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

Evelyne P. Baumrucker, Bernadette Fernandez, April Grady, Jean Hearne, Elicia J. Herz, and Chris L. Peterson, Domestic Social Policy Division

October 18, 2007

Abstract. This side-by-side comparison provides a description of current law and the changes that would be made to Medicaid and SCHIP under H.R. 3162, S. 1893/H.R. 976, and the bicameral agreement.

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Updated October 18, 2007

Evelyne P. Baumrucker, Coordinator, Bernadette Fernandez, April Grady, Jean Hearne, Elicia J. Herz, and Chris L. Peterson Domestic Social Policy Division



Prepared for Members and Committees of Congress

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

Summary

Medicaid, authorized under Title XIX of the Social Security Act, is a federalstate 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.

The 110th Congress has considered legislation that 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, among 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.

A bicameral agreement on SCHIP reauthorization passed the House as an amendment to H.R. 976 on September 25, and also passed the Senate on September 27. President Bush vetoed the legislation on October 3, 2007. The House sustained the President's veto with a vote on October 18, 2007.

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, S. 1893/H.R. 976, and the bicameral agreement. Medicare provisions in Titles II through VII of H.R. 3162, provisions related to support to injured service members, military family job protection, and Sense of the Senate regarding health care access are not described here. This report will be updated as legislative activity warrants.

Key Policy Staff: The Children's Health and Medicare Protection Act of 2007 and The Children's Health Insurance Program Reauthorization Act of 2007

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Contents

Background	1
Recent Legislative Activity	
Medicaid and SCHIP Provisions in H.R. 3162, S. 1893/H.R. 976, and	
the Bicameral Agreement	3
Funding/Financing	
Eligibility	
Enrollment/Access	
Premium Assistance/Employer Buy-In	
Benefits	
Monitoring Quality	
Payments	
References to Title XXI; Elimination of Confusing Program References	
H§155. References to Title XXI.	
S§606. Elimination of confusing program references.	. 8
A§1. Short Title; Amendments to Social Security Act; References;	
Table of Contents.	
A§612. References to Title XXI.	. 8
	0
Funding/Financing	
CHIP appropriations	
H§101. Establishment of new base CHIP allotments.	
S§101. Extension of CHIP.	
A§101. Extension of CHIP.	
S§103. One-time appropriation.	
A§108. One-time appropriation.	
Allotment of federal CHIP funds to states	
H§101. Establishment of new base CHIP allotments.	
S§102. Allotments for the 50 states and the District of Columbia.	
A§102. Allotments for states and territories.	9
Allotment of federal CHIP funds to territories	
H§101. Establishment of new base CHIP allotments.	. 16
S§104. Improving funding for the territories under CHIP and	
Medicaid.	
A§102. Allotments for states and territories.	
Period of availability of CHIP allotments	
H§102. 2-year initial availability of CHIP allotments.	. 17
S§109. Two-year availability of allotments; expenditures counted	
against oldest allotments.	
A§105. 2-year initial availability of CHIP allotments.	
CHIP funds for shortfall states	
H§102. 2-year initial availability of CHIP allotments.	. 17
H§103. Redistribution of unused allotments to address state	
funding shortfalls.	
S§105. Incentive bonuses for states.	. 17
A§106. Redistribution of unused allotments to address state	
funding shortfalls.	. 17

H§101. Establishment of new base CHIP allotments	
S§108. CHIP contingency fund	
A§103. Child enrollment contingency fund	
Extension of option for qualifying states	
H§104. Extension of option for qualifying states	22
S§111. Option for qualifying states to receive the enhanced portion	
of the CHIP matching rate for Medicaid coverage of certain	
children	22
A§107. Option for qualifying states to receive the enhanced portion	
of the CHIP matching rate for Medicaid coverage of certain	
children	
Bonuses for increasing enrollment of children	23
H§111. CHIP performance bonus payment to offset additional	
enrollment costs resulting from enrollment and retention efforts. 2	
S§105. Incentive bonuses for states	23
A§104. CHIP performance bonus payment to offset additional	
enrollment costs resulting from enrollment and retention efforts. 2	
H§135. No federal funding for illegal aliens	
A§605. No federal funding for illegal aliens	
Medicaid funding for the territories	
H§811. Payments for Puerto Rico and territories	
Enhanced matching funds for certain data systems in the territories 3	
H§811. Payments for Puerto Rico and territories	51
S§104. Improving funding for the territories under CHIP and	1
Medicaid	<i>i</i> I
A§109. Improving funding for the territories under CHIP and	1
Medicaid	
Medicaid FMAP	52
H§813. Adjustment in computation of Medicaid FMAP to disregard	.
an extraordinary employer pension contribution)2
A§615. Adjustment in computation of Medicaid FMAP to disregard))
an extraordinary employer pension contribution	
CHIP E-FMAP)4
S§110. Limitation on matching rate for states that propose to	
cover children with effective family income that exceeds 300	24
percent of the poverty line)4
A§114. Limitation on matching rate for states that propose to	
cover children with effective family income that exceeds 300 percent of the poverty line	21
	94
Eligibility	86
Premium grace period	
H§123. Premium grace period	
A§504. Premium grace period	
Optional coverage of older children under CHIP	
H§131. Optional coverage of children up to age 21 under CHIP 3	
Optional coverage of legal immigrants in Medicaid and CHIP	
H§132. Optional coverage of legal immigrants under the	
Medicaid program and CHIP	37
Optional coverage of pregnant women under CHIP	
H§133. State option to expand or add coverage of certain pregnant	-
women under CHIP.	38

S§107. State option to cover low-income pregnant women under
CHIP through a state plan amendment
A§111. State option to cover low-income pregnant women under
CHIP through a state plan amendment
A§113. Elimination of counting Medicaid child presumptive
eligibility costs against title XXI allotment
Nonpregnant childless adult coverage under CHIP
H§134. Limitation on waiver authority to cover adults
S§106. Phase-out coverage for nonpregnant childless adults under
CHIP
A§112. Phase-Out of coverage for nonpregnant childless adults
under CHIP; conditions for coverage of parents
Parent coverage under CHIP
S§106. Conditions for coverage of parents
A§109. Phase-Out of coverage for nonpregnant childless adults
under CHIP; conditions for coverage of parents
Medicaid TMA
H§801. Modernizing transitional Medicaid
A§115. State Authority Under Medicaid
Spousal impoverishment rules
H§804. State option to protect community spouses of individuals
with disabilities
Medicaid asset verification
H§817. Extension of SSI web-based asset demonstration project to
the Medicaid and ensure (19
the Medicaid program
A§619. Extension of SSI web-based asset demonstration project to
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 S§203. Demonstration project to permit States to rely on findings by
 A§619. Extension of SSI web-based asset demonstration project to the Medicaid program
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 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. 49
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 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. 49 A§203. State option to rely on finding from an Express Lane 49
 A§619. Extension of SSI web-based asset demonstration project to the Medicaid program
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 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. 49 A§203. State option to rely on finding from an Express Lane agency to conduct simplified eligibility determinations. 49 Out-stationed eligibility determinations 54
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 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. 49 A§203. State option to rely on finding from an Express Lane agency to conduct simplified eligibility determinations. 49 Out-stationed eligibility determinations 49 Out-stationed eligibility determinations 54 H§113. Application of Medicaid outreach procedures to all children 54
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 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. 49 A§203. State option to rely on finding from an Express Lane agency to conduct simplified eligibility determinations. 49 Out-stationed eligibility determinations 54 H§113. Application of Medicaid outreach procedures to all children and pregnant women. 54
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 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. 49 A§203. State option to rely on finding from an Express Lane agency to conduct simplified eligibility determinations. 49 Out-stationed eligibility determinations 54 H§113. Application of Medicaid outreach procedures to all children and pregnant women. 54 Funding for outreach and enrollment 55
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 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. 49 A§203. State option to rely on finding from an Express Lane agency to conduct simplified eligibility determinations. 49 Out-stationed eligibility determinations 54 H§113. Application of Medicaid outreach procedures to all children and pregnant women. 54 Funding for outreach and enrollment 55 H§114. Encouraging culturally appropriate enrollment and 55
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 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. 49 A§203. State option to rely on finding from an Express Lane agency to conduct simplified eligibility determinations. 49 Out-stationed eligibility determinations 49 Out-stationed eligibility determinations 54 H§113. Application of Medicaid outreach procedures to all children and pregnant women. 54 Funding for outreach and enrollment 55 H§114. Encouraging culturally appropriate enrollment and retention practices. 55
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 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. 49 A§203. State option to rely on finding from an Express Lane agency to conduct simplified eligibility determinations. 49 Out-stationed eligibility determinations 54 H§113. Application of Medicaid outreach procedures to all children and pregnant women. 54 Funding for outreach and enrollment 55 H§114. Encouraging culturally appropriate enrollment and retention practices. 55 S§201. Grants for outreach and enrollment. 55
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 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. 49 A§203. State option to rely on finding from an Express Lane agency to conduct simplified eligibility determinations. 49 Out-stationed eligibility determinations 54 H§113. Application of Medicaid outreach procedures to all children and pregnant women. 54 Funding for outreach and enrollment 55 S§201. Grants for outreach and enrollment. 55 A§201. Grants and enhanced administrative funding for outreach 55
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 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. 49 A§203. State option to rely on finding from an Express Lane agency to conduct simplified eligibility determinations. 49 Out-stationed eligibility determinations 54 H§113. Application of Medicaid outreach procedures to all children and pregnant women. 54 Funding for outreach and enrollment 55 S§201. Grants for outreach and enrollment. 55 A§201. Grants and enhanced administrative funding for outreach and enrollment. 55
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 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. 49 A§203. State option to rely on finding from an Express Lane agency to conduct simplified eligibility determinations. 49 Out-stationed eligibility determinations 54 H§113. Application of Medicaid outreach procedures to all children and pregnant women. 54 Funding for outreach and enrollment 55 S§201. Grants for outreach and enrollment. 55 A§201. Grants and enhanced administrative funding for outreach and enrollment. 55
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 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. 49 A§203. State option to rely on finding from an Express Lane agency to conduct simplified eligibility determinations. 49 Out-stationed eligibility determinations 54 H§113. Application of Medicaid outreach procedures to all children and pregnant women. 54 Funding for outreach and enrollment 55 S§201. Grants for outreach and enrollment. 55 A§201. Grants and enhanced administrative funding for outreach and enrollment. 55 Continuous eligibility under CHIP 56 H§115. Continuous eligibility under CHIP. 56
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 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. 49 A§203. State option to rely on finding from an Express Lane agency to conduct simplified eligibility determinations. 49 Out-stationed eligibility determinations 54 H§113. Application of Medicaid outreach procedures to all children and pregnant women. 54 Funding for outreach and enrollment 55 S§201. Grants for outreach and enrollment. 55 A§201. Grants and enhanced administrative funding for outreach and enrollment. 55 Continuous eligibility under CHIP 56 H§115. Continuous eligibility under CHIP. 56 Commission to monitor access and other matters 57
A§619. Extension of SSI web-based asset demonstration project to the Medicaid program. 48 Enrollment/Access 49 "Express lane" eligibility determinations 49 H§112. State option to rely on finding from an express lane agency to conduct simplified eligibility determinations. 49 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. 49 A§203. State option to rely on finding from an Express Lane agency to conduct simplified eligibility determinations. 49 Out-stationed eligibility determinations 54 H§113. Application of Medicaid outreach procedures to all children and pregnant women. 54 Funding for outreach and enrollment 55 S§201. Grants for outreach and enrollment. 55 A§201. Grants and enhanced administrative funding for outreach and enrollment. 55 Continuous eligibility under CHIP 56 H§115. Continuous eligibility under CHIP. 56

