

CHIPRA Impacts and Implementation Mandates

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Includes actions requiring MRMIB action and complimentary actions by DHCS

Summary of CHIPRA Provision	Impact on HFP	Important Dates and Action Items
COMPLETED		
Elimination of Counting Medicaid Child Presumptive Eligibility Costs Against Title XXI Allotment (SEC 113).		Effective date is April 1, 2009.
Eliminates a provision of federal law requiring that federal reimbursement for Medicaid benefits received by children who appeared to be Medicaid-eligible during periods of PE be made out of the Title XXI allotment rather than the Title XIX allotment.	<p>More funds remain available in California's federal CHIP allotment. CA estimates this is about \$80 million a year.</p> <p>The change lessens administrative burdens in reconciling claims for such expenditures between Titles XIX and XXI.</p>	<p>MRMIB submitted a State Plan Amendment (SPA #15) on June 29, 2009 to implement this change. CMS approved it on 12/29/09. It was retroactive to April 1, 2009.</p> <p>Effective April 1, 2009, DHCS discontinued claiming Title XXI for PE and began claiming against Title XIX.</p>
Strikes Medicaid requirements for deemed newborns regarding living arrangements with the mother, so that an infant under age 1 can retain Medi-Cal eligibility regardless of whether the baby lives with the mother.		DHCS sent an All County letter on April 13, 2009, instructing counties on the new deeming rules regarding living arrangements of infants.

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<p>Legal Immigrant Children and Pregnant Women (SEC 214).</p>		<p>Effective date is April 1, 2009.</p>
<p>Allows for federal financial participation (FFP) for coverage of legal immigrant children and pregnant women in both CHIP and Medi-Cal.</p> <p><i>Note:</i> The state cannot claim for pregnant women and children under CHIP unless it also does so under Medicaid.</p>	<p>This option reduces state costs in HFP and MC because CA formerly provided coverage for legal immigrant children with state only funds. California already receives FFP for prenatal women under a separate option.</p> <ul style="list-style-type: none"> • Without this provision, HFP would have spent an estimated \$18.8 million on coverage for legal immigrant children in state FY 2009-10. MRMIB estimates state savings of \$12.2 million General Fund in FY 2009-10, with additional savings in the Medi-Cal program. <p>Medi-Cal is now able to obtain FFP for non-emergency Medicaid covered services. Medi-Cal has received FFP for emergency services provided to legal immigrants for some time.</p>	<p>MRMIB submitted SPA # 15 to CMS in June 2009 to begin drawing down FFP as of 4/1/09 for the CA recent legal immigrant program. CMS granted approval on 12/29/09. MAXIMUS implemented this change in claiming at no cost to the state.</p> <p>DHCS submitted its SPA to CMS in June 2009. It is still pending final approval from CMS.</p>

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<p>Where the documentation provided at initial enrollment is not sufficient to establish continuing lawful residence, requires states, as part of the eligibility re-determination process, to verify that the enrolled individual is still lawfully residing in the U.S.</p>	<p>Previously, HFP required a copy of children's legal status documents upon initial enrollment but did not require further documentation at AER. Some children might have to provide additional documentation. Implementing these provisions may result in lower retention.</p>	<p>MRMIB adopted emergency regulations last fall and in January 2010 that add the necessary documentation requirements to the Annual Eligibility Review (AER), to meet the CHIPRA re-verification requirements. MAXIMUS implemented this change at no cost to the state. The service was valued at \$282,000.</p>

