cost sharing is imposed on benefits for preventive services, and CHIP rules related to income-related limitations on cost sharing are applied.	
		Qualifying providers would be responsible for providing payment in an amount that is equal to at least 50% of the portion of the cost of the family coverage that exceeds the amount of the family's cost sharing contribution.	
		Qualifying employers would be defined as an employer with a majority of its workforce that is composed of full time	

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		workers (where two, part-time workers are treated as a single full-time worker) with family incomes reasonably estimated by the employer (based on wage information) at or below 200% FPL.	
Premium assistance programs	Under Medicaid, states may pay a Medicaid beneficiary's share of costs for group (employer-based) health coverage for any Medicaid enrollee for whom coverage is available, comprehensive, and cost-effective for the state. An individual's enrollment in an employer plan is considered cost effective if paying the premiums, deductibles, coinsurance and other cost-sharing obligations of the employer plan is less expensive than the state's expected cost of directly providing Medicaid-covered services. States were also to provide coverage for those Medicaid covered services that are not included in the private plans.	No provision.	**S§401 Additional State option for providing premium assistance.** The Senate bill would allow states to offer a premium assistance subsidy for qualified employer sponsored coverage to all targeted low-income children who are eligible for child health assistance and have access to such coverage, or to parents of targeted low-income children. Qualified employer sponsored coverage would be defined as a group health plan or health insurance coverage offered through an employer that (1) qualifies as credible health coverage as a group health plan under the Public Health Service Act, (2) for which the employer contributes at least 40% toward the cost of the premium, and (3) is nondiscriminatory in a manner similar to section 105(h)of the Internal Revenue Code but would not allow employers to exclude workers who had less

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			than three years of service. The Bill explicitly excludes (1) benefits provided under a health flexible spending arrangement, (2) a high deductible health plan purchased in conjunction with a health savings account as defined in the Internal Revenue Code of 1986 as qualified coverage.
	Under SCHIP, the Secretary has the authority to approve funding for the purchase of "family coverage"under an employer-sponsored health insurance plan if it is cost effective relative to the amount paid to cover only the targeted low-income children and does not substitute for coverage under group health plans otherwise being provided to the children. In addition, states using SCHIP funds for employer-based plan premiums must ensure that SCHIP minimum benefits are provided and SCHIP cost-sharing ceilings are met. Because of these requirements, implementation of premium assistance programs under Medicaid and SCHIP are not widespread.		The Senate bill would establish a new cost effectiveness test for employer sponsored insurance (ESI) programs. The state would be required to establish that (1) the cost of such coverage is less than state expenditures to enroll the child or the family (as applicable) in CHIP, or (2) the aggregate amount of State expenditures for the purchase of all such coverage for targeted low-income children under CHIP (including administrative expenses) does not exceed the aggregate amount of expenditures that the State would have made for providing coverage under the CHIP state plan for all such children.
	Under the Bush Administration's Health Insurance Flexibility and Accountability (HIFA) Initiative, states were encouraged to seek approval for Section 1115 waiver		States would be required to provide supplemental coverage for a targeted low-income child enrolled in the ESI plan consisting of items or services that are not

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	programs to direct unspent SCHIP funds to extend coverage to uninsured populations with annual income less than 200% FPL and to use Medicaid and SCHIP funds to pay premium costs for waiver enrollees who have access to Employer Sponsored Insurance (ESI). ESI programs approved under the Section 1115 waiver authority are not subject to the same current law constraints required under Medicaid's Health Insurance Premium Payment (HIPP) program or SCHIP's family coverage variance option (i.e., the comprehensiveness and cost-effectiveness tests).		covered, or are only partially covered, and cost-sharing protections consistent with the requirements of CHIP. Plans that meet the CHIP benefit coverage requirements would not be required to provide supplemental coverage for benefits and cost-sharing protections as required under CHIP.
			States would be permitted to directly pay out-of-pocket expenditures for cost-sharing imposed under the qualified ESI coverage and collect all (or any) portion for cost-sharing imposed on the family. Parents would be permitted to disenroll their child(ren) from ESI coverage and enroll them in CHIP coverage effective on the first day of any month for which the child is eligible for such coverage.
			States would be permitted to establish an employer-family premium assistance purchasing pool for employers with less than

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			250 employees who have at least one employee who is a CHIP-eligible pregnant woman or at least one member of the family is a CHIP-eligible child. Eligible families would have access to not less than 2 private health plans where the health benefits coverage is equivalent to the benefits coverage available through a CHIP benchmark benefit package or CHIP benchmark equivalent coverage benefits package.
			Finally the Senate bill would require the Government Accountability Office to submit a report to Congress not later than January 1, 2009 regarding cost and coverage issues under State premium assistance programs.
Education and enrollment assistance in premium assistance programs	SCHIP state plans are required to include a description of the procedures in place to provide outreach to children eligible for SCHIP child health assistance, or other public or private health programs to (1) inform these families of the availability of public and private health coverage and (2) to assist them in enrolling such children in SCHIP. There is a limit on federal spending for SCHIP administrative expenses (i.e., 10% of a state's	No provision.	**S§402 Outreach, education, and enrollment assistance.** The Senate bill would require states to include a description of the procedures in place to provide outreach, education, and enrollment assistance for families of children likely to be eligible for premium assistance subsidies under CHIP or a waiver approved under §1115. For employers likely to provide qualified employer-sponsored coverage, the