H§142. Model of interstate coordinated enrollment and coverage
process
A§213. Model of interstate coordinated enrollment and coverage
process
Citizenship documentation
H§143. Medicaid citizenship documentation requirements 59
S§301. Verification of declaration of citizenship or nationality
for purposes of eligibility for Medicaid and CHIP 59
A§211. Verification of declaration of citizenship or nationality
for purposes of eligibility for Medicaid and CHIP 59
Elimination of Health Opportunity Accounts
H§145. Prohibiting initiation of new health opportunity
account demonstration programs
A§613. Prohibiting initiation of new health opportunity
account demonstration programs
Outreach and enrollment of Indians
S§202. Increased outreach and enrollment of Indians
A§202. Increased outreach and enrollment of Indians
Eligibility information disclosure
S§204. Authorization of certain information disclosures to simplify
health coverage determinations
A§203. State option to rely on finding from an Express Lane agency
to conduct simplified eligibility determinations
Reducing administrative barriers to enrollment
S§302. Reducing administrative barriers to enrollment
A§212. Reducing administrative barriers to enrollment
Preventing Crowd-Out
A§116. Preventing substitution of CHIP coverage for private
coverage
Medical Child Support Under SCHIP
A§116(f). Treatment of medical support order
Premium Assistance/Employer Buy-In Programs
Employer Buy-in to CHIP73
H§821. Demonstration project for employer buy-in
S§401. Additional State option for providing premium assistance 75
A§301. Additional State option for providing premium assistance75
Education and enrollment assistance in premium assistance programs79
S§402. Outreach, education, and enrollment assistance
A§302. Outreach, education, and enrollment assistance
Special enrollment period
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 coverage
A§311. Special enrollment period under group health plans in case of
termination of Medicaid or CHIP coverage or eligibility for
assistance in purchase of employment-based coverage;
coordination of coverage
Benefits
Dental services

H§121. Ensuring child-centered coverage	81
H§144. Access to dental care for children.	
S§608. Dental health grants.	
A§501. Dental benefits.	
Federally qualified health centers (FQHCs) and rural health centers (RHCs	
services	
H§121. Ensuring child-centered coverage.	
Mental health services	
H§121. Ensuring child-centered coverage.	
S§607. Mental health parity in CHIP plans.	
A§502. Mental health parity in CHIP plans	
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services	
H§121. Ensuring child-centered coverage	85
S§605. Deficit Reduction Act technical corrections	85
A§611(a). Deficit Reduction Act technical corrections - Clarification	
of requirement to provide EPSDT services for all children in	
benchmark benefit packages under Medicaid.	85
School-based health centers services	
H§121. Ensuring child-centered coverage.	
A§506. Clarification of coverage of services provided through	05
	05
school-based health centers.	
Benchmark coverage options	
H§121. Ensuring child-centered coverage.	
H§122. Improving benchmark coverage options	
Extension of family planning services and supplies	
H§802. Family planning services	87
Adult day health services	88
H§803. Authority to continue providing adult day health services	
approved under a State Medicaid plan.	88
Monitoring Quality	89
Quality measurement	
H§151. Pediatric health quality measurement program.	
S§501. Child health quality improvement activities for children	0)
enrolled in Medicaid or CHIP.	80
	09
A§401. Child health quality improvement activities for children	00
enrolled in Medicaid or CHIP.	
Information on access to coverage under CHIP	92
S§502. Improved information regarding access to coverage under	
СНІР.	92
A§402. Improved availability of public information regarding	
enrollment of children in CHIP and Medicaid.	92
Federal evaluation	93
H§153. Updated federal evaluation of CHIP	93
A§603. Updated federal evaluation of CHIP.	
Payments	95
Medicaid Drug Rebate	
H§812. Medicaid Drug Rebate.	
Moratorium on certain payment restrictions	
H§814. Moratorium on certain payment restrictions.	90

A§616. Moratorium on certain payment restrictions	
Tennessee and Hawaii DSH	97
H§ 815. Tennessee DSH	97
A§617. Medicaid DSH allotments for Tennessee and Hawaii	97
Monitoring erroneous payments	
S§602. Payment error rate measurement ("PERM")	
A§601. Payment error rate measurement ("PERM")	
Payments for FQHCs and RHCs under CHIP 1	
H§121. Ensuring child-centered coverage	00
S§609. Application of prospective payment system for services provided by Federally-qualified health centers and rural health	
clinics	00
A§503. Application of prospective payment system for services provided by federally-qualified health centers and rural health	
clinics	00
chines	.00
Miscellaneous	01
Purpose of Title XXI	
H§100. Purpose	
A§2. Purpose	
Citizenship auditing	
H§136. Auditing requirement to enforce citizenship restrictions on	. • 1
eligibility for Medicaid and CHIP benefits	01
Managed care safeguards	
H§152. Application of certain managed care quality safeguards to	
CHIP	03
S§503. Application of certain managed care quality safeguards to	
СНІР 1	03
A§403. Application of certain managed care quality safeguards to	
CHIP 1	
Access to records for CHIP 1	
H§154. Access to records for IG and GAO audits	
A§604. Access to records for IG and GAO audits	
Effective date	
H§156. Reliance on law; exception for state legislation	
S§801. Effective date	04
A§3. General effective date; exception for state legislation;	
contingent effective date; reliance on law	
County Medicaid health insuring organizations	
H§805. County Medicaid health insuring organizations	.06
A§614. County Medicaid health insuring organizations; GAO	
report on Medicaid managed care payment rates	
Clarification of treatment of regional medical center	
H§816. Clarification treatment of regional medical center	
A§618. Clarification treatment of regional medical center 1	
Diabetes grants	
H§822. Diabetes grants	
S§613. Demonstration projects relating to diabetes prevention 1	
A§505. Demonstration projects relating to diabetes prevention 1	.09
S§501. Child health quality improvement activities for children enrolled in Medicaid and CHIP	10
Collection of data used in providing CHIP funds	.10

S§604. Improving data collection
A§602. Improving data collection
S§105. Incentive bonuses for states
Technical correction
H§823. Technical correction
S§605. Deficit Reduction Act technical corrections
A611(b). Deficit Reduction Act technical corrections — Correction
of reference to children in foster care receiving child welfare
services
S§605. Deficit Reduction Act technical corrections
A§611(c). Transparency
Technical corrections regarding current state authority under Medicaid
S§601. Technical corrections regarding current state authority under
Medicaid
Elimination of counting of Medicaid child presumptive eligibility costs
against CHIP allotments
S§603. Elimination of counting Medicaid child presumptive
eligibility costs against title XXI allotment
A§113. Elimination of counting Medicaid child presumptive
eligibility costs against title XXI allotment
Outreach to small businesses
S§614. Outreach regarding health insurance options available to
children
A§623. Outreach regarding health insurance options available to
children

List of Tables

Table 1. Medicaid and SCHIP Provisions	
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Medicaid and SCHIP Provisions in H.R. 3162, S. 1893/H.R. 976, and Agreement

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Recent Legislative Activity

The 110th Congress has considered legislation that 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

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

tobacco tax and other 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. An August 24 estimate from CBO and JCT³ indicates that the Senate bill would increase SCHIP outlays by \$28.1 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 and JTC estimate indicates that the Senate bill would increase net outlays by \$35.2 billion over 5 years and by \$71.0 billion over 10 years.⁴ These costs would be offset by an increase in the federal tobacco tax and other changes, which CBO and JCT estimate would increase net revenue by \$36.1 billion over 5 years and by \$72.8 billion over 10 years.

A bicameral agreement on SCHIP reauthorization passed the House as an amendment to H.R. 976 on September 25, and also passed the Senate on September 27. President Bush vetoed the legislation on October 3, 2007. The House sustained the President's veto with a vote of 273 to 156 on October 18, 2007 — a vote that failed to achieve the two-thirds majority of voting members required for an override. A continuing resolution that contains short-term funding for SCHIP (H.J.Res. 52) was passed by the House on September 26, and the Senate on September 27, and signed into law on September 29, 2007, as P.L. 110-92.

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 CBO, letter to the Honorable Max Baucus (August 24, 2007), available at [http://www.cbo.gov/ftpdocs/85xx/doc8584/08-28-CHIP.pdf].

⁴ As described above, the Senate bill would specify national allotment funding for five years. In FY2012, this funding would consist of two semi-annual allotments of \$1.75 billion each plus a one-time appropriation of \$12.5 billion to accompany the first semi-annual allotment. For years beyond FY2012, CBO is required to assume that national allotment funding continues at the level prescribed by existing law, which appears to be \$3.5 billion under the Senate bill. In contrast, the SCHIP baseline under current law assumes an appropriation of \$5.04 billion for years beyond FY2007. As a result of this difference, CBO's cost estimate for national allotments in the Senate bill shows *savings* in years beyond FY2012. For more information on budget baselines and scorekeeping, see CRS Report 98-560, *Baselines and Scorekeeping in the Federal Budget Process*, by Bill Heniff Jr.

A September 24 estimate from CBO and JCT⁵ indicates that the SCHIP agreement would increase net outlays by \$34.9 billion over 5 years and by \$71.5 billion over 10 years.⁶ These costs would be offset by an increase in the federal tobacco tax and other changes, which CBO and JCT estimate would increase net revenue by \$36.3 billion over 5 years and by \$72.8 billion over 10 years.

Medicaid and SCHIP Provisions in H.R. 3162, S. 1893/H.R. 976, and the Bicameral Agreement

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, S. 1893/H.R. 976, and the bicameral agreement.⁷ Medicare provisions in Titles II through VII of H.R. 3162, provisions related to support to injured service members, military family job protection, and the Sense of the Senate regarding health care access are not described in this report. A comparison of some of the key provisions across all three bills is described below.

Funding/Financing. *Allotments.* 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 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 agreement uses the national appropriations and the FY2008 allotment formula specified in the Senate legislation. For FY2009 to FY2012, the allotment formula would be structured according to the House bill, in which the FY2009 and FY2011 allotments are based on the prior year's *allotment*, and the FY2010 and FY2012 allotments are based on the prior year's federal SCHIP *spending*. As in the House legislation, the agreement would reduce SCHIP allotments' period of

⁵ CBO, letter to the Honorable Max Baucus (September 25, 2007), available at [http://www.cbo.gov/ftpdocs/86xx/doc8655/hr976.pdf].

⁶ For an explanation of why CBO's cost estimate for national allotments in the agreement shows savings in years beyond FY2012, see earlier footnote on the Senate bill.

