



## Federal CHIP Reauthorization: An Opportunity for California to Cover More Uninsured Children

The enactment of a robust Children's Health Insurance Program (CHIP) reauthorization bill – H.R. 2 (CHIPRA 2009) – demonstrates a strong commitment by Congress and President Obama to cover millions of the nation's uninsured children during this difficult economic time.

This federal leadership on children's health gives California critical resources to finish the job of providing health coverage for our 683,000 uninsured children. California leaders now have the opportunity and responsibility to do their part to invest in children's health. If not, CHIP funds will go to other states that can capitalize on the newly available dollars and many of California's children will remain uninsured. This is the moment for California to step up for children as several other state leaders are doing. For example, Washington's governor announced that the state is moving forward with plans to extend coverage to children in families up to 300% of the federal poverty level (FPL) – about \$55,000/yr for a family of three – a policy the governor had previously put on hold.

Below is a brief summary of the key provisions in the federal CHIP bill and what California will need to do to take advantage of the opportunities presented in the legislation.

### FEDERAL FUNDING

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#### \*State Allotment Level

**Key Provisions:** CHIPRA 2009 funds CHIP through Federal Fiscal Year (FFY) 2013 and includes an additional \$32.8 billion above current federal CHIP spending. Under this bill, states' CHIP allotments have increased significantly from \$5 billion a year currently, up to \$17.4 billion in 2013. How states' allotments are calculated is also markedly different, building on actual state spending rather than the number of uninsured children. States' allotments are rebased in FFY 2011 and FFY 2013, based on actual state spending.<sup>1</sup> The bill also establishes a child enrollment contingency fund. If a state's federal CHIP spending in FFY 2009 – 2013 exceeds its available allotments, and if the state experiences enrollment that exceeds its target average number, it will receive payments from the contingency fund.<sup>2</sup>

**California Impact:** California's CHIP program, called Healthy Families, is administered by the Managed Risk Medical Insurance Board (MRMIB). California's projected allotment for FFY 2009 is \$1.5 billion. This is 85% larger

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<sup>1</sup> FFY 2009 federal CHIP allotments for states under CHIPRA 2009 will be based on the largest of three state-specific amounts: a state's FFY 2008 federal CHIP spending multiplied by a growth factor; a state's FFY 2008 federal CHIP allotment multiplied by a growth factor; and a state's own projection of federal CHIP spending for FFY 2009, as submitted in February 2009. The largest of these three amounts would be increased by 10% and would serve as the state's FFY 2009 federal CHIP allotment, as long as the total \$10.5629 billion appropriation is adequate to cover all the states' and territories' FFY 2009 allotments. If not, allotments would be reduced proportionally. By including 10 percent more than a state likely needs to simply sustain its existing program, the formula provides every state with new federal matching funds that can be used to reach a greater share of already-eligible children, improve benefits, or expand coverage. A state's FFY 2010 allotment will equal its FFY 2009 allotment, adjusted for health care inflation and child population growth. If the state relies on the child enrollment contingency fund in FFY 2009, this spending will also be built into its FFY 2010 allotment. In FFY 2011 (and again in FFY 2013), a state's allotment will be updated to reflect its actual use of CHIP funds. For example, when allotments are set for FFY 2011, a state that used only \$10 million of a \$20 million allotment in FFY 2010 will receive an allotment in FFY 2011 of only \$10 million (adjusted for health care inflation and child population growth). When updating or "re-basing" allotments in FFY 2011 (and again in FFY 2013), the CHIP law calls for taking into account all of a state's spending on CHIP – including spending out of a state's allotments from earlier years, redistributed funds from other states, and the child enrollment contingency fund – and updating it for health care inflation and child population growth. FFY 2012 will look like FFY 2010 and FFY 2013 will look like FFY 2011.

<sup>2</sup> The amount would be the product of: (1) the amount by which the average monthly caseload exceeds the target number, (2) the projected per capita costs of those individuals, and (3) the federal share of the CHIP expenditures paid by the federal government for that state.

than allotments under the previous law.<sup>3</sup> California's new FFY 2009 federal allotment is sufficient to cover the more than 1.2 million children currently covered under Title XXI in California and to meet other spending obligations. In fact, there is enough federal money left over that California could cover the estimated 180,000 Healthy Families-eligible but uninsured children, and extend coverage to uninsured children in families up to 300% of FPL.<sup>4</sup> For California to maximize this available federal CHIP allotment funding and cover these uninsured children, California would need to invest roughly \$100 million above its current spending.