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	spending on benefit coverage in a given fiscal year). Administrative expenses include activities such as data collection and reporting, as well as outreach and education. In addition, states are required to provide a description of the state's efforts to ensure coordination between SCHIP and other health insurance coverage applies to State administrative expenses.		state is required to include the specific resources the State intends to use to educate employers about the availability of premium assistance subsidies under the CHIP state plan. Expenditures for such outreach activities would not be subject to the 10% limit on spending for administrative costs associated with the CHIP program.
Special enrollment period	Under the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act, a group health plan is required to provide special enrollment opportunities to qualified individuals. Such individuals must have lost eligibility for other group coverage, or lost employer contributions towards health coverage, or added a dependent due to marriage, birth, adoption, or placement for adoption, in order to enroll in a group health plan without having to wait until a late enrollment opportunity or open season. The individual still must meet the plan's substantive eligibility requirements, such as being a full-time worker or satisfying a waiting period. Health plans must give qualified individuals at least 30 days after the qualifying event (e.g.,	No provision.	**S§411 Special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage or eligibility for assistance in purchase of employment-based coverage; coordination of care.** The bill would amend applicable federal laws to streamline coordination between public and private coverage, including making the loss of Medicaid/CHIP eligibility a "qualifying event" for the purpose of purchasing employer-sponsored coverage. The bill would also require employers to: share information about their benefit packages with states so states can evaluate the need to provide "wraparound" coverage, and notify families of their potential eligibility for premium assistance.

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	loss of eligibility) to make a request for special enrollment.		
Benefits			
Dental services	Under SCHIP, states may provide coverage under their Medicaid programs, create a new separate SCHIP program, or both. Under separate SCHIP programs, states may elect any of three benefit options: (1) a benchmark plan, (2) a benchmark-equivalent plan, or (3) any other plan that the Secretary of HHS deems would provide appropriate coverage for the target population (called Secretary-approved coverage). Benchmark plans include (1) the standard Blue Cross/Blue Shield preferred provider option under FEHBP, (2) the coverage generally available to state employees, and (3) the coverage offered by the largest commercial HMO in the state. Benchmark-equivalent plans must cover basic benefits (i.e., inpatient and outpatient hospital services, physician services, lab/x-ray, and well-child care including immunizations), and must include at least 75% of the actuarial value of coverage under the selected benchmark plan for specific additional benefits (i.e., prescription drugs, mental health services, vision care and hearing services).	**H§121. Ensuring child-centered coverage.** The provision would make dental services a required benefit under CHIP. States would also be required to assure access to these services. The effective date would be October 1, 2008. **H§144. Access to dental care for children.** The provision would require the Secretary of HHS to develop and implement a program to deliver oral health education materials that inform new parents about risks for, and prevention of, early childhood caries and the need for a dental visit within a newborn's first year of life. States could not prevent an FQHC from entering into contractual relationships with private practice dental providers under both Medicaid and CHIP (effective January 1, 2008). The data that states submit to the federal government documenting receipt of EPSDT services each fiscal year	**S§608. Dental health grants.** As amended, would provide authority for new dental health grants to improve the availability of dental services and strengthen dental coverage for children under CHIP. To be awarded such a grant, states would describe quality and outcomes performance measures to be used to evaluate the effectiveness of grant activities, and must assure that they will cooperate with the collection and reporting of data to the Secretary of HHS, among several requirements. Grantees would be required to maintain state funding of dental services under CHIP at the level of expenditures in the fiscal year preceding the first fiscal year for which the new grant is awarded. Such states would not be required to provide any state matching funds for the new dental grant program. The Secretary would be required to submit to Congress an annual report on state activities and performances assessments under the new dental grant program. For the period FY2008 through FY2012, $200

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	Among other items, a state SCHIP plan must include a description of the methods (including monitoring) used to (1) assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan, and (2) assure access to covered services, including emergency services. Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit under Medicaid, most children under age 21 receive comprehensive basic screening services (i.e., well-child visits including age-appropriate immunizations) as well as dental, vision and hearing services. In addition, EPSDT guarantees access to all federally coverable services necessary to treat a problem or condition among eligible individuals. The EPSDT provision in Medicaid law also includes annual reporting requirements for states. The tool used to capture these EPSDT data is called the CMS-416 form. Three separate measures capture the unduplicated number of EPSDT eligibles receiving any dental services, preventive dental services and dental treatment services.	would be required to include parallel information on receipt of dental services among CHIP children. This reporting requirement would also apply to annual state CHIP reports. Such reporting would be required to include information on children enrolled in managed care plans, other private health plans, and contracts with such plans under CHIP (effective for annual state CHIP reports submitted for years beginning after the date of enactment of this Act). In addition, GAO would be required to conduct a study examining access to dental services by children in under-served areas, and the feasibility and appropriateness of using qualified mid-level dental providers to improve access. A report on this GAO study would be due not later than one year after the date of enactment of this Act.	million would be appropriated for this grant program, to remain available until expended. The provision would also require the Secretary of HHS to include on the *Insure Kids Now* website and hotline a current and accurate list of all dentists and other dental providers in each state that provide such services to Medicaid and CHIP children, and must update this listing at least on a quarterly basis. The Secretary would also be required to work with states to include a description of covered dental services for children under both programs (including under applicable waivers) for each state, and must post this information on the *Insure Kids Now* website. The provision would require GAO to conduct a study on children's access to oral health care, including preventive and restorative services under Medicaid and CHIP. The report on this study must include recommendations for such federal and state legislative and administrative changes necessary to address barriers to access to dental care under Medicaid and CHIP (and would be due not later than two years after the date of enactment of this Act). Also the provision would add an assessment of the