⁷ Medicare provisions in Titles II through VII of H.R. 3162 are not described here.

availability to two years, beginning with the FY2008 allotment. Also like the House bill, there is no limit in the amount of prior-year balances states could carry forward.

The House legislation calls for bonus payments to states that (1) increase their enrollment of children in Medicaid or SCHIP above certain levels and (2) implement certain activities to encourage enrollment and retention among Medicaid- and SCHIP-eligible children. 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. In addition, the Senate bill does not require the implementation of the specific enrollment and retention efforts. The payments would be based on fixed-dollar amounts specified in the legislation. The bonus payments in the agreement are structured after the House bill, except altered to yield smaller payments than under the House bill.⁸

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. The House, Senate, and agreement bills would not affect states' ability to use income disregards. However, the Senate and agreement bills 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 would allow states to cover individuals up to age 21 (rather than age 19) in their SCHIP programs. This provision is not in the agreement. 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 agreement follows the Senate bill with some modifications based on the House bill. 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 and the agreement do not include a comparable provision.

⁸ Over the five-year period of FY2008 to FY2012, CBO estimated the cost of the bonus payments at \$2.7 billion in the Senate bill, \$10.8 billion in the House bill, and \$2.6 billion in the agreement.

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 nonpregnant 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 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 and the agreement bills phase 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. Each of the bills include provisions to facilitate access and enrollment in Medicaid and SCHIP. Among the major provisions, the House and the agreement bills 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 or SCHIP. The Senate bill, by contrast, would allow up to 10 states to use Express Lane⁹ eligibility determinations for Medicaid and SCHIP enrollment and renewal through a three-year demonstration program. Like the House and agreement bills, 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. All three bills would drop the requirement for signatures on a Medicaid application form under penalty of perjury.

⁹ *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.

Current law and regulations require that SCHIP plans include procedures to ensure that SCHIP coverage does not substitute for coverage provided in group health plans, also known as crowd-out. In mid-August, the Administration issued a guidance letter explaining how CMS would apply existing requirements in reviewing state requests to extend SCHIP eligibility to children with income levels exceeding 250% FPL, including specified crowd-out strategies states would be required to implement within one year. The agreement also includes a new crowd-out provision. It would require states already covering children with income exceeding 300% FPL (and beginning in 2010, new states that propose to do so) to describe how they will address crowd-out and implement "best practices" to avoid crowd-out (to be developed by the Secretary in consultation with the states). Beginning in 2010, these higher income states cannot have a rate of public and private coverage for low-income children that is less than the target rate of coverage for low-income children (a measure to be calculated by the Secretary representing the average rate of private and public coverage among the 10 states and DC with the highest percentage of such coverage.) States failing to meet this requirement in a given fiscal year would not receive any federal SCHIP payments for higher income children until they come into compliance with this rule. States would develop corrective action plans and the Secretary would not be permitted to deny payments if there is a reasonable likelihood that such plans would bring affected states into compliance. Both the GAO and the IOM (with a \$2 million appropriation) would conduct related crowd-out analyses on best practices and measurement accuracy, respectively. This provision supersedes the August guidance letter.

Citizenship Documentation Rules. The House, Senate, and agreement bills would make some similar modifications of existing Medicaid citizenship documentation rules (e.g., by requiring additional documentation options for federally recognized Indian tribes and specifying the reasonable opportunity period for individuals who are required to present documentation). However, the Senate and agreement bills 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.

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 and the agreement bills 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 lowincome children. The agreement bill would also allow states to offer a premium assistance subsidy for qualified employer sponsored coverage (ESI) to Medicaideligible children and/or parents of Medicaid-eligible children where the family has access to ESI coverage. In addition, the agreement specifies that family participation in premium assistance programs would be optional.

Benefits. Both the House and Senate bills would make other changes to covered benefits under SCHIP. With respect to dental care, the agreement includes selected provisions from both the House and Senate bills, as well as new provisions. States would have the option to provide "benchmark dental benefit packages" meeting certain requirements and would be available through FEHBP, state employee coverage, and commercial HMOs. 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, both of which are included in the agreement. 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. The agreement includes a provision in the Senate bill to make available to the public information on dental providers and covered dental benefits. GAO would be required to evaluate access to dental care under both the House and Senate bills, and in the agreement. In addition, the Senate bill and the agreement include 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. The agreement follows the Senate bill. 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, and the agreement, 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 the agreement), and a second federal SCHIP evaluation (House bill and the agreement).

Payments. With respect to payment policies, both the House and Senate bills would require that payments for Federally Qualified Health Care Centers (FQHCs) and Rural Health Centers (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. However, in mid-August and early September, the Administration issued proposed rules for such payments. The agreement is the same as the House bill except that the Secretary would be prohibited from taking any action prior to May 28, 2008. 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. In mid-August, the Administration issued a final rule for PERM. The Senate bill and the agreement stipulate several requirements for a final rule on PERM and require the Secretary of HHS to coordinate these two systems and reduce redundancies.

Table 1. Medicaid and SCHIP Provisions

A§1. Short title; amendments to Social Security Act; references; table of contents.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement		
	References to Title XXI; Elimination of Confusing Program References				
Secretary of HHS or any other ederal officer or employee, with respect to references to the program under Title XXI, in any publication or efficial communication to use the term	-	program references. Same as House bill.			

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement		
Funding/Financing					
CHIP appropriations					
Act specifies the following SCHIP appropriation amounts (of which the territories receive 0.25%): 4.3 billion annually from FY1998 to F 2001 ; 3.15 billion annually from FY2002 to FY2004; 4.05 billion in FY2005 and FY2006; and 5.0 billion in F 2007 .	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.	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.	Senate bill. A§108. One-time appropriation. Same as Senate bill.		
Allotment of federal CHIP funds to state	25				
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 threshold) and the	H§101. Establishment of new base CHIP allotments. <i>FY2008.</i> 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	and the District of Columbia. <i>FY2008.</i> 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	territories. <i>FY2008.</i> Same as Senate bill.		

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
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	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.	adjustment (described below); (2) the state's FY2007 federal CHIP <i>allotment</i> 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	Agreement
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.	Adjustment for cost and child population growth. The allotment	adjustment; and (4) the state's <i>FY 2008</i> federal CHIP projected spending as of August 2007 and certified by the state not later than September 30, 2007. Adjustment for cost and child population growth. The annual	population growth. Same as House bill.
		adjustment for health care cost growth and child population growth is the	

CK3-12

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
s org/wiki/CRS-RL34129	percentage increase in the projected per capita amount of National Health Expenditures over the prior year's. The child population growth factor would be	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	
http://wikileak	<i>FY2009 onward.</i> For FY2009 and every future odd-numbered fiscal year, a state's federal CHIP allotment would be equal to the prior year's <i>allotment</i> (including "performance-based shortfall adjustment" described below) multiplied by the allotment increase factor.	FY2011, a state's allotment would be calculated as 110% of its projected spending for that year.	bill. The FY2009 allotment and the
		available to states in FY2012 (that is, the \$1.75 billion provided semi- annually reduced by payments to the	state's federal CHIP allotment would be

CRS-	1	3	
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
http://wikileaks.org/wiki/CRS-RL34129	federal CHIP <i>expenditures</i> multiplied by the allotment increase factor.	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	allotments, contingency funds, and redistribution funds) multiplied by the allotment increase factor. For FY2012, although the national appropriation is the same as the Senate bill, the funds would be allotted to states based on the House bill's rebasing to FY2011 federal CHIP expenditures (though accommodating the semi- annual nature of the national appropriation). Specifically, the full- year allotment amount for FY2012 would be calculated as the state's FY2011 federal CHIP <i>expenditures</i> (from the state's available allotments, contingency funds, and redistribution funds) multiplied by the allotment increase factor. Approximately 89% of this amount would be allotted on October 1, 2011, and the remainder would be allotted on April 1, 2012.
			Increase in allotment to account for approved program expansions. For determining allotments in FY2009 to FY2011, if a state has an approved State Plan Amendment (SPA) or waiver to

CRS-14	
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
/wiki/CRS-RL34129			expand CHIP eligibility or benefits and if the state requests an expansion allotment adjustment that specifies (i) the additional expenditures attributable to the expansion by not later than August 31 before the beginning of the fiscal year and (ii) the extent to which the additional expenditures are projected to exceed the allotment, the amount of the state's allotment would be increased by the amount in (i).
http://wikileaks.org		calculated exceed the available national allotment, states' allotments would be	For FY2008 to FY2012, if the state allotments as calculated exceed the available national allotment, states' allotments would be reduced proportionally.

CRS-1	15
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
http://wikileaks.org/wiki/CRS-RL34129		<i>Increases in states' projected spending.</i> 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 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	

CRS-	16
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
http://wikileaks.org/wiki/CRS-RL34129		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.	
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CRS-17	
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
		for FY2008 after December 31, 2007.	
Allotment of federal CHIP funds to terr	itories		
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 a p p r o p r i a t i o n a m o u n ts i n \$2104(c)(4)(B): \$32 million in F¥1999; \$34.2 million in F¥2000 and F¥2001; \$25.2 million in FY2002 to F¥2004;		territories under CHIP and Medicaid. There would be no separate CHIP appropriation for the territories. <i>FY2008</i> . 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. <i>FY2009 to FY2012</i> . Each territory's allotment would be the prior	territories. As in both the House and Senate bills, there would be no separate CHIP appropriation for the territories; as with the states, the territories' allotments would come entirely from the national appropriation. <i>FY2008</i> . Same as Senate bill. <i>FY2009 to</i> <i>FY2012</i> . Territories would be treated like states (that is, allotments in FY2009 and FY2011 based on prior-year allotment, and allotments in FY2010 and FY2012 based on prior-year spending).

CRS-1	8
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
Period of availability of CHIP allotmen	ts		
SCHIP allotments are available for three years.		allotments; expenditures counted	
CHIP funds for shortfall states			
available for redistribution to states that had exhausted that particular allotment by the end of the three-year period of	CHIP allotments. H§103. Redistribution of unused allotments to address state funding shortfalls.	Redistribution of unspent FY2005 allotments. FY2005 allotments unspent after their three-year period of	A§106. Redistribution of unused allotments to address state funding shortfalls. <i>Redistribution of unspent</i> <i>FY2005 allotments.</i> Same as Senate bill, except that it would not apply if the

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
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 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	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 would be redistributed in proportion to their FY2007 allotment. <i>Redistribution</i> <i>of subsequent allotments</i> . None provided. Unspent funds from subsequent allotments used for bonus payments, discussed below.	already occurred by the bill's date of enactment. <i>Redistribution of</i> <i>subsequent allotments</i> . Same as House bill.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
http://wikileaks.org/wiki/CRS-RL34129	H§101. Establishment of new base CHIP allotments. Source of funds. Performance-based shortfall adjustment would be calculated as part of a state's	S§108. CHIP contingency fund. Source of funds. 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	A§103. Child enrollment contingency fund. Source of funds. Similar to the Senate bill, a Child Enrollment Contingency Fund would be established in the U.S. Treasury. The Contingency Fund would receive deposits through a separate appropriation. For FY2008, its appropriation would be 20% 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 20% 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 20% limit shall be deposited into the Incentive Pool.