## ELIGIBILITY RULES

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### \*State Flexibility to Determine Income Eligibility Level

**Key Provisions:** CHIPRA 2009 preserves state flexibility to determine income eligibility levels for CHIP. States will receive the enhanced federal CHIP matching rate for eligible children with incomes up to 300% FPL, with state deductions. Coverage for children above 300% FPL will be matched at the regular Medicaid matching rate.

**California Impact:** California could receive a 65% federal match if it extends Healthy Families coverage from the current level of 250% FPL to 300% FPL. There are roughly 50,000 uninsured children in California between 250% and 300% FPL.<sup>5</sup> The state could also cover kids above 300% FPL at its 50% Medicaid match rate. *To take advantage of this state eligibility flexibility and new federal funds will require state legislation and state matching funds.* In California's economic recession – with a 9.3% unemployment rate that is much higher than the national average – families more than ever need affordable health insurance for their children as they lose their jobs and employer-based insurance. Covering more uninsured children at higher income levels would be particularly valuable in California where the cost of living is much higher than in other states. For example, a family at 300% FPL in San Francisco has a lower standard of living than a family at 200% FPL in Atlanta.

### \*Legal Immigrant Children and Pregnant Women

**Key Provisions:** Under CHIPRA 2009, states will be able to receive federal matching funds to cover legal immigrant children and pregnant women receiving Medicaid and CHIP during their first five years in the country. States may start claiming federal matching funds for these children as early as April 1, 2009. A state choosing this option under CHIP must also do so for Medicaid. Any state utilizing this option must demonstrate that those enrolled under this provision provide, at enrollment and renewal, documentation or other evidence of lawful residence.

**California Impact:** California has been covering this population primarily with state funds and can now get an influx of federal dollars to free up state General Fund dollars. *California should immediately act to claim this federal match for both Medi-Cal and Healthy Families.* California will need to submit a state plan amendment to do this. In the first year, California would receive roughly \$20 million additional federal dollars.<sup>6</sup> *The state should invest these freed-up state funds in children's health by using them to provide coverage to more uninsured children.* The Medi-Cal and Healthy Families Programs currently require immigration documents to be produced at the time of enrollment. At the time of renewal, if the documentation is still valid (according to its expiration date), renewal should proceed seamlessly; requiring additional documentation at renewal would create a barrier that could cause eligible children to unnecessarily lose coverage. In addition, California should explore other means of verifying immigration status at renewal, including using third party databases, to satisfy this federal rule.

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<sup>3</sup> C. Peterson, "Projections of FY2009 Federal CHIP Allotments Under CHIPRA 2009," Congressional Research Service (January 15, 2009).

<sup>4</sup> P. Harbage, "Funding California's CHIP Coverage, What Will it Cost? 2009," Prepared for the California Healthcare Foundation (publication forthcoming).

<sup>5</sup> Ibid.

<sup>6</sup> op. cit. (4)

## \*Rescission of the “August 17<sup>th</sup>” CMS Directive

**Key Provisions:** The directive released by the previous Administration would have imposed limitations on states’ ability to cover uninsured children above 250% FPL via CHIP. The Obama Administration has since instructed the Center for Medicare & Medicaid Services (CMS) to rescind this directive. As a result, CHIPRA 2009 did not need to address this issue.

**California Impact:** With this eligibility barrier removed, California no longer has a federal barrier to expanding Healthy Families coverage to 300% FPL.

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## ENROLLMENT AND RETENTION OPPORTUNITIES

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### \*Performance Bonus System

**Key Provisions:** CHIPRA 2009 offers financial incentives to states to find and enroll Medicaid-eligible uninsured children. The performance bonus offers additional payments in FFY 2009 to FFY 2013 to states that (1) increase their Medicaid enrollment among low-income children above a target enrollment, and (2) implement five of a specified eight outreach and enrollment activities. In FFY 2009, the Medicaid target enrollment is equal to the average monthly number of Medicaid children enrolled in 2007, increased by the child population growth rate for the state, plus four percentage points for 2008 and then again in 2009. For subsequent years 2010 through 2012, the Medicaid target enrollment is the prior year’s enrollment increased by the child population growth rate for the state, plus 3.5 percentage points. The bonus payment is either 15% or 62.5% of the state share of the average per capita child’s Medicaid expenditures.<sup>7</sup> To be eligible for performance bonus payments, a state must implement (throughout the entire fiscal year) at least five of the following practices for children in CHIP and Medicaid: 1) 12-month continuous eligibility; 2) elimination of the asset test (or the state must allow self-declaration when appropriate); 3) elimination of in-person interview requirements; 4) use of a joint application and the same information verification process; 5) use of streamlined or “administrative” renewal; 6) use of presumptive eligibility; 7) use of the Express Lane option; and 8) the use of premium assistance subsidies. The amount of money that states can receive in performance bonus payments is not capped.