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<p>Citizenship Documentation Requirement (SEC 211).</p>		<p>Effective date is January 1, 2010</p>
<p>Extends Medicaid citizenship documentation and identification requirements to CHIP. The statute limits the types of documentation that can be used to demonstrate U.S. citizenship and requires proof of identity.</p> <p>Citizenship Documentation</p> <ul style="list-style-type: none"> • The law clarifies that children born in the U.S. to mothers on Medicaid shall be deemed to have provided satisfactory documentation of citizenship and shall not be required to provide further documentation. 	<ul style="list-style-type: none"> • MRMIB developed a process that: <ul style="list-style-type: none"> • Validates citizenship with vital statistics birth records through an electronic data match (validates for around 92% of California-born enrollees) • Validates citizenship through parent provided documentation within 2 months of enrollment (either validates citizenship or results in disenrollment). As a last resort, MRMIB will continue to accept copies of birth certificates (in lieu of face to face verification). 	<ul style="list-style-type: none"> • Implemented California vital statistics match Dec. 31, 2009, <p>MRMIB also plans to 1) assess the capability of linking to a national database that provides electronic vital statistics data from other states and 2) obtain citizenship verification already known to MEDS.</p>

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<ul style="list-style-type: none"> • Gives states the option of meeting the citizenship documentation requirement for both MC and CHIP by submitting the names and Social Security Numbers (SSNs) of individuals enrolled in Medicaid and CHIP to the Social Security Administration (SSA) at least monthly. If SSA finds that the name and SSN do not match, the state must make a reasonable effort to address the discrepancy while providing coverage to the otherwise eligible individual. If the issue is not resolved, individuals have 90 days to establish citizenship or fix the problem with their SSN after which they are disenrolled within 30 days. <p>The HHS Secretary may impose penalties on states if more than three percent of the names and SSNs they submit to the SSA are deemed “invalid” and not corrected. The law provides for a federal match of 90 percent for the design, development or installation of the SSN matching system and 75 percent match for costs attributed to the operation of the system.</p>	<p>Presently HFP does not require children’s SSNs as state policymakers have viewed such a requirements as a deterrent to enrollment. Requiring SSNs would require HFP to change the application, program regulations and operations.</p> <p>Medi-Cal, which is required to collect SSNs, is pursuing the SSN match option.</p>	

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<p>Identification Again, related to Sec. 211, this addresses proof of identity provisions that relate to the types of documentation that may be used to demonstrate the identity of each child being applied for.</p>	<p>Establishes a new requirement for proof of a subscriber's identity.</p>	<p>In January 2010, MRMIB began using a revised joint HFP application that includes a new declaration whereby the applicant attests to the identity of the child for whom they are applying for coverage. This mirrors the current process used by Medi-Cal to comply with the DRA requirements.</p> <p>MRMIB also plans to obtain identity verification already known to MEDS.</p>
<p>Regarding both documentation and identification, another provision requires that states accept documentation from Federally Recognized Indian tribes as evidence of citizenship and identification.</p>	<p>MRMIB must develop procedures to comply.</p>	<p>Work in process.</p>

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Completed Pending Receipt of Clarifying information		
Dental Providers and Dental Benefits Listed on Insure Kids Now (IKN) Website (SEC 501).		August 4, 2009
<p>Requires CMS to post, on the IKN website, a list of all dentists and other dental providers from each state that serve children enrolled in CHIP and Medicaid, and to update the list quarterly. Also requires each state to post its dental benefits offered under CHIP.</p>	<p>CMS initially interpreted this section to require states to send lists of participating CHIP dental providers to CMS to post on the IKN website. Under existing contracts, HFP participating plans (dental, health and vision) provide MRMIB quarterly updates of provider networks for uploading to HFP website, where subscribers can search by location, specialty, languages spoken, sex of provider. States complained about sending provider lists and asked to be able to hyperlink to their own websites. CMS is now allowing these hyperlinks, but may again seek the providers' listings.</p> <ul style="list-style-type: none"> A data element CMS wants reported for each dental provider is whether the provider can accommodate special needs children. CMS has not defined "special needs," and this is not a data element HFP plans report to MRMIB. 	<p>MRMIB made provider lists and benefits information available on the Insure Kids Now (IKN) website. MRMIB provided CMS the URL which links to HFP provider directories (from which subscribers can select a dentist) as well as a description of the dental benefits provided in HFP.</p> <ul style="list-style-type: none"> MRMIB is awaiting clarification from CMS on its definition of "special needs" children.