UND-21

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
		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).	
http://wikileaks.org/wiki/CRS-RL34129	expenditures in a fiscal year (beginning with FY2008) exceeds the amount of federal CHIP allotments available to the state (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. For FY2008, the target number is the average monthly CHIP enrollment in FY2007 increased by 1% and by the state's child population growth. For subsequent fiscal years, the target number is the prior year's target number increased by 1% and by the state's child population growth. The adjustment would be calculated as the product of (1) the amount by which the actual	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 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 5% shortfall in federal funds), without regard to any payments	not enough to make payments, then payments would be reduced proportionally; the Comptroller General would not be required to audit the data used in determining contingency fund payments; payments based on a fiscal year's data would occur in that fiscal year, with reconciliation committed based on the submission of actual expenditures.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
http://wikileaks.org/wiki/CRS-RL34129	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 accuracy of the data used for the allotment adjustment and make recommendations to Congress	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 of the state access to the Fund, as	

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
		determined by the Secretary.	
L34129		Application to territories. Territories would not be eligible for contingency fund payments.	Application to territories. Territories would be eligible for contingency fund payments once the Secretary determines there are satisfactory methods for collecting and reporting the necessary enrollment information reliably.
p://wikileaks.org/wiki/CRS-FL34129		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 qualifyin $\frac{1}{2}$ states			
funds may be used to pay the difference between SCHIP's enhanced Federal Medical Assistance Percentage (FMAP)	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).	receive the enhanced portion of the CHIP matching rate for Medicaid coverage of certain children.	coverage of certain children. Same as Senate bill.

CRS-24	1
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
of the state's original SCHIP allotment amounts (if available) from FY1998-FY2001 and FY2004-FY2007; and (2) the state's available balances of those allotments. The statutory definitions for qualifying states capture most of those that had expanded their upper-income eligibility levels for children in their Medicaid programs to 185% of poverty prior to the enactment of SCHIP. Based on statutory definitions, 11 states were determined to be qualifying states: Connecticut, Hawaii, Maryland, Minnesota New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington and Wisconsin.		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.	
Bonuses for increasing enrollment of ch	nildren		
No provision.	payment to offset additional enrollment costs resulting from enrollment and retention efforts. From FY2009 to FY2013, performance	percentage of low-income children in the state without health insurance.	payment to offset additional enrollment costs resulting from enrollment and retention efforts. Like the House bill, from FY2009 to

CRS-25

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
	children above specified target levels.		efforts and enrolling eligible children above specified target levels.
http://wikileaks.org/wiki/CRS-RL34129	appropriations specified.	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	the bonus pool would receive an initial deposit of \$3 billion in FY2008, to be available until expended, along with transfers from four different potential sources. The four additional sources for deposits would be as follows: (1) from 2008 to 2012, any of the national CHIP appropriation not allotted to the states; (2) as of November 15 of fiscal years 2009 through 2012, the amount of unspent allotments available for redistribution that were not used for redistribution to shortfall states or were not spent by those states; (3) on October 1 of FY2009 through FY2012, any amounts in the CHIP Contingency Fund in excess of the fund's aggregate cap; and (4) on October 1, 2009, any amounts set aside for transition off of CHIP coverage for childless adults that are not expended by September 30, 2009.

CRS-2

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
o://wikileaks.org/wiki/CRS-RL34129		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 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.	
htt	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	Qualifying for bonus payments. 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. Qualifying	

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
ki/CRS-RL34129	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 state's share of projected Medicaid and CHIP per capita expenditures.	for bonus payments. Same as House bill.	
http://wikileaks.org/w ¹	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 such calculations, projected per	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. For FY2010 to FY2012, the coverage period would consist of the last two quarters of the preceding fiscal year and	

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
ki/CRS-RL34129	federal and state Medicaid and CHIP expenditures for children for the most recent fiscal year, increased by the	· ·	
http://wikileaks.org/w	enrollment and the baseline averages would consist only of Medicaid- and CHIP-enrolled children who would	<i>Qualifying children</i> . Average monthly enrollment and the baseline averages would exclude Medicaid-enrolled children who would not meet the income eligibility criteria in effect on July 19, 2007.	bill.
	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. For the first tier above	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)	Amount of bonus payments. Same as House bill, except for the percentage of the state share of expenditures used to calculate bonus payments. For the first tier above baseline child Medicaid enrollment, the state would receive 15% of the state share of those projected expenditures. For the first tier above

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
¢i/CRS-RL34129	share of those projected expenditures. For the first tier above baseline child CHIP enrollment, the state would	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).	state would receive 10% of the state share of those projected expenditures.
http://wikileaks.org/wi	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. For the second tier	preceding coverage period.	Medicaid enrollment, the state would receive 60% of the state share of those projected expenditures. For the second tier above baseline child CHIP
		If the funds in the Incentive Pool were inadequate to cover the amounts calculated for all the eligible states, the	

CRS-30

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
		amount would be reduced proportionally.	
kS-RL34129			Application to territories. Territories would be eligible for bonus payments once the Secretary determines there are satisfactory methods for collecting and reporting the necessary enrollment information reliably.
http://wikileaks.org/wiki/CB	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			
unauthorized aliens who meet all other program criteria are only eligible for			A§605. No federal funding for illegal aliens. Same as the House bill.

CRS	-31
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
complicate the pregnancy 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			
subject to spending caps. For F_{2}^{2} 1999		_	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.		

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
• For Guam, \$12,270,000.	• For Guam, \$5,000,000 for each of fiscal years 2009 through 2012.		
• 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 \$8,29 000.	• 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 de	ata systems in the territories		
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	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.	territories under CHIP and Medicaid. Same as the House bill, but would also require a GAO study (due to Congress no later than September 30, 2009) regarding federal funding under	territories under CHIP and Medicaid. Same as Senate bill.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
the territories up to the spending caps.			
Medicaid FMAP			
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).	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% of the total increase in personal income in that state for the period involved.		A§615. 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 or insurance fund contribution would be disregarded in computing state per capita income, but not U.S. per capita income. A significantly disproportionate employer pension and insurance fund contribution would be defined as any identifiable employer contribution towards pension or other employee insurance funds that is estimated to accrue to residents of such state for a calendar year (beginning with calendar year 2003) if the increase in the amount so estimated exceeds 25% of the total increase in personal income in that State for the year involved.

CRS-34

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
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 result of methodological improvements and more complete source data.			For estimating and adjusting an FMAP already calculated as of the date of enactment for a state with a significantly disproportionate employer pension and insurance fund contribution, the Secretary shall use the personal income data set originally used in calculating such FMAP. If in any calendar year the total personal income growth in a state is negative, an employer pension and insurance fund contribution for the purposes of calculating the state's FMAP for a calendar year shall not exceed 125% of the amount of such contribution for the previous calendar year for the State. No state would have its FMAP for a fiscal year reduced as a result of the application of this section. Not later than May 15, 2008, the Secretary shall submit to the Congress a report on the
			problems presented by the current treatment of pension and insurance fund contributions in the use of Bureau of Economic Affairs calculations for the

CRS-35	į
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		FMAP and for Medicaid and on possible alternative methodologies to mitigate such problems.
	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-	for states that propose to cover children with effective family income that exceeds 300 percent of the poverty line. Same as the Senate bill, with an additional statement that nothing in the amendments made by the section shall be construed as: (1) changing any income eligibility level for children under CHIP or (2) changing the flexibility provided states under CHIP to establish the income eligibility level for targeted low-income children under a state child health plan and the methodologies used by the state to determine income or assets under such
ro		vision. 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

CRS-36

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
There are two types of income		poverty line.	
disregards used by states. The first type			
excludes particular dollar amounts or			
types of income (or certain expenses,			
such as child care expenses). 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			
excludes an entire block of			
percent-of-poverty income. For			
example, New Jersey's SCHIP program			
covers children with gross family			
income up to 350% FPL by excluding			
all family income between 200% and			
350% of poverty (thereby reducing <i>net</i>			
family income to 200% of poverty).			

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
Eligibility			
Premium grace period			
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 disenrollment or other retention issues, such as failure to pay premiums" Federal regulations requires 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:			A§504. Premium grace period. Same as House bill.

CRS	-38
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
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.			
Optional coverage of older children und	ler CHIP		
Medicaid is limited to persons under age 19 (or in some cases, under age 18, 19, 20 or 21). Under SCHIP, children are	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.
Optional coverage of legal immigrants	in Medicaid and CHIP		
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	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		No provision.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
	such legal immigrants, and the cost of such assistance would not be considered an unreimbursed cost.		
Optional coverage of pregnant women	under CHIP		
women ages 19 and older through waiver authority or by providing coverage to unborn children as permitted through regulation. In the	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 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	income pregnant women under CHIP through a state plan amendment. Would allow states to provide optional coverage under CHIP to pregnant	income pregnant women under CHIP through a state plan amendment. Same as the Senate bill with modifications based on the House bill. With respect to minimum income eligibility levels, states may cover pregnant women under CHIP through a state plan amendment if the minimum Medicaid income level for certain groups of pregnant women is at least 185% FPL (or such higher percentage as the state has in effect), but in no case lower than the percent in effect for such groups as of July 1, 2007, as per the House bill. An additional condition would be added to coverage of pregnant women under CHIP as per the House bill — for children under age 19 in CHIP or Medicaid, the income eligibility threshold must be at least

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
http://wikileaks.org/wiki/CRS-RL34129	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 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	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. States may continue to provide coverage to pregnant women through waivers and the unborn child regulation. States covering pregnant women through the	A§113. Elimination of counting Medicaid child presumptive eligibility costs against title XXI allotment. Includes amendments to Medicaid that are the same as the House bill (Sec. 133) with respect to (1) continuous eligibility of newborns through age 1 regardless of their living arrangements and mothers' eligibility, and (2) allowing entities that make presumptive eligibility determinations for children under Medicaid to make such determinations for pregnant women under Medicaid.

CKS-41

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
s://wikileaks.org/wiki/CRS-RL34129	determinations for pregnant women under CHIP. The provision also amendments Medicaid to (1) no longer require that a newborn deemed eligible for Medicaid at birth through age 1 remain in the mother's household and that the mother remain eligible for Medicaid during this period in order for such a newborn to remain eligible for Medicaid, and (2) allow entities qualified to make presumptive eligibility determinations for children under Medicaid to also be allowed to make such determinations for pregnant women under Medicaid.		
Nonpregnant childless adult $cov \ddot{{f e}}$ rage u	nder CHIP		
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).	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	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	nonpregnant childless adults under CHIP; conditions for coverage of parents. Same as Senate bill.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
state plan for purposes of federal reimbursement. Costs associated with waiver programs are subject to each state's enhanced-FMAP. Under SCHIP Section 1115 waivers, states must meet an "allotment neutrality test" where combined federal expenditures for the state's regular SCHIP program and for the state's SCHIP demonstration		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, 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	

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
RS-RL34129		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.	
http://wikileaks.org/wiki/			

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
Parent coverage under CHIP			
Same as above. http://wikileaks.org/wiki/CRS-RL34129	Same as above.	parents. Would prohibit the approval	

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
CRS-RL34129		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.	
http://wikileaks.org/wiki/CRS-RL34129		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.	