**California Impact:** By FFY 2010, California will likely meet five of the eight enrollment and outreach activities necessary to qualify for a performance bonus so long as California restores its previous continuous eligibility (and annual renewal policy).<sup>8</sup> California must also increase children’s Medi-Cal enrollment to meet target enrollment levels and receive the performance bonus dollars. The most effective strategy for increasing enrollment to target levels in order to access the performance bonus is to establish a system of coverage for all uninsured children in California. As has been demonstrated by California’s local Children’s Health Initiative (CHI) models, when there is a system of coverage for all children, uninsured children who were already eligible also enroll in large numbers. In addition, implementing recent streamlining laws (SB 437) will also increase enrollment to 94,000 eligible but uninsured children. Clearly, bonus payments could dramatically reduce the state cost for implementing a system of coverage for all kids while also covering the 205,000 Medi-Cal-eligible but uninsured children in California.

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<sup>7</sup> A state receives 15% of the average state share of cost of Medicaid expenditures for the number of enrollees in Tier 1 (the number exceeding the target enrollment by up to 10%) and 62.5% of the average state share of cost of Medicaid expenditures for the number of enrollees in Tier 2 (the number exceeding the target enrollment by more than 10%).

<sup>8</sup> The activities that California may qualify under are: elimination of the asset test, elimination of in-person interview requirements, the use of presumptive eligibility and Express Lane Eligibility (ELE) (although the federal ELE option was only just enacted). A fifth criterion that California needs to qualify by FFY 2010 performance payments is 12-month continuous eligibility, which our state must restore in order to receive Medicaid match (FMAP) relief through the recent economic recovery package. Because a repeal is still pending, California may not qualify in FFY 09.

## \*Outreach

**Key Provisions:** CHIPRA 2009 includes \$100 million for outreach, above and beyond the regular CHIP allotments for FFYs 2009 through 2013. In addition to a national enrollment campaign, outreach and enrollment grants will be available to state and local governments and other organizations. Grant funds will focus on rural areas and underserved populations and will also be targeted at proposals that address cultural and linguistic barriers to enrollment.

**California Impact:** The grant funds for outreach present an opportunity for California to reinstate its community-based outreach grants as well as build supplemental targeted outreach opportunities. It will cost the state \$15 million General Fund, annually, to reinstate community-based grants. The additional federal grant funds could reduce the state's share of these grant costs. This outreach money would be an augmentation of dollars atop the enhanced match California can already get for outreach.

## \*Express Lane Eligibility

**Key Provisions:** CHIPRA 2009 gives states the option to use Express Lane Eligibility (ELE) as a tool to increase the enrollment of already-eligible but uninsured children. ELE authorizes Medicaid/CHIP to use another agency's eligibility finding or determination for programs with similar eligibility rules as a component of determining eligibility for Medi-Cal/Healthy Families, despite differences in methodology. The bill also allows parents to consent to ELE through methods other than signing a formal Medicaid/CHIP application form.

**California Impact:** This new authority should be applied to the design of the yet-to-be-funded and implemented Gateway through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) by allowing relevant findings from a WIC application to form the basis of a Medi-Cal and Healthy Families eligibility determination. Second, the new authority could be used to improve the efficiency and effectiveness of the Child Health and Disability Prevention (CHDP) Program Gateway, which currently provides a presumptive eligibility link to health coverage. And third, to make the existing Express Enrollment program through the National School Lunch Program (NSLP) more efficient, relevant findings from an NSLP determination could be used to form the basis of a Medi-Cal and Healthy Families determination, instead of the current practice that requires additional, duplicative information from families. In order for ELE to be as effective as possible, the state will need to make improvements to its eligibility systems and to enable greater cross-agency data sharing capabilities. ELE strategies have the potential to enroll hundreds of thousands of California's uninsured but eligible children in health coverage, and can help the state meet the standards necessary to receive performance bonus payments.