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			quality of dental care provided to Medicaid and CHIP children to the Secretary's annual reports to Congress under the new child health quality improvement activities authorized in the Senate-passed bill.
Services provided by federally qualified health centers (FQHCs) and rural health centers (RHCs)	In SCHIP statute, a number of coverable benefits are listed such as "clinic services (including health center services) and other ambulatory health care services." Services provided by FQHCs and RHCs are a mandatory benefit for most beneficiaries under Medicaid.	**H§121. Ensuring child-centered coverage.** The provision would make the services provided by FQHCs and RHCs required benefits under CHIP. States would also be required to assure access to these services. The effective date would be October 1, 2008.	No provision.
Mental health services	For an explanation of the benchmark coverage options under SCHIP, see the current law description in the "dental services" row above. Under the Mental Health Parity Act (MHPA), Medicaid and SCHIP plans may define what constitutes mental health benefits (if any). The MHPA prohibits group plans from imposing annual and lifetime dollar limits on mental health coverage that are more restrictive than those applicable to medical and surgical coverage. Full parity is not required, that is, group plans may still impose more restrictive treatment limits (e.g., with respect to total	**H§121. Ensuring child-centered coverage.** The provision would increase the minimum actuarial value for mental health services from 75% to 100% for benchmark-equivalent coverage under CHIP. The effective date would be October 1, 2008.	**S§607. Mental health parity in CHIP plans.** The provision would ensure that the financial requirements (e.g., such as annual and lifetime dollar limits) and treatment limitations applicable to mental health or substance abuse benefits (when such benefits are covered) are no more restrictive than the financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered under the state CHIP plan. State CHIP plans that include coverage of EPSDT services (as defined in Medicaid statute) would be deemed to satisfy this mental health parity

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	number of outpatient visits or inpatient days) or cost-sharing requirements on mental health coverage compared to their medical and surgical services.		requirement.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services	The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) gave states the option to provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage that is nearly identical to plans available under SCHIP (described above in the "dental services" row). For any child under age 19 in one of the major mandatory and optional eligibility groups in Medicaid, wrap-around benefits to the DRA benchmark and benchmark-equivalent coverage includes EPSDT. In traditional Medicaid, EPSDT is available to most individuals under age 21.	**H§121. Ensuring child-centered coverage.** The provision would require coverage of the EPSDT benefit for individuals under age 21, whether such persons are enrolled in benchmark plans, benchmark-equivalent plans or otherwise under Medicaid. The effective date would be the same as the original DRA provision (i.e., March 31, 2006).	**S§605. Deficit Reduction Act technical corrections.** The provision would require that EPSDT be covered for any individual under age 21 who is eligible for Medicaid through the state Medicaid plan under one of the major mandatory and optional coverage groups and is enrolled in benchmark or benchmark-equivalent plans authorized under DRA. The provision would also give states flexibility in providing coverage of EPSDT services through the issuer of benchmark or benchmark-equivalent coverage or otherwise. In addition, the Secretary would be required to publish in the *Federal Register* and on the internet website of CMS, a list of the provisions in Title XIX that the Secretary has determined do not apply in order to enable a state to carry out a state plan amendment to provide benchmark or benchmark-equivalent coverage under Medicaid. In such publications, the Secretary must also provide the reason for each such determination. The

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			effective date would be the same as the original DRA provision (i.e., March 31, 2006).
Services provided by school-based health centers	A number of coverable benefits are listed in the SCHIP statute, such as "clinic services (including health center services) and other ambulatory health care services."	**H§121. Ensuring child-centered coverage.** The provision would add "school-based health center services" to the "clinic services" benefit category in CHIP statute. The effective date would be on or after the date of enactment of this Act.	No provision.
Benchmark coverage options	Under SCHIP, states may provide coverage under their Medicaid programs, create a new separate SCHIP program, or both. Under separate SCHIP programs, states may elect any of three benefit options: (1) a benchmark plan, (2) a benchmark-equivalent plan, or (3) any other plan that the Secretary of HHS deems would provide appropriate coverage for the target population (called Secretary-approved coverage). Benchmark plans include (1) the standard Blue Cross/Blue Shield preferred provider option under FEHBP, (2) the coverage generally available to state employees, and (3) the coverage offered by the largest commercial HMO in the state. Benchmark-equivalent plans must cover basic benefits (i.e., inpatient and	**H§121. Ensuring child-centered coverage.** The provision would require that benchmark coverage under CHIP be at least equivalent to the benchmark benefit packages specified in statute. The effective date would be October 1, 2008. **H§122. Improving benchmark coverage options.** The provision would continue to allow Secretary-approved coverage under both CHIP and the DRA option under Medicaid, but only if such coverage is at least equivalent to a benchmark benefit package. The provision would also more explicitly	No provision.

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	outpatient hospital services, physician services, lab/x-ray, and well-child care including immunizations), and must include at least 75% of the actuarial value of coverage under the selected benchmark plan for specific additional benefits (i.e., prescription drugs, mental health services, vision care and hearing services). The DRA also allowed similar benchmark coverage options under Medicaid.	define state employees benchmark coverage for both CHIP and the DRA option for Medicaid to include the state employee plan that has been selected the most frequently, by employees seeking dependent coverage, among such plans that provide dependent coverage, in either of the previous two years. The effective date would be October 1, 2008.	
Extension of family planning services and supplies	State Medicaid programs must offer family planning services and supplies to categorically needy individuals of childbearing age, including minors considered to be sexually active. Family planning services must be available to eligible pregnant women through the 60th day following the end of the pregnancy. Coverage of the medically needy other than pregnant women may include family planning. States receive a 90% federal matching rate for expenditures attributable to the offering, arranging, and furnishing of family planning services and supplies.	**H§802 Family planning services.** The House bill would create a state option to extend family planning services and supplies (at the 90% federal Medicaid match rate) to women who are not pregnant and whose annual income does not exceed the highest income eligibility level established under the Medicaid State plan (or under title XXI) for pregnant women. States would be permitted to include individuals eligible for Medicaid §1115 family planning waivers that were approved as of January 1, 2007.	No provision.
		Federal financial participation for medical assistance made available to such individuals would be limited to	