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
		Would require a Government Accountability Office study regarding effects of adult coverage on the increase in child enrollment or quality of care.	
Medicaid TMA			
benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation is called transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections, as well as those who lose eligibility due to an increase in earned income or hours of employment. Congress expanded work-related TMA under section 1925 of the Social Security Act in 1988, requiring states to provide TMA to families who lose Medicaid for work-related reasons for at least six, and up to 12, months. Since 2001, work-related TMA requirements under	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 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		No provision.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
series of short-term extensions, most recently through September 30, 2007.	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.		
State authority to expand income or res	ource eligibility for children		
States have the ability under current law to extend Medicaid coverage to children in families with income below 133% of FPL for children under age 6, or 7, or 8 and below 100% of FPL for children under age 19. States also are able to define income and resource counting methodologies. Part of this flexibility includes the ability to disregard certain amounts form income or resources for the purpose of determining Medicaid eligibility. A targeted low-income child qualifying for enhanced federal matching payments is one who is under		No provision.	A§115. State Authority Under Medicaid. The provision clarifies that nothing in the bill should be construed as limiting the flexibility of states to increase the income or resource eligibility levels for children under Medicaid state plans or under Medicaid waivers. In addition, the provision would protect the ability of states to extend Medicaid coverage beyond the Medicaid applicable income level effectively allowing a shift of children from a targeted low-income eligibility pathway to a traditional Medicaid

CRS-48	,
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
the age of 19 years without health			eligibility pathway.
insurance, and who would not have been			
eligible for Medicaid under the rules in			
effect in the state on March 31, 1997.			
States can set the upper income level for			
targeted low-income children up to			
200% of the federal poverty level			
(FPL), or 50 percentage points above			
the applicable pre-SCHIP Medicaid			
income level.			
Spousal impoverishment rules $\sum_{\underline{B}}^{\Bbbk}$			
Medicaid law grants states the option to	H§804. State option to protect	No provision.	No provision.
	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		
medically needy persons enrolled in	÷		
incurrently needy persons enfonce in	1715(1) unu (j).		

CRS-49)
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
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 incedy			
individuals, subject to the Secretary's			
approval.			
Medicaid asset verification			
The Social Security Administration	H§817. Extension of SSI web-based	No provision.	A§619. Extension of SSI web-based
(SSA) is piloting a financial account	asset demonstration project to the	-	asset demonstration project to the
	Medicaid program. Under the House		Medicaid program. Same as the
	bill, the Secretary of HHS would be		House bill, except that the provision
	required to provide for application of		would apply beginning on October 1,
	the current law SSI pilot to asset		FY2012.
	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		
manetal institutions. Fait of this phot	provided. For purposes of applying the		

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
	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		
(about 5 percent) of applicants and recipients who were overpaid $b \stackrel{\circ}{\oplus} ed$ on			
this financial account verification			
system. A bill (H.R. 3668) that would			
apply the pilot to Medicaid beginning			
on October 1, 2007, and ending on			
September 30, 2012, was passed by the			
House on September 26.			
//wiki	Enrollme	nt/Access	
"Express lane" eligibility determination	15		
Medicaid law and regulations contain	H§112. State option to rely on finding	S§203. Demonstration project to	A§203. State option to rely on finding
requirements regarding determinations	from an express lane agency to	permit States to rely on findings by an	from an Express Lane agency to
	conduct simplified eligibility		
	determinations. Beginning in January		
	2008, the bill would allow States to rely		
	on an eligibility determination finding		
	made within a State-defined period from		
	an Express Lane Agency to determine		
	whether a child under age 19 (or up to		
eligibility determination.	age 21 at state option) has met one or	renewal. The demonstration would	whether a child under age 19 (or up to

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
http://wikileaks.org/wiki/CRS-RL34129	(e.g., income, assets or resources, citizenship, or other criteria) necessary to determine an individual's initial eligibility, eligibility redetermination, or	the demonstration, states would be permitted to rely on a finding made by an Express Lane Agency within the preceding 12 months to determine	more of the eligibility requirements (e.g., income, assets or resources, citizenship, or other criteria) necessary to determine an individual's initial eligibility, eligibility redetermination, or renewal of eligibility for medical assistance under Medicaid or CHIP. Under the agreement, however, states would be required to verify citizenship or nationality status, and such eligibility determinations would not be permitted after September 30, 2012.
SCHIP defines a targeted low-income child as one who is under the age of 19 years with no health insurance, and who would not have been eligible for Medicaid under the rules in effect in the State on March 31, 1997. Federal law requires that eligibility for Medicaid and SCHIP be coordinated when States implement separate SCHIP programs. In	CHIP screen and enroll requirements by using either or both of the following requirements: (1) establishing a threshold percentage of the Federal poverty level that exceeds the highest income eligibility threshold applicable under Medicaid for the child by a	Like the House provision the Senate's provision would establish criteria for how a state would meet screen and enroll requirements, would not relieve states of their obligation to determine eligibility for Medicaid, and would require the state to inform families that they may qualify for lower premium payments or more comprehensive health	

CRS-52

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
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		Error rates associated with incorrect eligibility determinations would be monitored.	Same as Senate bill.

CRS-53

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
Security number (e.g., income from the Social Security Administration (SSA), unearned income from the Internal Revenue Service (IRS), unemployment information from the appropriate State agency, qualified aliens must present documentation of their immigration status, which States must then verify with the Immigration and Naturalization Service, and the State must verify the SSN with the Social Security Administration). States must establish a Medicaid eligibility guality control (MEQC) program designed to reduce erroneous expenditures by			
monitoring eligibility determina	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	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	

CRS-	-54
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
eaks.org/wiki/CRS-RL34129		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 as an Express Lane agency.	
accuracy of the information submitted on their applications, and $\overset{\pm}{=}$ sign	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	bill would drop the requirement for signatures under penalty of perjury. The provision would permit signature requirements for a Medicaid application to be satisfied through an electronic signature and would monitor error rates	

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
	Medicaid, and would impose criminal	information with the CHIP or Medicaid	
x.{//wikileaks.org/wiki/CRS-RL34129	No provision.	appropriate \$5 million in new federal funds for fiscal years 2008 through FY2011 for the purpose of conducting an evaluation of the effectiveness of these demonstration programs. The Secretary would be required to submit a report to Congress with regard to the	Like the Senate bill, the agreement would authorize and appropriate \$5 million in new federal funds for fiscal years 2008 through FY2011 for the purpose of conducting an evaluation of the effectiveness of this state plan option, and the Secretary would be required to submit a report to Congress with regard to the evaluation findings no later than September 30, 2011.
Out-stationed eligibility determinations			t
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 for such application forms to vary across outstation	-	No provision.

CRS-	56
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
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.	locations.		
Funding for outreach and enrollment			
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)	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%	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%	and enrollment. Same as Senate bill with the following changes: (1) the agreement is silent as to whether grant funds would be subject to current law restrictions on expenditures for outreach activities, (2) in addition to the enhanced matching rate available for

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
for other specific health care activities cannot exceed 10% of the total amount of expenditures for SCHIP benefits and other specific health care activities combined. The federal and state governments share in the costs of both Medicaid and SCHIP, based on formulas defining the federal contribution in federal law. The federal match for administrative expenditures does not vary by state and is generally 50%, but certain administrative functions have a higher federal matching rate.			
Continuous eligibility under CHIP			
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	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	-	No provision.

CRS-	-58
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
the child's circumstances change (e.g.,	annual family income is less than 200%		
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.			
Commission to monitor access and othe	r matters		
In accordance with P.L. 92-263, En May	H§141. Children's Access, Payment	No provision.	No provision.
	and Equality Commission. Would		
0	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		

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
http://wikileaks.org/wiki/CRS-RL34129	under employer-sponsored or other private health insurance. Commission recommendations would be required to consider budget consequences, be voted on by all members, and the voting results would be included in Commission reports. Certain MEDPAC provisions would apply to this new commission (i.e., relating to membership with the addition of Medicaid and CHIP beneficiary representatives, staff and consultants, and powers). The provision would authorize to be appropriated such sums as necessary to carry out the duties of the new Commission.		
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,		A§213. Model of interstate coordinated enrollment and coverage process. Like the House bill, except the agreement would require <i>the Secretary</i> <i>of HHS</i> , in consultation with State Medicaid, CHIP directors, and organizations representing program beneficiaries to develop a model process (and report for Congress) for the

CRS-60	
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
	and coverage of children who frequently change their residency due to migration of families, emergency evacuations, educational needs, etc.		coordination of enrollment, retention, and coverage of children who frequently change their residency due to migration of families, emergency evacuations, educational needs, etc.
Citizenship documentation 68	-		
apply for full Medicaid benefits have been required since 1986 to present documentation that indicates a "satisfactory immigration status." Due to recent changes, citizens and nationals also must present documentation that proves citizenship and documents personal identity in order for states to receive federal Medicaid reimbursement for services provided to them. This citizenship documentation requirement	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 Act. See H§136 (under Miscellaneous) for auditing requirements. See H§112(a) for ability of "Express Lane" agencies to	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 of establishing Medicaid eligibility, a state would be required to provide that it satisfies existing Medicaid citizenship	citizenship or nationality for purposes of eligibility for Medicaid and CHIP. Same as the Senate bill regarding a new option for meeting citizenship documentation requirements, except that in the case of an individual whose name or SSN is invalid, the state would have to make a reasonable effort to identify and address the causes of such invalid match (including through typographical or other clerical errors) by contacting
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.		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	of the name or SSN submitted and taking such additional actions as the Secretary or the state may identify, and continue to provide the individual with medical assistance while making such

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
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 Fertain 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 SCHIP enrollees would be asked to present evidence of citizenship.		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	be required to notify the individual, provide him or her with a period of 90 days to either present evidence of citizenship as defined in section 1903(x) or cure the invalid determination with the Commissioner of Social Security (and continue to provide the individual with medical assistance during such 90- day period), and disenroll the individual within 30 days after the end of the 90-day period if evidence is not provided or the invalid determination is not cured.
htt		validation option would be required to establish a program under which the	

CRS-62	,
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
http://wikileaks.org/wiki/CRS-RL34129		would be allowed to enter into an agreement with the Commissioner to provide for the electronic submission and verification of the name and SSN of	In establishing the program, the state would be allowed to enter into an agreement with the Commissioner: (1) to provide for the electronic submission and verification, through an on-line system or otherwise, of the name and SSN of an individual enrolled in the State plan under this title; (2) to submit to the Commissioner the names and SSNs of such individuals on a batch basis, provided that such batches are submitted at least on a monthly basis; or (3) to provide for the verification of the names and SSNs of such individuals through such other method as agreed to by the state and the Commissioner and approved by the Secretary, provided that such method is no more burdensome for individuals to comply with than any burdens that may apply under a method described in (1) or (2). The program would be required to provide that, in the case of any individual who is required to submit an SSN to the state and who is unable to provide the state with such number,