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Legislation, Regulation, Staffing or Major Systems Changes Required/Fiscal Impacts		
<p>Medicaid Managed Care Standards Applied to CHIP (SEC 403).</p>		<p>Effective date is January 1, 2011 for provisions requiring state statute change and July 1, 2009 for those that do not.</p>
<p>Requires states to apply Medicaid managed care standards to CHIP, specifically related to the following: 1) enrollment; 2) provision of information; 3) beneficiary protections; 4) quality assurance standards; 5) protection from fraud and abuse; and 6) sanctions for non-compliance.</p>	<p>CMS has issued two State Health Official (SHO) letters on this subject— one on the managed care standards overall (CHIPRA #4; SHO #09-008) and one specific to the quality assurance standards (CHIPRA #8; SHO #09-013).</p>	
	<p><u>Managed Care Standards</u>. Among other things, SHO Letter CHIPRA #4; SHO #09-008 states CMS' view that CHIPRA:</p> <ul style="list-style-type: none"> ▪ Requires states operating a CHIP managed care delivery system to submit CHIP managed care contracts extended, renewed, or substantively amended on or after July 1, 2009 to the CMS Regional Office for review and approval. 	<ul style="list-style-type: none"> ▪ MRMIB gave CMS a copy of the draft model contract for benefit year 2010-11 in November 2009. CMS has yet to issue rules for CHIP contracts, but the rules for Medicaid managed care contracts are 22 pages long and represent a complex set of requirements for which MRMIB is not staffed.

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	<ul style="list-style-type: none">▪ Gives CHIP subscribers the right to disenroll from their current managed care plan and still be able to receive benefits. CMS says this requires that states must, in each area, have a second managed care service plan or an alternate delivery system. Options for compliance include: Contract with a second managed care plan, create a fee-for-service option, or contract with some or all of the state's existing Medicaid provider network.	<ul style="list-style-type: none">• MRMIB is planning to provide a second option by offering Medi-Cal FFS in counties where there is not a second plan. This would require state legislation. Presently, there are 8 counties with only one plan, but this number could increase in the budget year. Implementation is expected to take time due to the complexity of the project and Medi-Cal's transition to a new fiscal intermediary contractor.

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	<ul style="list-style-type: none"> • Requires that managed care organizations participating in CHIP must provide the state with encounter and claims data. The requirement applies to health plans and may also apply to dental plans. 	<ul style="list-style-type: none"> • MRMIB has been trying to create an encounter and claims data system for several years but was blocked by state legal barriers and financing. <p>Under CHIPRA, MRMIB has authority to collect encounter and claims data from plans as of July 1, 2009. However, given the 18 month time period required for claims to mature MRMIB needs data back to July 2006 if it is to conduct data analysis. State legislation is needed to authorize MRMIB to receive data prior to July 1, 2009.</p> <p>Although MRMIB has been working with plans for several years to create an encounter and claims system, this will be a new contractual requirement for them. Prior contracts expressed MRMIB's intention to collect the data.</p>

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	<p>Requires states to develop and implement a Quality Assessment and Improvement Strategy for CHIP benefits. Further requires that managed care plans undergo an annual review of their quality of care by an independent external reviewer</p>	<p>(See below).</p>
	<p><u>Quality Assurance Standards</u>. SHO Letter CHIPRA #8; SHO #09-013 requires states contracting with managed care plans to:</p> <ul style="list-style-type: none"> ▪ Develop and implement a Quality Assessment and Improvement Strategy addressing access to care standards and other measures of care and service related to quality. ▪ Include mandatory annual external review in plan contracts of quality of care provided by managed care plan conducted by qualified independent external quality review organization. 	<ul style="list-style-type: none"> • The David and Lucile Packard Foundation has funded a consultant to assist MRMIB in constructing a quality framework and assisting with the solicitation for an quality review organization (EQRO). The goal is to have the EQRO contract in place by July 1, 2011.