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		family planning services and supplies including medical diagnosis or treatment services, and only for the duration of the woman's eligibility under this state option or during a period of presumptive eligibility.	
		Finally, the House bill would prohibit the enrollment of such individuals in a Medicaid benchmark and benchmark-equivalent state plan option, unless such coverage includes medical assistance for family planning services and supplies.	
Adult day health services	Adult day care programs provide health and social services in a group setting on a part-time basis to certain frail older persons and other persons with physical, emotional, or mental impairments. Generally, states that cover adult day care under Medicaid do so under home and community-based waivers, the Program for All-Inclusive Care for the Elderly (PACE) or section 1115 waiver authority. Some states cover adult day care under their Medicaid state plans even though Medicaid law does not list adult day care as a mandatory or optional benefit. There have been concerns that CMS may not continue to allow adult day care to be	**H§803. Authority to continue providing adult day health services approved under a State Medicaid plan.** The provision would require the Secretary to provide for federal financial participation for adult day health care services, as defined under a state Medicaid plan, approved during or before 1994. The provision would be effective beginning November 3, 2005 and ending on March 1, 2009.	No provision.

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	offered under a state's Medicaid plan without the use of a waiver.		
Monitoring Quality			
Quality measurement	The Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) are both actively involved in funding and implementing an array of quality improvement initiatives, though only AHRQ has engaged in activities specific to children. The federal share of states' Medicaid costs varies by type of expenditure. For benefits, the federal medical assistance percentage (FMAP) is based on a formula that provides higher reimbursement to states with lower per capita incomes (and vise versa); it has a statutory minimum of 50% and a maximum of 83%. All states receive a 90% match for family planning services. The federal matching rates for administrative expenses does not vary by state and is generally 50%, but certain administrative functions have a higher federal match. For example, a 75% match rate applies to the operation of an approved Medicaid management information system (MMIS) for	**H§151. Pediatric health quality measurement program.** The provision would require the Secretary to establish a child health care quality measurement program. The purpose would be to develop and implement pediatric quality measures, a system for reporting such measures, and measures of overall program performance that may be used by public and private health care purchasers. By September 30, 2009, the Secretary would be required to publish the recommended measures for years beginning with 2010. In developing and implementing this program, the Secretary would be required to consult with a number of entities. The Secretary could award grants and contracts to develop, validate and disseminate these measures, and would be required to provide technical assistance to states to establish such reporting under Medicaid and CHIP. By January 1, 2009, and annually	**S§501. Child health quality improvement activities for children enrolled in Medicaid or CHIP.** The provision would direct the Secretary of HHS to develop (1) child health quality measures for children enrolled in Medicaid and CHIP, and (2) a standardized format for reporting information, and procedures that encourage states to voluntarily report on the quality of pediatric care in these programs. The Secretary would be required to disseminate information to states regarding best practices in measuring and reporting such data. A total of $45 million would be appropriated for these provisions, of which specific amounts would be earmarked for certain activities (identified below). (The childhood obesity demonstration described below would have its own separate appropriation.) The Secretary would be required to award grants and contracts to develop, test and update (as needed) evidence-based measures, and to disseminate such measures. Each state would

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	claims and information processing. Start-up expenses for MMISs are matched at 90%.	thereafter, the Secretary would be required to make available in an on-line format a complete list of all measures in use by states to measure the quality of medical and dental services provided to Medicaid and CHIP children. By January 1, 2010, and every two years thereafter, the Secretary would be required to report to Congress on the quality of care for children enrolled in CHIP and Medicaid, and patterns of utilization by pediatric characteristics.	be required to report annually to the Secretary on a variety of measures. In addition, the Secretary would be required to award up to 10 grants to states and child health providers to conduct demonstrations to evaluate promising ideas for improving the quality of children's health care under Medicaid and CHIP, for which $20 million would be appropriated. The Secretary would also be required to conduct a demonstration to develop a comprehensive and systematic model for reducing childhood obesity through grants to eligible entities (e.g., local government agencies, Indian tribes, community based organizations). This demonstration would be authorized at $25 million over five years ($5 per year). The Secretary would be required to submit a report to Congress on this demonstration. The Secretary would also be required to establish a program to encourage the creation and dissemination of a model electronic health record format for children enrolled in Medicaid and CHIP. A total of $5 million would be appropriated for this purpose. The Institute of Medicine would be required to study and report to Congress on the extent

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			and quality of efforts to measure child health status and quality of care for children. Up to $1 million would be appropriated for this activity. Finally, the federal share of costs incurred by states for the development or modification of existing claims processing and retrieval systems as is necessary for the efficient collection and reporting on child health measures would be based on the FMAP rate for benefits used under Medicaid.
Information on access to coverage under CHIP	Annually, states submit reports to the Secretary of HHS assessing the operation of their SCHIP programs, including for example, progress made in reducing the number of uninsured low-income children, progress made in meeting other strategic objectives and performance goals identified in the state plan, effectiveness of discouraging substitution of public coverage for private coverage, identification of expenditures by type of beneficiary (e.g., children versus adults), and current income standards and methodologies.	No provision.	**S§502. Improved information regarding access to coverage under CHIP.** The provision would add several reporting requirements to states' annual CHIP reports that are submitted to the Secretary of HHS. Examples of these new reporting requirements include (1) data on eligibility criteria, enrollment and continuity of coverage, (2) use of self-declaration of income for applications and renewals, and presumptive eligibility, (3) data on denials of eligibility and redeterminations of eligibility, (4) data regarding access to primary and specialty care, networks of care and care coordination, and (5) if the state provides premium assistance for employer-based