CRS-63	3
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
34129			shall be provided with at least the same reasonable opportunity to present evidence that is provided under section 1137(d)(4)(A) of the Social Security Act to noncitizens who are required to present evidence of satisfactory immigration status.
http://wikileaks.org/wiki/CRS-RL		information to the Secretary on the percentage of invalid names and SSNs submitted each month, and could be subject to a penalty if the average monthly percentage for any fiscal year is greater than 7%. If a state entered into an agreement with the Commissioner of Social Security as described above, the invalid name and	States would be required to provide information to the Secretary on the percentage of invalid names and SSNs submitted each month, and could be subject to a penalty if the average monthly percentage for any fiscal year is greater than 3%. A name or SSN would be treated as invalid and included in the determination of such percentage only if: (1) the name or SSN does not match Social Security Administration records; (2) the inconsistency between the name or SSN could not be resolved by the State; (3) the individual was provided with a reasonable period of time to resolve the inconsistency with the Social Security Administration or provide satisfactory documentation of citizenship and did not successfully

CRS-64

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
			resolve such inconsistency; and (4) payment has been made for an item or service furnished to the individual under this title.
ki/CRS-RL34129			If a state entered into an agreement with the Commissioner of Social Security as described above, the invalid name and SSN percentages and penalties described here would not apply.
http://wikileaks.org/w [:]		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.	
	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	requirements under the existing section $1903(x)$. It is similar to the House provision regarding the inclusion of an	

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
http://wikileaks.org/wiki/CRS-RL34129	H§131(b)(1) is also relevant because it would explicitly allow one year of deemed eligibility for all children born to women on Medicaid, including emergency Medicaid, by removing the requirement that a newborn remain in his or her Medicaid-eligible mother's household in order to qualify for deemed eligibility under 1902(e)(4) of the Social Security Act). The provision would require additional documentation options for federally recognized Indian tribes. It would also specify that states must provide citizens with the same reasonable opportunity to present evidence that is provided under section 1137(d)(4)(A) of the Social Security Act to noncitizens who are required to present evidence of satisfactory	provision would not include additional language to reiterate that states must not deny medical assistance on the basis of failure to provide documentation until an individual has had a reasonable opportunity. In addition, although the Senate provision would clarify that deemed eligibility applies to children born to noncitizen women on emergency Medicaid and would require separate identification numbers for children born to these women, the bill would not remove the requirement that a newborn remain in his or her Medicaid-eligible mother's household in order to qualify for deemed eligibility under 1902(e)(4).	

CRS-66	

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
0://wikileaks.org/wiki/CRS-RL34129		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.	
htt	included in the Deficit Reduction Act of 2005. States would be allowed to provide retroactive eligibility for certain individuals who had been determined	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.	

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement		
Elimination of Health Opportunity Acco	Elimination of Health Opportunity Accounts				
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.		No provision.	A§613. Prohibiting initiation of new health opportunity account demonstration programs. Same as House bill.		
Outreach and enrollment of Indians					
State SCHIP plans must include a description of procedures used to ensure	No provision.	S§202. Increased outreach and enrollment of Indians. Would	A§202. Increased outreach and enrollment of Indians. Same as the		
the provision of child health assistance		encourage states to take steps to enroll			
to American Indian and Alaskan Native		Indians residing in or near reservations			
children. Certain non-benefit payments		in Medicaid and CHIP. These steps			
under SCHIP (e.g., for other child health		may include outstationing of eligibility			
assistance, health service initiatives,		workers [at certain hospitals and			
outreach, and program administration)		Federally Qualified Health Centers];			
cannot exceed 10% of the total amount		entering into agreements with Indian			
of expenditures for benefits and these		entities (i.e., the IHS, tribes, tribal			
non-benefit payments combined.		organizations) to provide outreach;			
		education regarding eligibility, benefits,			

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
ki/CRS-RL34129		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.	
Eligibility information disclosur $\overset{\Bbbk}{\underline{k}}$			
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		information disclosures to simplify health coverage determinations. The Senate bill would authorize federal or	

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
validity of Social Security number, unearned income, unemployment information, etc. 671F8TI34156 (http://www.state.org/alionality.com/ 671F8TI34156 (http://www		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.	
Reducing administrative barriers to enr	rollment		
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		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	Senate bill.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
program.		appropriate to reduce newly identified barriers to enrollment.	
Preventing Crowd-Out			
Current law and regulations require that state SCHIP plans include procedures to ensure that SCHIP coverage does not substitute for coverage provided in group health plans (also know as "crowd out"). State SCHIP plans must also include procedures for outreach and coordination with other public and private health insurance programs. On August 17, 2007, the Bush Administration released a letter to state health officials to explain how CMS would apply these existing requirements in reviewing state requests to extend SCHIP eligibility to children in families with income exceeding 250% FPL. Such states will now be required to implement specific crowd-out prevention strategies, including some already adopted by many states (e.g., imposing waiting periods, requiring cost-sharing similar to policies for private coverage, verifying family		No provision.	A§116. Preventing substitution of CHIP coverage for private coverage. The agreement defines "CHIP crowd- out" as the substitution of CHIP coverage for health benefits coverage other than Medicaid or CHIP. The agreement would require that states already covering children with income exceeding 300% FPL (and beginning in 2010, new states that propose to do so) to describe how they will address crowd-out and implement "best practices" to avoid crowd-out (to be developed by the Secretary in consultation with state). Beginning in 2010, these "higher income eligibility states" cannot have a rate of public and private coverage for low-income children that is statistically significantly less than the "target rate of coverage of low-income children" (i.e., the average rate of both private and public health benefits coverage as of 1/1/10, among

CRS-71

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
insurance status). Such states must also			the 10 states and DC with the highest
provide certain assurances regarding			percentage of such coverage, to be
policies targeting the "core" low-income			calculated by the Secretary). States that
child population (e.g., enrollment of at			fail to meet this requirement in a given
least 95% of children below 200% FPL			fiscal year would not receive any federal
in either Medicaid or SCHIP) and			CHIP payments for higher income
policies expected to minimize growd-			children until they are able to establish
out (e.g., monitoring changes in private			that they are in compliance with this
insurance coverage for the dataget			rule. States would have an opportunity
population). While all states will be			to submit and implement a corrective
monitored for adherence to these			action plan prior to the start of the
policies, states covering children above			affected fiscal year. The Secretary
250% FPL are expected to amend their			would not be permitted to deny
state SCHIP plans (and/or waivers as			payments before the beginning of such
applicable) in accordance with this			a fiscal year and must not deny
review strategy within 12 months, or			payments if there is a reasonable
CMS may pursue corrective action.			likelihood that the corrective action plan
			would bring the state into compliance
			with the target rate of coverage for low-
			income children. Not later than 18
			months after the date of enactment of
			this Act, GAO would be required to
			submit to the Congressional committees
			with jurisdiction over CHIP and the
			Secretary of HHS, a report describing
			the best practices of states in addressing
			CHIP crowd-out. Analyses must

CRS-72	
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CRS-	73
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
			appropriates \$2 million for this IOM study for the period ending September 30, 2009.
Medical Child Support Under SCHIP			
The Child Support Enforcement Program, within the Administration for Children and Families, provides assistance in obtaining support (both financial and medical) to children through locating parents, establishing paternity and support obligations, and enforcing those obligations. The federal government has a major rele in determining the main components of state programs, funding, monitoring, and providing technical assistance, but the basic responsibility of administering the Child Support Enforcement Program is left to the states. Provisions for health insurance coverage, called medical support, are required to be included in support orders and may affect a child's eligibility for SCHIP.		No provision.	A§116(f). Treatment of medical support order. The agreement would specify that nothing in title XXI of the Social Security Act (CHIP) shall be construed to allow the Secretary to require that a state deny CHIP eligibility for a targeted low-income child on the basis of the existence of a valid medical support order being in effect. A state could elect to limit eligibility on the basis of the existence of a valid medical support order, but only if the state does not deny eligibility in cases where the child asserts that the order is not being complied with for specified reasons (failure of the noncustodial parent to comply with the order; failure of an employer, group health plan or health insurance issuer to comply with such an order; or the child resides in a geographic area in which benefits under the health benefits coverage are

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
			generally unavailable), unless the state demonstrates that none of the reasons apply.
Effective Date for Amendment Affecting	Crowd-Out and Medical Child Support		
No provision leaks.org/wiki/CRS-RL34129	No provision	No provision	The amendments made by this section shall take effect as if enacted August 16, 2007. The Secretary may not impose (or continue in effect) any requirement on the basis of any policy or interpretation relating to CHIP crowd- out or medical support order other than amendments made by this section.
//wikd	Premium Assistance/Em	ployer Buy-In Programs	
Employer Buy-in to CHIP			
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	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		No provision.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
costs of administering the buy-in program.	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 to eligible children.		
/wikileaks.org/wiki/CRS-RL	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.		
http:	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		

CRS-76	
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
	the portion of the cost of the family coverage that exceeds the amount of the family's cost sharing contribution.		
aks.org/wiki/CRS-RL34129	Qualifying employers would be defined as an employer with a majority of its workforce that is composed of full time 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		providing premium assistance. The Senate bill would allow states to offer a premium assistance subsidy for qualified employer sponsored coverage (ESI) to all targeted low-income children who are eligible for CHIP, or parents of CHIP-eligible children where the family has access to ESI coverage. Qualified employer sponsored coverage would be defined as a group health plan	A§301. Additional State option for providing premium assistance. Same as Senate bill, however, the agreement would also allow states to offer a premium assistance subsidy for qualified employer sponsored coverage (ESI) to Medicaid-eligible children and/or parents of Medicaid-eligible children where the family has access to ESI coverage. In addition, the agreement specifies that family participation in the premium assistance

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
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.		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 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		cost effectiveness test for employer sponsored insurance (ESI) programs that are approved after the date of enactment of this Act. The state would be required to establish that (1) the cost of such coverage is less than state	The agreement would make the following modifications to the cost effectiveness tests included in the Senate bill: (1) with regard to the "individual test," administrative costs would be taken into account when determining the cost-effectiveness of extending ESI coverage to the child or

CRS-78	8
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
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.		(individual test), 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	
Under the Bush Administration's Health Insurance Flexibility and Accountability (HIFA) Initiative, states were encouraged to seek approval for Section 1115 waiver 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		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 covered, or are only partially covered, and cost-sharing protections consistent with the requirements of CHIP. Plans that meet the CHIP benefit coverage requirements (i.e., as determined to be actuarially equivalent to CHIP benchmark or benchmark- equivalent coverage) would not be required to provide supplemental coverage for benefits and cost-sharing protections as required under CHIP.	