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	<p><u>General Understanding.</u> CMS will be issuing subsequent SHO letters on the many other provisions of Medicaid managed care that were applied to CHIPRA</p>	<ul style="list-style-type: none">• MRMIB is evaluating the other legal and practical issues related to implementation of this provision.

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<p>Quality Initiative for Children (SEC 401).</p>		<p>Various child health quality reports to be released by HHS, the Institutes of Medicine and the GAO beginning in January 1, 2010.</p> <p>Pediatric Quality Measures Program to be established by HHS by January 2011.</p>
<p>Not later than January 1, 2010, the federal HHS Secretary shall—among other things—identify and publish for comment an initial recommended core set of child health quality measures addressing the quality and availability of care, and duration and stability of children’s coverage. Those measures provide guidance to the states but are voluntary. Contrary to earlier statements, states will not receive enhanced administrative funding for collecting and reporting on child health quality measures.</p> <p>The federal HHS Secretary will disseminate best practice measurements and facilitate the adoption of these practices. HHS will develop a standardized format for reporting on quality of health care for children in MC and CHIP, and will also establish a Pediatric Quality Measures Program by January 2011, to identify gaps in</p>	<p>CMS released a proposed list in January 2010 of 24 core quality measures that states may voluntarily report.</p> <p>MRMIB currently collects 10 of the 24 proposed core measures from HFP plans. There are 9 other proposed core measures that MRMIB may be able to collect from plans but it would increase plan costs to do so.</p> <p>As CMS formalizes its quality regulations for CHIPRA, there will likely be increasing costs for plan compliance.</p>	<p>MRMIB submitted comments on the measures on 2/28/10.</p>

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existing pediatric quality measures and establish priorities for their development and advancement.		
States also are required to conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and report results in their annual report.	HFP has conducted CAHPS surveys periodically when funding was provided. A survey is now an annual requirement.	Assuming funds are provided in the 2010-11 budget, MRMIB would conduct the CAHPS survey in the Fall of 2010.
Quality Studies (SEC 401 & 402) By July 2010, the Institute of Medicine will report to Congress on pediatric health and health quality measures beyond the core measures CMS releases. By March 2011, the GAO will issue a report on children's access to primary and specialty care under CHIP and Medicaid and make recommendations for improving such access.	The Institute of Medicine has convened a workgroup to identify gaps in knowledge related to children's health status, health care quality and health disparities.	The first meeting of the workgroup is 3/23/10.
Quality Demonstration Project Grants (SEC 401) In FFYs 2009 through 2013, requires the HHS to award 10 grants (\$100 million total over 5 years) to establish demonstration projects for states and child health providers to use and test child health quality measures and to promote the use of health information technology for children. In addition, the demonstration projects will evaluate provider-based models and demonstrate the impact of electronic health record models.		<ul style="list-style-type: none"> • DHCS submitted a proposal to CMS for a CHIPRA Quality Demonstration Project Grant that would test a provider-based model of care for children with certain CCS conditions. The grant proposal was submitted on January 8, 2010. CMS did not select the proposal for funding.

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		<ul style="list-style-type: none"> MRMIB was also planning to seek funding for development of a quality framework for HFP but concluded that it could not, due to a CMS requirement that plans participating in a grant under that category must report all 24 measures CMS has issued. Plans in HFP report 10 and reporting all 24 would be cost prohibitive for plans at a time when they are unlikely to receive a rate increase.
The law also includes \$25 million in demonstration project funding to combat obesity.	The state will consider applying when CMS releases grant guidelines.	
Dental Coverage (SEC 501). Requires CHIP plans to include coverage of dental services.		Effective date is July 1, 2009 or January 1, 2011 if state statute change is needed.
Coverage must meet articulated standards or be equivalent to specified benchmark dental benefit standards. The available benchmarks are federal employee dependent coverage, state employee dependent coverage, or commercial dental coverage with largest enrollment.	HFP has provided dental coverage to subscribers since its inception. It is based on similar coverage available to the dependents of state employees, but with more restrictive orthodontia. State employee orthodontia coverage has a high cost-sharing requirement, something that would not fall within CHIP cost-sharing rules.	At this time, MRMIB assumes state statute changes are needed to comply with this requirement. This determination will depend on CMS' evaluation of the current HFP dental benefits.