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			insurance, data regarding the extent to which such coverage is available to CHIP children, the range of monthly premium amounts, the number of children/families receiving such assistance on a monthly basis, the income level of the children/families involved, the benefits and cost-sharing protections for such children/families, the strategies used to reduce administrative barriers to such coverage, and the effects of such premium assistance on preventing substitution of CHIP coverage for employer-based coverage. The provision would also require GAO to conduct a study on access to primary and speciality care under Medicaid and CHIP, and report to Congress its findings and recommendations for addressing existing barriers to children's access to care under these programs.
Federal evaluation	The Secretary was required to conduct an independent evaluation of 10 states with approved SCHIP plans, and to submit a report on that study to Congress by December 31, 2001. Ten million dollars was appropriated for this purpose in FY2000 and was available for expenditure through FY2002. The 10 states chosen for the evaluation were to be ones that	**H§153. Updated federal evaluation of CHIP.** The provision would require the Secretary to conduct an independent evaluation of 10 states with approved CHIP plans, directly or through contracts or interagency agreements, as before. The new evaluation would be submitted to Congress by December 31, 2010. Ten	No provision.

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	utilized diverse approaches to providing SCHIP coverage, represented various geographic areas (including a mix of rural and urban areas), and contained a significant portion of uninsured children. A number of matters were included in this evaluation, including (1) surveys of the target populations, (2) an evaluation of effective and ineffective outreach and enrollment strategies, and identification of enrollment barriers, (3) the extent to which coordination between Medicaid and SCHIP affected enrollment, (4) an assessment of the effects of cost-sharing on utilization, enrollment and retention, and (5) an evaluation of disenrollment or other retention issues.	million dollars would be appropriated for this purpose in FY2009 and made available for expenditure through FY2011. The current-law language for the types of states to be chosen and the matters included in the evaluation would also apply to this new evaluation.	
Payments			
Medicaid Drug Rebate	Pharmaceutical manufacturers that wish to have their products available to Medicaid beneficiaries must enter into "rebate agreements" under which they agree to provide state Medicaid programs with rebates for drugs provided to Medicaid beneficiaries. Basic rebates for single source drugs (generally, those still under patent) and "innovator" multiple source drugs (drugs originally marketed under a patent or original new drug application	**H§812 Medicaid Drug Rebate.** The provision would increase the rebate percentage for the basic rebate for single source and innovator multiple source drugs to 22.1% of the AMP or the difference between the AMP and the best price. The higher rebate percentage would become effective after December 31, 2007.	No provision.

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	(NDA) but for which generic competition now exists) are calculated to be equal to the greater of 15.1% of the average manufacturer's price (AMP) or the difference between the AMP and the best price. Additional rebates are required if the weighted average prices for all of a given manufacturer's single source and innovator multiple source drugs rise faster than inflation. For non-innovator multiple source drugs, rebates are equal to 11% of the AMP.		
Moratorium on certain payment restrictions	No provision in current law. In the President's FY2008 Budget, some proposals affecting Medicaid and SCHIP would be implemented administratively (e.g., via regulatory change, issuance of program guidance, or other possible methods) rather than through legislation. Two such administrative proposals were to phase out Medicaid reimbursement for certain school-based transportation and administrative claiming, and to clarify through regulation the types of service that may be claimed as Medicaid rehabilitation services.	**H§814. Moratorium on certain payment restrictions.** The provision would prohibit the Secretary of HHS from taking any action through regulation, official guidance, use of federal payment audit procedures, or other administrative action, policy or practice to restrict Medicaid coverage or payments for rehabilitation services, or school-based administration, transportation, or medical services if such actions are more restrictive in any aspect than those applied to such coverage or payment as of July 1, 2007. This prohibition would be in effect for one year after the date of enactment of	No provision.

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		this Act.	
Tennessee DSH	When establishing hospital payment rates, state Medicaid programs are required to recognize the situation of hospitals that provide a disproportionate share of care to low-income patients with special needs. Such "disproportionate share (DSH) payments" are subject to statewide allotment caps. Allotments for the state of Tennessee, however, are equal to zero. This is because the state has, in the past, operated its state Medicaid program under the provisions of a research and demonstration waiver. The requirement to make disproportionate share payments is one of the provisions that have been waived by the state under the conditions of their research and demonstration waiver.	**H§ 815. Tennessee DSH.** The provision would set a DSH allotment for the state of Tennessee for fiscal years beginning with 2008 to be equal to $30 million for each year. In addition, the provision would allow the Secretary of HHS to limit the total amount of payments made to hospitals under Tennessee's research and demonstration waiver authorized under Section 1115 of the Social Security Act only to the extent that such limitation is necessary to ensure that a hospital does not receive a payment in excess of Tennessee's annual state DSH allotment or is necessary to ensure that the spending under the waiver remains budget neutral.	No provision.
Monitoring erroneous payments	Federal agencies are required to annually review programs that are susceptible to significant erroneous payments, and to estimate the amount of improper payments, to report those estimates to Congress, and to submit a report on actions the agency is taking to reduce erroneous payments. A new regulation regarding the Payment Error Rate Measurement	No provision.	**S§602. Payment error rate measurement ("PERM").** The provision would apply a federal matching rate of 90% to expenditures related to administration of PERM requirements applicable to CHIP. The provision also would exclude from the 10% cap on CHIP administrative costs all expenditures related to the administration of