CRS-	7	9
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
Health Insurance Premium Payment (HIPP) program or SCHIP's family coverage variance option (i.e., the comprehensiveness and cost- effectiveness tests).			
ttp://wikileaks.org/wiki/CRS-RL34129		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.	
ц ц		an employer-family premium assistance purchasing pool for employers with less than 250 employees who have at least one employee who is a CHIP-eligible pregnant woman or at least one member	

CRS-80)
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
		available through a CHIP benchmark benefit package or CHIP benchmark equivalent coverage benefits package.	
/CRS-RL34129		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 assist ance 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 spending on benefit coverage in a given fiscal year). Administrative expenses include activities such as data collection 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	

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
reporting, as well as outreach and		subsidies under the CHIP state plan.	
education. In addition, states are		Expenditures for such outreach	
required to provide a description of the		activities would not be subject to the	
state's efforts to ensure coordination		10% limit on spending for	
between SCHIP and other health		administrative costs associated with the	
insurance coverage applies to State		CHIP program.	
insurance coverage applies to State administrative expenses.			
Special enrollment period $\frac{1}{2}$			
Under the Internal Revenue Coge, the	No provision.	S§411. Special enrollment period	A§311. Special enrollment period
Employee Retirement Income Security			under group health plans in case of
Act, and the Public Health Servie Act,		termination of Medicaid or CHIP	termination of Medicaid or CHIP
a group health plan is required to			coverage or eligibility for assistance
provide special enrollment opportanities			in purchase of employment-based
to qualified individuals. Such			coverage; coordination of coverage.
individuals must have lost eligibility for		The bill would amend applicable federal	Same as Senate bill.
other group coverage, or lost employer		laws to streamline coordination between	
contributions towards health coverage,		public and private coverage, including	
or added a dependent due to marriage,		making the loss of Medicaid/CHIP	
birth, adoption, or placement for		eligibility a "qualifying event" for the	
adoption, in order to enroll in a group		purpose of purchasing employer-	
health plan without having to wait until		sponsored coverage. Individuals may	
a late enrollment opportunity or open		request for such coverage up to 60 days	
season. The individual still must meet		after the qualifying event. The bill	
the plan's substantive eligibility		would require health plan administrators	
requirements, such as being a full-time		to disclose to the state, upon request,	
worker or satisfying a waiting period.		information about their benefit packages	

CRS	-82
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
Health plans must give qualified		so states can evaluate the need to	
individuals at least 30 days after the		provide wraparound coverage. The bill	
qualifying event (e.g., loss of eligibility)		also would require employers to notify	
to make a request for special		families of their potential eligibility for	
enrollment.		premium assistance.	
129	Ben	efits	
Dental services			
Under SCHIP, states may provide	H§121. Ensuring child-centered	S§608. Dental health grants. As	A§501. Dental benefits. The provision
	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,		
benchmark plan, (2) a benchmark-			a required benefit under CHIP and
equivalent plan, or (3) any other plan			would include services necessary to
	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		
· · ·	*	Â	equivalent to "benchmark dental benefit packages." These include (1) a dental
	and the need for a dental visit within a		
			been selected most frequently by
	could not prevent an FQHC from		
Targest commercial rivio in the state.	could not prevent an i Qile nom	for which the new grant is awalued.	employees seeking dependent coverage,

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
Benchmark-equivalent plans must cover	entering into contractual relationships	Such states would not be required to	among such plans that offer such
	with private practice dental providers		
outpatient hospital services, physician	under both Medicaid and CHIP	new dental grant program. The	plan years, (2) a dental benefits plan
services, lab/x-ray, and well-child care	(effective January 1, 2008). The data	Secretary would be required to submit	offered and generally available to state
	that states submit to the federal	č i	
			frequently by employees seeking
	EPSDT services each fiscal year would		
	be required to include parallel		
	information on receipt of dental services		
			benefits plan that has the largest
	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		
			services under CHIP. The effective date
	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		
			of newborns, (2) dental services through
	access to dental services by children in		
	under-served areas, and the feasibility		
· · ·	and appropriateness of using qualified		
			agreement includes the provision in the
	access. A report on this GAO study		regarding information on dental
dental, vision and hearing services. In	would be due not later than one year	GAO to conduct a study on children s	regarding information on dentar

CRS-	84
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
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 toel 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 idental services and dental treatment services.	after the date of enactment of this Act.	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 quality of dental care provided to Medicaid and CHIP children to the Secretary's annual reports to Congress under the new child health quality	providers and descriptions of covered dental services under Medicaid and CHIP, to be made available to the public via the <i>Insure Kids Now</i> website and hotline. The agreement would expand measurement of the availability of dental care to include dental treatment and services to maintain dental health under the child health quality improvement activities (Sec. 501 of the Senate bill). Finally, the GAO study of dental services for children in the agreement follows the Senate bill with some additional provisions taken from the House bill (e.g., regarding the availability of mid-level dental providers). In addition, this GAO study would be due within 18 months of the date of enactment of this Act, rather than within 2 years as under the Senate bill.
Federally qualified health centers (FQHCs) and rural health centers (RHCs) services			
benefits are listed such as "clinic	H§121. Ensuring child-centered coverage. The provision would make the services provided by FQHCs and RHCs required benefits under CHIP.	-	No provision.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
	States would also be required to assure access to these services. The effective date would be October 1, 2008.		
Mental health services			
coverage options under SCHIP, zee the current law description in the dental services" row above.	increase the minimum actuarial value for mental health services from 75% to 100% for benchmark-equivalent coverage under CHIP. The effective date would be October 1, 2008.	plans. The provision would ensure that the financial requirements (e.g., such as annual and lifetime dollar limits) and treatment limitations applicable to	plans. Same as Senate bill.

CRS-80	5
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
services.			
Early and Periodic Screening, Diagnost	tic and Treatment (EPSDT) Services		
(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 Edental	effective date would be the same as the original DRA provision (i.e., March 31,	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	technical corrections - Clarification of requirement to provide EPSDT services for all children in benchmark benefit packages under Medicaid. Same as the Senate bill with some modifications. The agreement identifies specific sections of current Medicaid
School-based health centers services			
listed in the SCHIP statute, such as "clinic services (including health center	H§121. Ensuring child-centered coverage. The provision would add to the "clinic services" benefit category in CHIP statute "school-based health center services" for which coverage is	No provision.	A§506. Clarification of coverage of services provided through school- based health centers. The agreement provides that nothing in Title XXI shall be construed as limiting a state's ability

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
	otherwise provided under this title. Such providers must be authorized to cover such CHIP services under state law. The effective date would be on or after the date of enactment of this Act.		to provide CHIP for covered items and services furnished through school-based health centers.
Benchmark coverage options \mathfrak{A}			
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	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		

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
services, lab/x-ray, and well-child care including immunizations), and must include at least 75% of the actuarial			
Extension of family planning services an	nd supplies		
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	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.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
planning services and supplies.			
wiki/CRS-RL34129	Federal financial participation for medical assistance made available to such individuals would be limited to family planning services and supplies including medical diagnosis or treatment services, and only for the duration of the woman's eligibility under this state option or during a period of presumptive eligibility.		
http://wikileaks.org/	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			
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	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		No provision.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
	before 1994. The provision would be effective beginning November 3, 2005 and ending on March 1, 2009.		
ks.org/	Monitorin	g Quality	
Quality measurement			
Services (CMS) and the Agenety 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	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	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	improvement activities for children enrolled in Medicaid or CHIP. Same as the Senate bill. Adds a construction specifying that nothing in this provision supports restricting coverage under Medicaid and CHIP to only those services that are evidence-based.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
percentage (FMAP) is based on a	the recommended measures for years	required to disseminate information to	
		states regarding best practices in	
	implementing this program, the		
	Secretary would be required to consult		
	with a number of entities. The		
0	Secretary could award grants and		
	contracts to develop, validate and		
	disseminate these measures, and would		
	be required to provide technical	-	
		would have its own separate	
	reporting under Medicaid and CHIP.		
	By January 1, 2009, and annually		
	thereafter, the Secretary would be		
	required to make available in an on-line		
•	format a complete list of all measures in		
	use by states to measure the quality of		
—	medical and dental services provided to		
90%.		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	
	utilization by pediatric characteristics.	million would be appropriated. The	
		Secretary would also be required to	
		conduct a demonstration to develop a	
		conduct a demonstration to develop a	

CRS-	-92
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
		comprehensive and systematic model	
		for reducing childhood obesity through	
		grants to eligible entities (e.g., local	
		government agencies, Indian tribes,	
		community based organizations). This	
<u>.</u>		demonstration would be authorized at	
3412		\$25 million over five years (\$5 per	
- BIL		year). The Secretary would be required	
http://wikileaks.org/wiki/CRS-RL34129		to submit a report to Congress on this	
ki/C		demonstration. The Secretary would	
3/wi		also be required to establish a program	
s. or		to encourage the creation and	
leak		dissemination of a model electronic	
wiki		health record format for children	
///:e		enrolled in Medicaid and CHIP. A total	
httj		of \$5 million would be appropriated for	
		this purpose. The Institute of Medicine	
		would be required to study and report to	
		Congress on the extent and quality of	
		efforts to measure child health status	
		and quality of care for children. Up to	
		\$1 million would be appropriated for	
		this activity. Finally, the federal share	
		of costs incurred by states for the	
		development or modification of existing	
		claims processing and retrieval systems	
		as is necessary for the efficient	

CRS-9	3
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
		collection and reporting on child health measures would be based on the FMAP rate for benefits used under Medicaid.	
Information on access to coverage unde	r 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.		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 insurance, data regarding the extent to which such coverage is available to CHIP children,	A§402. Improved availability of public information regarding enrollment of children in CHIP and Medicaid. Same as Senate bill. The agreement adds a requirement that the Secretary specify a standardized format for states to use to report the new data required by the bill within one year of the date of enactment of this Act. Applicable states would be given up to 3 reporting periods to transition to the reporting of these new data in accordance with this standardized format. In addition, the agreement requires the Secretary to improve the timeliness of the data reported and analyzed from the Medicaid Statistical Information System (MSIS) with respect to enrollment and eligibility for children under Medicaid and CHIP, and to provide guidance to states regarding any new reporting requirements related

CRS	-94
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
http://wikileaks.org/wiki/CRS-RL34129		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	purpose, the agreement appropriates \$5 million to the Secretary in FY2008, to remain available until expended. Beginning no later than October 1, 2008, MSIS data on enrollment of low- income children in Medicaid or CHIP with respect to a fiscal year must be collected and analyzed by the Secretary within 6 months of submission.
Federal evaluation		L	
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	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		A§603. Updated federal evaluation of CHIP. Same as House bill.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
for expenditure through FY2002. The 10 states chosen for the evaluation were to be ones that utilized diverse approaches to providing SCHIP coverage, represented various geographic areas (including a mix of rural and urban areas), and contigued a			

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement		
	Payments				
Medicaid Drug Rebate	Aedicaid Drug Rebate				
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 2 drugs provided to Medicaid beneficiaries.			No provision.		

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement	
Moratorium on certain payment restrict	Aoratorium on certain payment restrictions			
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 hadministrative 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. On August 13 and September 7, 2007, the			A§616. Moratorium on certain payment restrictions. Same as the House bill, except that the Secretary would be prohibited from taking any action with respect to rehabilitation and school-based services prior to May 28, 2008 (rather than delaying such action for one year after the date of enactment of this Act).	