## \*Requirements for Documentation of Citizenship Status

**Key Provisions:** CHIPRA 2009 applies a new requirement on CHIP eligibility. Now, the Medicaid citizenship documentation requirement established by the Deficit Reduction Act must be met for CHIP eligibility. This means that CHIP will need to verify citizenship and the child's identification. The bill gives states a new option to meet the citizenship requirement by having the Social Security Administration (SSA) verify a child's social security number for the state and will provide money for states to improve the systems interface between the SSA and their CHIP agency. California should take advantage of this resource while it exists. In addition, states are permitted to enroll the child while they wait for verification of citizenship. The bill also provides an enhanced match for creating the systems improvements necessary to accomplish this.<sup>9</sup>

**California Impact:** The Healthy Families Program currently requires provision of a birth certificate at enrollment. This satisfies the citizenship verification requirement. As is already the case in Medi-Cal, a parental signature can attest to a child's identification. California currently provides limited-scope coverage to Medi-Cal children who are in the process of verifying citizenship. California can now utilize the new options provided for in CHIPRA 2009 to start enrolling these children in full coverage – for both Medi-Cal and Healthy Families – while they verify citizenship.

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<sup>9</sup> The Obama Administration will now be revisiting the regulations regarding the Deficit Reduction Act (DRA) and citizenship documentation and will likely change some of the restrictions that went beyond what the original DRA directed.

## \*Clarification of Federal Audit Requirements

**Key Provisions:** CHIPRA 2009 allows states to implement administrative verification of income and other eligibility information as allowed by federal law and not be penalized for doing so by the federal audit program, Payment Error Rate Measurement (PERM).<sup>10</sup>

**California Impact:** This clarification paves the way for California to use alternative methods, such as relying on third party database matches and post-enrollment sample checks, to verify the income of families applying for Medi-Cal and Healthy Families, rather than requiring families to provide paper documentation of income. CHIPRA 2009 clarifies that states do not need to have copies of income documentation in children's case files to satisfy federal audits. California should immediately fund implementation of the administrative verification policies enacted through SB 437 in 2006.

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## BENEFITS, ACCESS AND QUALITY OF CARE

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### \*Quality of Care

**Key Provisions:** CHIPRA 2009 creates a new initiative to improve the quality of care provided to children, including development and dissemination of new child-specific health quality measures, the creation of a new model electronic medical record for children, demonstration projects on quality improvement, and health information technology (HIT) for children. Specifically, there are \$20 million allocated annually to states, for distribution among the four grant program areas: 1) children's health quality measures; 2) evaluation of the impact of children's electronic health records on quality and cost; 3) care management and evidence-based approaches; and 4) HIT in pediatric care delivery.

**California Impact:** California did not benefit from the \$150 million given out in 2007 to help states make systemic improvements to their health care system through the Medicaid Transformation Grant program. Having missed that crucial funding opportunity, since no further funding is available through that grant program, California cannot afford to pass up this new opportunity to transform and improve the way it serves children. For instance, California could request these funds to design and implement an electronic records system for children, or to support telehealth efforts to link underserved children with needed services.

### \*Access to Care

**Key Provisions:** CHIPRA 2009 creates a commission to evaluate children's access to care and payment policies in Medicaid and CHIP.

**California Impact:** California will greatly benefit from clear findings about the extent to which our state is facing difficulties in the areas of access to care and payment policies.

### \*Dental Coverage

**Key Provisions:** CHIPRA 2009 requires dental benefits in the CHIP package and allows states that already cover uninsured children to 250% of FPL to use CHIP funds to provide dental coverage to otherwise eligible underinsured children (e.g., children who have health but not dental insurance). CHIPRA 2009 also requires new standardized reporting of information about children's dental health, and improved accessibility of dental provider information for Medicaid and CHIP enrollees.

**California Impact:** The federal decision to require all states to provide dental benefits in CHIP bolsters California, which already provides dental benefits through Healthy Families. In addition, California could seize the opportunity

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<sup>10</sup> PERM was created to measure improper payments in Medicaid and CHIP and was designed to comply with the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300).

to provide dental-only supplemental coverage through CHIP with an enhanced federal match. Such a move would help the 35% of children in families 100-299% FPL who had no dental insurance in 2007, according to the UCLA California Health Interview Survey. If California chooses to implement the state option, preliminary estimates put the total cost (state and federal) in the low tens of millions of dollars.

### **\*Application of Certain Managed Care Quality Safeguards to CHIP**

**Key Provisions:** CHIPRA 2009 applies some additional Medicaid managed care standards to CHIP – including the process for health plan enrollment and termination and for changing health plans, provision of information to beneficiaries, beneficiary protections, quality assurance standards (for preventive services, treatment, and services for acute and chronic conditions, among others), protections against fraud and abuse, and sanctions for non-compliance. This provision applies to health plan contract years beginning on or after July 1, 2009 (January 1, 2011 if a change in state law is needed). The law also requires that the federal Government Accountability Office (GAO) report to Congress by August 4, 2010 on the actuarial soundness of state Medicaid payment rates for managed care organizations.