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	(PERM) for Medicaid and SCHIP was effective on October 1, 2006. With respect to these two programs, the subset of states selected for review in a given year must conduct reviews of a statistically valid random sample of beneficiary claims to determine if improper payments were made based on errors in the state agency's eligibility determinations. States must have a CMS-approved sampling plan. In addition to reporting error rates, states must also submit a corrective action plan based on the error rate analysis, and must return overpayments of federal funds. A predecessor to PERM, called the Medicaid Eligibility Quality Control (MEQC) system, is operated by state Medicaid agencies for similar purposes.		PERM requirements applicable to CHIP. The Secretary must not calculate or publish national or state-specific error rates based on PERM for CHIP until six months after the date on which a final PERM rule is in effect for all states. Calculations of national- or state-specific error rates after such a final rule is in effect for all states could only be inclusive of errors, as defined in this rule or in guidance issued after the effective date that includes detailed instructions for the specific methodology for error determinations. The final PERM rule would be required to include (1) clearly defined criteria for errors for both states and providers, (2) a clearly defined process for appealing error determinations by review contractors, and (3) clearly defined responsibilities and deadlines for states in implementing any corrective action plans. Special provisions would apply to states for which the PERM requirements were first in effect under interim final rules for FY2007 or FY2008 and their application would depend on when the final PERM rule is in effect for all states. The Senate bill would also require the Secretary to review the Medicaid Eligibility Quality Control

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			(MEQC) requirements with the PERM requirements and coordinate consistent implementation of both sets of requirements, while reducing redundancies. For purposes of determining the erroneous excess payments ratio applicable to the state under MEQC, a state may elect to substitute data resulting from the application of PERM after the final PERM rule is in effect for all states, for the data used for the MEQC requirements. The Secretary would also be required to establish state-specific sample sizes for application of the PERM requirements to CHIP for FY2009 forward. In establishing such sample sizes, the Secretary must minimize the administrative cost burden on states under Medicaid and CHIP, and must maintain state flexibility to manage these programs.
Payments for FQHCs and RHCs under CHIP	Under current Medicaid law, payments to FQHCs and RHCs are based on a prospective payment system. Beginning in FY2001, per visit payments were based on 100% of average costs during 1999 and 2000 adjusted for changes in the scope of services furnished. (Special rules applied to entities first	**H§121. Ensuring child-centered coverage.** The provision would require that payments for FQHC and RHC services provided under CHIP follow the prospective payment system for such services under Medicaid. The effective date would be October 1, 2008.	**S§609. Application of prospective payment system for services provided by Federally-qualified health centers and rural health clinics.** The provision would require states that operate separate and/or combination CHIP programs to reimburse FQHCs and RHCs based on the Medicaid prospective

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	established after 2000). For subsequent years, the per visit payment for all FQHCs and RHCs equals the amounts for the preceding fiscal year increased by the percentage increase in the Medicare Economic Index applicable to primary care services, and adjusted for any changes in the scope of services furnished during that fiscal year. In managed care contracts, states are required to make supplemental payments to the facility equal to the difference between the contracted amount and the cost-based amounts.		payment system. This provision would apply to services provided on or after October 1, 2008. For FY2008, $5 million would be appropriated (to remain available until expended) to states with separate CHIP programs for expenditures related to transitioning to a prospective payment system for FQHCs/RHCs under CHIP. Finally, the Secretary would be required to report to Congress on the effects (if any) of the new prospective payment system on access to benefits, provider payment rates or scope of benefits.
Miscellaneous			
Purpose	No provision.	**H§100. Purpose.** The provision states that the purpose of the CHIP title of the House bill is to provide dependable and stable funding for children's health insurance under Titles XXI (CHIP) and XIX (Medicaid) of the Social Security Act in order to enroll all six million children who are eligible, but not enrolled, for coverage today.	No provision.

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Citizenship auditing	Under current law, the Medicaid statute and associated Medicaid Eligibility Quality Control (MEQC) regulations specify an allowable error rate (3%) for erroneous excess payments that are due to eligibility errors, as well as a methodology for determining a state's error rate. Because state error rates discovered through MEQC programs were consistently below 3% as of the mid-1990s, CMS offered states the option to develop alternative ways to identify and reduce erroneous payments. Under the Improper Payments Information Act of 2002 (P.L. 107-300), federal agencies are also required to identify programs that are susceptible to significant improper payments, estimate the amount of overpayments, and report annually to Congress on those figures and on the steps being taken to reduce such payments. A new regulation regarding Payment Error Rate Measurement (PERM) for Medicaid and SCHIP was effective on October 1, 2006. With respect to these two programs, the subset of states selected for review in a given year are reviewed using a statistically valid random sample of claims and eligibility determinations to determine error rates. States must submit a corrective action plan based on	**H§136. Auditing requirement to enforce citizenship restrictions on eligibility for Medicaid and CHIP benefits.** Under the House bill, each state would be required to audit a statistically based sample of individuals whose Medicaid or CHIP eligibility is determined under: (1) optional citizenship documentation rules for children (specified in **H§143** of the bill) or (2) optional coverage rules for legal immigrant pregnant women and children (specified in **H§132** of the bill) to demonstrate to the satisfaction of the Secretary that federal Medicaid and CHIP funds are not unlawfully spent on individuals who are not legal residents. In conducting such audits, a state may rely on MEQC or PERM eligibility reviews. States would be required to remit the federal share of any unlawful expenditures which are identified under the required audit.	See **S§301** (under Enrollment/Access) for information on monitoring of invalid names and SSNs submitted for citizenship documentation purposes.