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	<p>CMS has issued a SHO Letter (CHIPRA #7; SHO #09-012) stating CMS' interpretation of the CHIPRA requirement that coverage must include "dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions." Orthodontia is required to the extent medically necessary to comply with this definition.</p>	
	<p>The SHO Letter further clarifies CMS' view that states with separate CHIP programs may comply with this requirement in two ways:</p> <ul style="list-style-type: none"> ▪ By defining the dental benefit package, including the amount, frequency and duration of services, and demonstrating that it includes all of the services required by CHIPRA. ▪ By providing a dental benefit package that is equivalent to one of three dental benchmark packages as follows: (1) the most 	<p>CMS has been contacting states that have been providing dental coverage to ascertain if the coverage satisfies CHIPRA requirements. MRMIB is in discussions with CMS.</p>

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<p>The law also requires the federal HHS Secretary to implement dental education for parents of newborns and strategies for increasing access to dental services, including the creation of online provider lists.</p> <p>The law requires reports on type of dental coverage provided by age.</p>	<p>frequently selected federal employee children’s dental coverage; (2) the most frequently selected state employee dependent dental coverage; or (3) the commercial dental coverage with the largest non-Medicaid dependent enrollment in the state.</p> <p>Complying with the reporting requirements may necessitate an encounter and claims-based data system for dental coverage. MRMIB does not currently have such a system. Developing one would be a cost to the state. MRMIB may need to revise the measures dental plans report to ensure that the measures conform to the statute.</p>	<p>MRMIB is seeking clarification and confirmation from CMS</p>

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<p>Application of Prospective Payment System to CHIP Services Provided by FQHCs and RHCs (SEC 503).</p>		<p>Effective date is January 1, 2011 because state statute change is needed.</p>
<p>Requires the application of Medicaid’s prospective payment system (PPS) to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for CHIP services provided after October 1, 2009.</p>	<p>MC complies with this requirement by paying clinics an interim rate to account for the higher costs of the PPS system above the payment received from managed care plans and then conducting an audit to establish the final (PPS) rates.</p> <p>Presently, MRMIB contracts solely with managed care organizations. Existing plan contracts specify that they must pay FQHCs and RHCs as they do similar providers (similar requirement under Medi-Cal).</p> <p>The Board reviewed options for compliance and directed staff to build on the approach used by DHCS in the Medi-Cal program.</p>	<p>State statute change is needed since HFP statute currently authorizes only a managed care approach with rates limited by “Family Value Package” rules.</p>

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<p>The federal HHS Secretary will award \$5 million in grants to CHIP states for expenditures related to the transition to PPS rates for services provided by FQHCs and RHCs.</p>		<p>CMS just issued a grant application due 3/25/10; MRMIB staff is reviewing.</p>
<p>Mental Health and Substance Abuse Parity (SEC 502).</p>		<p>Effective date is October 1, 2010.</p>
<p>By making recently-enacted federal mental health parity laws applicable to CHIP, requires that if a state provides mental health or substance abuse services through CHIP, the financial requirements and treatment limitations for those benefits cannot be more restrictive than those for medical and surgical benefits.</p> <p>Provision of the benefits not optional if included in benchmark state selects.</p>	<p>This section requires that HFP eliminate caps on services for mental health and substance abuse services that are different than caps for physical health and clarify plan responsibilities for services to children with serious emotional disturbances. Clarification of plan responsibilities was controversial with plans which argued that it would increase plan costs. MRMIB does not believe the clarification would increase plan costs and asked that plans apprise MRMIB of any issues on an ongoing basis</p>	<p>MRMIB has concluded that statute changes are not needed to comply with this requirement and is currently reviewing recently-released parity regulations. Comments on the rule are due May 3, 2010.</p> <p>MRMIB has clarified in its plan contracts that the plans are responsible for ensuring that children with SED receive necessary covered services either through the county mental health delivery system or from the plans directly.</p> <p>MRMIB is also promulgating regulations eliminating benefit caps for mental health services and substance abuse treatment that do</p>