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
Tennessee and Hawaii DSH			
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 Tennessee and Hawaii have, in the past, been equal to zero. This is because those states have operated their Medicaid programs under the provisions of research and demonstration waivers. Both states have had special DSH			A§617. Medicaid DSH allotments for Tennessee and Hawaii. The provision includes the House bill language. In addition, it would set a DSH allotment for the state of Hawaii for FY2008 of \$10 million. For FY2009 and thereafter, DSH allotments for Hawaii would be increased in the same manner as for all low DSH states. The provision also prohibits the Secretary from imposing a limit on payments made to hospitals under Hawaii's QUEST Section 1115 demonstration project except to the extent necessary to ensure that a hospital does not receive payments in excess of its hospital specific cap, or that payments do not exceed the amount that the Secretary determines is equal to the federal share of DSH within the budget neutrality provision of the QUEST demonstration project.

Monitoring erroneous paymentsFederal agencies are required to annually review programs that are susceptible to significant erroneous payments, and to estimate the amount of improper payments, to reports those estimates to Congress, and to submit a report on actions the agency is taking to reduce erroneous payments. On Sugust 21, 2007, CMS issued a final rule for PERM for Medicaid and SCHIP (effective October 1, 2007) which responded to comments received on a 2006 interim final rule, and included some changes to that interim final rule.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 administration of PERM requirements applicable to CHIP. The take into account payment error rates all expenditures related to the administration of PERM requirements applicable to CHIP. The Secretary must not calculate or publish national or PERM for CHIP until six months after the date on which a final PERM rule is in effect for all states. Calculations or state-specific error rates legibility determinations are made. A predecessor to PERM, called theNo provision.A \$601. Payment error rate measurement ("PERM"). The measurement ("PERM"). Follows Senate bill with some modification that are provision would apply a federal matching rate of 90% to expenditures administrative costs all expenditures related to the administration of PERM requirements applicable to CHIP. The Secretary must not calculate or publish national or state-specific error rates based on applicable under regulations issue eritying such information statisfies requirements defined and managed care services, as well as eligibility determinations are made. A predecessor to PERM, called the<	Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
annually review programs that are susceptible to significant erroneous payments, and to estimate the amount of improper payments, to reports those estimates to Congress, and to submit a report on actions the agency is taking to reduce erroneous payments. On August 21, 2007, CMS issued a final rule for PERM for Medicaid and SCHIP (effective October 1, 2007) which responded to comments received on a 2006 interim final rule, and included some changes to that interim final rule. Assessments of payment errorer rates related to claims for both fee-for-service and managed care services, as well as eligibility determinations are made. A preducessor to PERM, called the	Monitoring erroneous payments			
Medicaid Eligibility Quality Control (MEQC) system, is operated by state Medicaid agencies for similar purposes.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 ruleinterim rules (now obsolete) FY2008. The agreement also guidance data for Medicaid eligibility reviews data required for PERM purposes,	Federal agencies are required to annually review programs that are susceptible to significant erroneous payments, and to estimate the amount of improper payments, to reports those estimates to Congress, and to submit a report on actions the agency is taking to reduce erroneous payments. On August 21, 2007, CMS issued a final rile for PERM for Medicaid and SCHIP (effective October 1, 2007) which responded to comments received on a 2006 interim final rule, and included some changes to that interim final rule. Assessments of payment error rates related to claims for both fee-for-service and managed care services, as well as eligibility determinations are made. A predecessor to PERM, called the Medicaid Eligibility Quality Control (MEQC) system, is operated by state	No provision.	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 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	measurement ("PERM"). Follows the Senate bill with some modifications. The agreement specifies that the payment error rate for a state must not take into account payment errors resulting from the state's verification of an applicant's self-declaration or self- certification of eligibility for, and the correct amount of, Medicaid or CHIP assistance, if the state process for verifying such information satisfies the requirements for such a process applicable under regulations issued by or otherwise approved by the Secretary. In addition, the agreement deletes language that would have been applicable to states for which PERM requirements were in effect under interim rules (now obsolete) for FY2008. The agreement also gives states the option to substitute MEQC data for Medicaid eligibility reviews for

CRS-100

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
http://wikileaks.org/wiki/CRS-RL34129	House: H.K. 3162		based on a broad, representative sample of Medicaid applicants or enrollees.

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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
wiki/CRS-RL34129		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		
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	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 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	payment system for services provided by federally-qualified health centers and rural health clinics. Same as Senate bill.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement		
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.		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.			
CRS	Miscell	aneous			
Purpose of Title XXI	Purpose of Title XXI				
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.		A§2. Purpose. Same as the House bill, except that the purpose would refer to the entire agreement.		
Citizenship auditing					
and associated Medicaid Eligibility Quality Control (MEQC) regulations	enforce citizenship restrictions on	for information on monitoring of invalid names and SSNs submitted for	See A§201 (under Enrollment/Access) for information on monitoring of invalid names and SSNs submitted for citizenship documentation purposes.		

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
	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		
annually to Congress on those figures	reviews. States would be required to		
	remit the federal share of any unlawful		
	expenditures which are identified under		
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.			
determinations to determine error rates.			

CRS-	104
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement		
States must submit a corrective action plan based on the error rate analysis, and must return overpayments of federal funds.					
Managed care safeguards					
XXI (SCHIP) in the same mathematical and th	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	managed care quality safeguards to CHIP. Same as the House bill, but with no effective date specified.	managed care quality safeguards to		
Access to records for CHIP					
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	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		A§604. Access to records for IG and GAO audits. Same as the House bill, except that it would also apply for the purpose of evaluating and auditing the Medicaid program.		

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
benefits coverage under Medicaid. The Comptroller General of the United States must monitor these audits and, not later than March 1 of each fiscal			
Effective date			
No provision.	for state legislation. The House bill does not specify an effective date for the bill in its entirety, however it states that	whether or not final regulations to carry out provisions in the bill have been promulgated by that date.	exception for state legislation; contingent effective date; reliance on law. Same as the Senate bill with

CRS-	1	06
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
-RL34129	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.		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
http://wikileaks.org/wiki/CRS	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 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.		Same as the Senate and House bills in the case of a state that requires legislation.

CRS-107	
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
http://wikileaks.org/wiki/CRS-RL34129			The agreement would specify a contingent effective date for CHIP funding for FY2008. If funds are appropriated under any law (other than the agreement) to provide allotments to states under CHIP for all (or any portion) of FY2008: (1) any amounts that are so appropriated that are not so allotted and obligated before the date of enactment of the agreement would be rescinded and (2) any amount provided for CHIP allotments to a state under the agreement for such fiscal year would be reduced by the amount of such appropriations so allotted and obligated before such date.
County Medicaid health insuring organ	izations		
requirements described in section 1903(m)(2)(A) of the Social Security Act. However, certain county-operated managed care plans in California that	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.	-	A§614. County Medicaid health insuring organizations; GAO report on Medicaid managed care payment rates. Same as the House bill, except for the addition of a GAO report. Not later than 18 months after the date of the enactment, the Comptroller General of the United States would be required to submit a report to the Committee on

CRS-108

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
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, 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 mether 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).			Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives analyzing the extent to which state payment rates for Medicaid managed care organizations are actuarially sound.
Clarification of treatment of regional m	edical center		
in the cost of the Medicaid program. Sometimes hospitals fund the state share	H§816. Clarification treatment of regional medical center. The provision would prohibit the Secretary from denying federal matching payments	-	A§618. Clarification treatment of regional medical center. Same as House provision.

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
thereby ensuring that federal matching	when the state share has been		
funds will be available even if the state	transferred from certain publicly-owned		
cannot pay its share. Such	regional medical centers in other states		
"inter-governmental transfers" of	if the Secretary determines that the use		
certified public expenditures made by	of such funds is proper and in the		
those types of health care providers to	interest of the Medicaid program		
fund the non-federal share of states'			
Medicaid expenditures are allowable but			
only under			
certain circumstances. Some of those			
circumstances are described in detailed			
federal regulations. Other limitations are			
based on recent CMS administrative			
actions. For example, CMS has recently			
denied federal matching payments when			
the state share was comprised of			
payments transferred from out-of-state			
hospitals.			

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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
Diabetes grants			
Service Act specifies that the Secretary, directly or through grants, must provide for research into the prevention and cure		relating to diabetes prevention. The Senate bill, as amended, would create a new demonstration project to fund up to	relating to diabetes prevention. Same as Senate bill.

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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
http://wikileaks.org/wiki/CRS-RL34129		degree to which funded activities improve health outcomes related to type 2 diabetes among children in participating states. The provision would authorize to be appropriated a total of \$15 million during FY2008 through FY2012 to fund this demonstration. 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 CH	IIP 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		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	

CRS-1	12
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
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 ⁵⁰ was appropriated annually, beginning in FY2000.		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 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	

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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
		avoids adverse impacts on states.	
http://wikileaks.org/wiki/CRS-RL34129		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 enrollment data could be collected and analyzed by the Secretary within six months of submission.	
Technical correction			
provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage which is nearly identical to	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,	technical corrections. Same as House bill.	

CRS-1	14
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
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 pitle IV of the Social Security Act and children receiving foster care or adoption assistance under Part E of such title.			
The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) gave states the option to provide Medicaid to state- specific 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).		<i>Federal Register</i> and on the internet website of CMS, a list of the provisions in Title XIX that the Secretary has determined do not apply in order to enable a state to carry out a state plan	agreement would require the Secretary to publish on the CMS internet website only the list of provisions in Title XIX that do not apply in order to enable a state to provide benchmark coverage under Medicaid on the date that such approval is given (rather than within 30 days of such approval). It would also require the Secretary to publish these same findings in the <i>Federal Register</i> within 30 days of the date of approval. The effective date would be the same as the original DRA provision (i.e., March

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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
		2006).	
Technical corrections regarding curren	t 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 83%. The entranced FMAP (E-FMAP) under SCHIP builds on top of the regular FMAP for Medicaid. The E-FMAP can range from 65% to 85%.		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 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.	

Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement			
Elimination of counting of Medicaid chi	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.	-	Medicaid child presumptive eligibility	A§113. Elimination of counting Medicaid child presumptive eligibility costs against title XXI allotment. Same as Senate bill.			
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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
Outreach to small businesses		•	
No provision. 01182/Wiki/CRS-RI34129	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	insurance options available to children. Same as the Senate bill.

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Current Law	House: H.R. 3162	Senate: H.R. 976	Agreement
		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	
[29		with any appropriate small business or health advocacy group, and designate	
CRS-RL34129		outreach programs at HHS regional	
SA H-SA		offices to work with SBA district	
ki/C		offices. It would require the SBA	
g/wij		website to prominently display links to	
s. or		state eligibility and enrollment	
tileal		requirements for Medicaid and CHIP, and would require a report to Congress	
///wit		every two years.	
http://www.international.com		, , , , , , , , , , , , , , , , , , ,	