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	the error rate analysis, and must return overpayments of federal funds.		
Managed care safeguards	A number of sections of the Social Security Act apply to states under Title XXI (SCHIP) in the same manner as they apply to a state under Title XIX (Medicaid). These include section 1902(a)(4)(C) (relating to conflict of interest standards); paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment); section 1903(w) (relating to limitations on provider taxes and donations); and section 1920A (relating to presumptive eligibility for children).	**H§152. Application of certain managed care quality safeguards to CHIP.** The House bill would add subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932, which relate to requirements for managed care, to the list of Title XIX provisions that apply under Title XXI. It would apply to contract years for health plans beginning on or after July 1, 2008.	**S§503. Application of certain managed care quality safeguards to CHIP.** Same as the House provision, but with no effective date specified.
Access to records for CHIP	Every third fiscal year (beginning with FY2000), the Secretary (through the Inspector General of the Department of Health and Human Services) must audit a sample from among the states with an approved SCHIP state plan that does not, as part of such plan, provide health benefits coverage under Medicaid. The Comptroller General of the United States must monitor these audits and, not later than March 1 of each fiscal year after a fiscal year in which an audit is conducted, submit a report to Congress on the results of the audit conducted during the prior fiscal year.	**H§154. Access to records for IG and GAO audits.** Under the House bill, for the purpose of evaluating and auditing the CHIP program, the Secretary, the Office of Inspector General, and the Comptroller General would have access to any books, accounts, records, correspondence, and other documents that are related to the expenditure of federal CHIP funds and that are in the possession, custody, or control of states, political subdivisions of states, or their grantees or contractors.	No provision.

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Effective date	No provision.	**H§156. Reliance on law; exception for state legislation.** The House bill does not specify an effective date for the bill in its entirety, however it states that with respect to amendments made by Title I (CHIP) or Title VIII (Medicaid) of the bill that become effective as of a date: (1) such amendments would be effective as of such date whether or not regulations implementing such amendments have been issued, and (2) federal financial participation for medical or child health assistance furnished under Medicaid or CHIP on or after such date by a state in good faith reliance on such amendments before the date of promulgation of final regulations (if any) to carry out such amendments, or the date of guidance (if any) regarding the implementation of such amendments shall not be denied on the basis of the state's failure to comply with such regulations or guidance.	**S§801. Effective date.** The effective date of the Senate bill (unless otherwise provided) would be October 1, 2007, whether or not final regulations to carry out provisions in the bill have been promulgated by that date.
		In the case of CHIP and Medicaid state plans, if the Secretary of HHS determines that a state must pass new state legislation to implement the requirements	Same as the House bill in the case of a state that requires legislation.

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		of the CHIP and Medicaid titles of the bill, the state plan, if applicable, would not be regarded as failing to comply solely on the basis of its failure to meet such requirements before 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 of the House bill. In the case of a state that has a two-year legislative session, each year of such session would be considered a separate regular session of the state legislature.	
County Medicaid health insuring organizations	In general, Medicaid managed care organizations are subject to contracting requirements described in section 1903(m)(2)(A) of the Social Security Act. However, certain county-operated managed care plans in California that serve Medicaid beneficiaries, which are referred to as "county organized health systems" or "health insuring organizations" (HIOs), are exempt from these contracting requirements. The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) grandfathered the 1903(m)(2)(A) exemption for HIOs operating before January 1,	**H§805. County Medicaid health insuring organizations.** The House bill would add an exemption for HIOs operated by Ventura County and Merced County, and would raise the allowable percentage of beneficiaries to 16%. The provision would be effective upon enactment.	No provision.

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	1986. In addition, the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) provided an exemption for up to three county-operated HIOs in California that became operational on or after January 1, 1986, provided that certain requirements were met. For example, the three entities could enroll no more than 10% of all Medicaid beneficiaries in California, later raised to 14% by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (incorporated by reference in P.L. 106-554).		
Clarification of treatment of regional medical center	The states and federal government share in the cost of the Medicaid program. Sometimes states fund their share of program costs by using funds transferred from certain health care institutional providers that are publicly-owned or are governmental providers. Such "inter-governmental transfers" of certified public expenditures made by those types of health care providers to fund the non-federal share of a state's Medicaid expenditures are allowable but only when transferred to the state in which the facility is located.	**H§816. Clarification treatment of regional medical center.** The provision would establish that funds transferred from the Regional Medical Center of Memphis, a hospital in a tri-state region that provides a significant amount of uncompensated care to individuals in all three states, can be used to fund a state other than Tennessee's share of Medicaid costs if the Secretary determines that the use of such funds is proper and in the interest of the Medicaid program.	No provision.

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Diabetes grants	Section 330B of the Public Health Service Act specifies that the Secretary, directly or through grants, must provide for research into the prevention and cure of Type I diabetes. Appropriations are set at $150 million per year during the period FY2004 through FY2008. Section 330C of the Public Health Service Act specifies the Secretary must make grants for providing services for the prevention and treatment of diabetes among American Indian and Alaska Natives. Appropriations are set at $150 million per year during the period FY2004 through FY2008.	**H§822. Diabetes grants.** The provision would provide $150 million for FY2009 for each of these two diabetes grant programs under the Public Health Service Act, as part of the appropriation for CHIP under this bill.	**S§613. Demonstration projects relating to diabetes prevention.** The Senate bill, as amended, would create a new demonstration project to fund up to 10 states over three years to promote children's receipt of screenings and improvements in healthy eating and physical activity to reduce the incidence of type 2 diabetes. Activities could include reductions in cost-sharing or premiums when children receive regular screenings and reach certain benchmarks in healthy eating and physical activity. States would be permitted to provide (1) financial bonuses for partnerships with entities (e.g., schools) that increase education and other activities to reduce the incidence of type 2 diabetes, and (2) incentives to providers serving Medicaid and CHIP children to perform screening and counseling regarding healthy eating and exercise. The Secretary of HHS would be required to provide a report to Congress on the degree to which funded activities improve health outcomes related to type 2 diabetes among children in participating states. The provision would authorize to be appropriated a total of $15 million during FY2008 through FY2012 to