**California Impact:** The application of Medicaid managed care standards to CHIP will likely result in increased retention and an improved experience for families with children in the Healthy Families Program. Currently, MRMIB is in the process of trying to understand the requirements of the application of these standards, assessing whether or not they are in compliance, and outlining action if needed.

### **\*Translation and Interpretation Services**

**Key Provisions:** In 2000, the federal government issued guidance to states reminding them of an obligation to provide meaningful access to services for limited-English proficient individuals, and that matching funds are available for the provision of language services in the Medicaid and CHIP programs. Only 13 states have chosen to take advantage of these matching funds, primarily due to increased state costs associated with providing interpretation and translation services. CHIPRA 2009 provides an enhanced matching rate in CHIP and Medicaid for translation and interpretation services provided to limited-English proficient beneficiaries. The enhanced matching rate for translation and interpretation services for CHIP is the highest of 75% or the state's current enhanced match rate plus 5%. The enhanced matching rate for translation and interpretation services for Medicaid is 75%. This enhanced match is available to states when an individual receives interpretation and translation services while enrolling, renewing, or utilizing coverage.

**California Impact:** To date, California has not dedicated any specific funds for the purposes of reimbursing providers for the provision of language services, but health plans may be providing these resources with the cost, albeit unknown, included in the plan's capitation rate. However, a Language Access Services Taskforce was created in 2006 to begin analyzing ways that California could draw down available federal funds for language services. The Taskforce researched other states' models, explored best practices of California's providers and health plans, and submitted recommendations for improving language access services to the Department of Health Care Services. The Taskforce's recommendations have not yet been implemented. However, CHIPRA creates an incentive for the Department of Health Care Services to revisit the recommendations and take advantage of federal dollars for language services by at least tracking current state spending on such services, such as those embedded in capitation rates to health plans, and potentially investing additional state dollars in language access services.

## \*Mental Health Parity

**Key Provisions:** There is no requirement in CHIPRA 2009 that mental health services are provided as a CHIP benefit. The bill does require, however, that if a state provides mental health or substance abuse services through CHIP, the annual and lifetime dollar limits and the treatment limitations are no more restrictive than those for all medical and surgical benefits covered under the state CHIP plan. State CHIP plans that include coverage of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are deemed to satisfy this mental health parity requirement.

**California Impact:** Healthy Families currently provides basic mental health services through the health plans, with seriously emotionally disturbed (SED) children "carved out" and served through the county system. Since this involves referrals and negotiations between individual health plans and each of the 58 counties, there are existing coordination problems. This manner of serving children would have to undergo scrutiny to determine whether it meets mental health parity standards. MRMIB will have to decide whether to revise the current "carve out" system. If mental health services continue to be provided through the health plans, they may have to review their contracts to ensure full mental health parity under the new CHIPRA definition.

## \*School-Based Health Centers (SBHCs)

**Key Provisions:** CHIPRA 2009 clarifies that states can provide benefits and services under CHIP through school-based health centers. This is the first explicit recognition of SBHCs as a potential provider of CHIP services. The language validating SBHCs as CHIP providers, and the existence of a statutory definition, should ease the way for the establishment of federal laws and regulations to ensure that SBHCs are reimbursed by government programs, and possibly, for the creation of a federal grant program for SBHCs.

**California Impact:** California's school-based health centers obtain Healthy Families reimbursement only if they are a child's designated primary care provider under a contracted health plan. To consolidate the current patchwork of SBHCs into a comprehensive system to help increase access to primary care, the state should work with health plans to develop mechanisms for reimbursement of out-of-network services. Such reimbursement would enable SBHCs to cover costs associated with providing access to primary care to all children in a school. California should also ensure that schools and SBHCs are incorporated into a permanent system for outreach and enrollment into Healthy Families.

## \*Employer Buy-in Option

**Key Provisions:** CHIPRA 2009 allows states to create a purchasing pool for employers with less than 250 employees who have at least one employee who is a CHIP-eligible pregnant woman or the parent of a CHIP-eligible child. Eligible families would have access to not less than two private health plans with benefits equivalent to a CHIP benchmark benefit package. States can provide CHIP-funded subsidies for premium costs for CHIP-eligible children. Administrative costs associated with the start up or operation of a purchasing pool could only be covered by CHIP funds if they meet the definition of allowable administrative expenses under CHIP. The GAO is required to submit a report to Congress by January 1, 2010 regarding cost and coverage issues under state premium assistance packages.

**California Impact:** The employer buy-in option could be a valuable opportunity for California employers who want to cover employees' dependents while potentially also sharing in the state cost of Healthy Families-eligible children.