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			fund this demonstration. **S§501. Child health quality improvement activities for children enrolled in Medicaid and CHIP.** Would include a childhood obesity demonstration project that would also include activities designed to improve health eating and physical activity among children.
Collection of data used in providing CHIP funds	The Secretary of Commerce was required to make appropriate adjustments to the Current Population Survey (CPS), which is the primary current-law data source for determining states' SCHIP allotments, (1) to produce statistically reliable annual state data on the number of low-income children who do not have health insurance coverage, so that real changes in the uninsurance rates of children can reasonably be detected; (2) to produce data that categorizes such children by family income, age, and race or ethnicity; and (3) where appropriate, to expand the sample size used in the state sampling units, to expand the number of sampling units in a state, and to include an appropriate verification element. For this purpose, $10 million was appropriated annually, beginning in FY2000.	No provision.	**S§604. Improving data collection.** Besides the $10 million provided annually for the CPS since FY2000, an additional $10 million (for a total of $20 million additionally) would be appropriated from FY2008 onward. In addition to the current-law requirements of the appropriation, for data collection beginning in FY2008, in appropriate consultation with the HHS Secretary, the Secretary of Commerce would be required to make adjustments to the CPS to develop more accurate state-specific estimates of the number of children enrolled in CHIP or Medicaid, or who are without coverage and to assess whether estimates from the American Community Survey (ACS) produce more reliable estimates than the CPS for

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			CHIP allotments and payments. On the basis of that assessment, the Commerce Secretary would recommend to the HHS Secretary whether ACS estimates should be used in lieu of, or in some combination with, CPS estimates for CHIP purposes.
			If the Commerce Secretary recommends to the HHS Secretary that ACS estimates should be used instead of, or in combination with, CPS estimates for CHIP purposes, the HHS Secretary may provide a transition period for using ACS estimates, provided that the transition is implemented in a way that avoids adverse impacts on states.
			S§105. Incentive bonuses for states. An appropriation of $5 million would be provided to the Secretary for FY2008 for improving the timeliness of data reported from the Medicaid Statistical Information System (MSIS) and to provide guidance to states with respect to any new reporting requirements related to such improvements. Amounts appropriated are available until expended. The resulting improvements are to be designed and implemented so that, no later than October 1, 2008, Medicaid and CHIP

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			enrollment data could be collected and analyzed by the Secretary within six months of submission.
Technical correction	P.L. 109-171 gave states the option to provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage which is nearly identical to plans available under CHIP. This law identifies a number of groups as exempt from mandatory enrollment in benchmark or benchmark equivalent plans. These exempted groups may be enrolled in such plans on a voluntary basis. One such exempted group is children in foster care receiving child welfare services under Part B of title IV of the Social Security Act and children receiving foster care or adoption assistance under Part E of such title.	**H§823. Technical correction.** The provision would make a correction to the reference to children in foster care receiving child welfare services in P.L 109-171; this change would be effective as if included in this law (i.e., March 31, 2006).	**S§605. Deficit Reduction Act technical corrections.** Same as House bill.
Technical corrections regarding current state authority under Medicaid	The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and visa versa); it has a statutory minimum of 50% and maximum of	No provision.	**S§601. Technical corrections regarding current state authority under Medicaid.** With respect to Medicaid expenditures for FY2007 and FY2008 only, the provision would allow states to elect (1) to cover optional, poverty-related children and, may apply less restrictive income methodologies to such individuals, for which the regular

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	83%. The enhanced FMAP (E-FMAP) under SCHIP builds on top of the regular FMAP for Medicaid. The E-FMAP can range from 65% to 85%.		Medicaid matching rate, rather than the enhanced matching rate under CHIP, would apply to determine the federal share of such expenditures, or (2) to receive the regular Medicaid matching rate, rather than the enhanced CHIP matching rate, for CHIP children under an expansion of the state's Medicaid program. This provision would be repealed as of October 1, 2008 (i.e., the beginning of FY2009). States electing these options would be "held harmless" for related expenditures in FY2007 and FY2008, once this repeal takes effect.
Elimination of counting of Medicaid child presumptive eligibility costs against CHIP allotments	CHIP statute sets the federal share of costs incurred during periods of presumptive eligibility for Medicaid children (i.e, up to two months of coverage while a final determination of eligibility is made) at the Medicaid matching rate. The law also allows payment out of CHIP allotments for Medicaid benefits received by Medicaid children during periods of presumptive eligibility.	No provision.	**S§603. Elimination of counting medicaid child presumptive eligibility costs against title XXI allotment.** The provision would strike these current law provisions.

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Outreach to small businesses	No provision.	No provision.	**S§614. Outreach regarding health insurance options available to children.** The Senate bill would establish a task force, consisting of the Administrator of the Small Business Administration (SBA) and the Secretaries of HHS, Labor, and the Treasury, to conduct a nationwide campaign of education and outreach for small businesses regarding the availability of coverage for children through private insurance, Medicaid, and CHIP. The campaign would include information regarding options to make insurance more affordable, including federal and state tax deductions and credits and the federal tax exclusion available under employer-sponsored cafeteria plans; it would also include efforts to educate small businesses about the value of health insurance coverage for children, assistance available through public programs, and the availability of the hotline operated as part of the Insure Kids Now program at HHS. The task force would be allowed to use any business partner of the SBA, enter into a memorandum of understanding with a chamber of commerce and a partnership with any appropriate small business or health

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			advocacy group, and designate outreach programs at HHS regional offices to work with SBA district offices. It would require the SBA website to prominently display links to state eligibility and enrollment requirements for Medicaid and CHIP, and would require a report to Congress every two years.