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		not exist for physical health services and will bring these emergency regulations to its Board in April 2010 for adoption.
Performance Bonuses (SEC 104).		Effective date is April 1, 2009.
<p>Includes new performance bonuses to encourage states to enroll more of the uninsured children who are already eligible for Medicaid.</p> <p>States that have simplified their enrollment procedures and increase enrollment of these children above a target level receive a federal payment for each extra child enrolled to help defray the added cost of successful outreach efforts. The size of the payment can vary from 15 to 62.5 percent of the per capita state Medicaid expenditures for children.</p> <p>Target levels are adjusted over time by growth in a state's child population plus 4 percentage points through 2009; 3.5 percentage points for 2010, 2011, and 2012; 3 percentage points for 2013, 2014 and 2015; and 2.5 percentage points in future years.</p>	<p>Eligibility for the bonuses requires states to have the simplified enrollment procedures in place for a full fiscal year in both Medi-Cal and CHIP. The state must meet 5 of 8 requirements in order to qualify for the performance bonus. CMS found that California did meet 5 of 8 requirements.</p> <p>Any bonus funds would apply only to Medi-Cal.</p>	<p>DHCS, in collaboration with MRMIB, submitted a request for the Performance Bonus. California did not receive funding because the increase in enrollment in HFP and Medi-Cal did not reach the level which warranted a bonus.</p>

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<p>Payment of the bonus during a child's presumptive eligibility period is contingent on the child's subsequent enrollment in Medicaid and will not include children covered at the state's option under the newly qualified immigrant expansion provisions.</p> <p>Beginning in federal fiscal year 2009, \$3.2 billion will be made available through a separate appropriation.</p>		
<p>Enhanced FMAP for Translation or Interpretation Services (SEC 201).</p>		<p>Effective date is April 1, 2009.</p>
<p>Provides an enhanced matching rate in CHIP (the higher of 75 percent or the sum of the enhanced FMAP plus 5 percent) and Medicaid (75 percent of the sum expended) for translation and interpretation services in connection with enrollment of, retention of, and use of services for families whose primary language is not English.</p>	<p>Interpretation and Translation Services</p> <ul style="list-style-type: none"> • MAXIMUS operates a call center in 11 languages and translates materials in up to 11 languages. • HFP plans translate materials into languages when their enrollment reaches certain thresholds. Providers must have interpreters available • DHCS translates the joint application into 11 languages. <p>CMS has opined that any translation or interpretation services that are paid for</p>	<p>MRMIB has implemented a new translation and interpretive services expenditure report submitted by the administrative vendor monthly. MRMIB will seek federal approval through a SPA in the near future.</p> <p>DHCS may be able to claim enhanced FMAP for application translation costs.</p>

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	<p>via capitation are ineligible.</p> <p>If CMS' opinion changes, there are also administrative costs to documenting the costs.</p>	
Express Lane Option (SEC 203).		Effective date is February 4, 2009
<p>Gives states the option of using relevant findings within a “reasonable” period as determined by the state from school lunch programs, WIC, and other public agencies when determining children’s eligibility for CHIP and Medicaid during initial determination of eligibility, re-determination, or both.</p> <ul style="list-style-type: none"> • To assist states with implementation, the law outlines enrollment procedures states can use to meet “screen and enroll” rules under the Express Lane option. The law also lays out evaluation and error rate procedures states must meet when implementing the Express Lane option; specifically, the error rate will not be applied to the entire CHIP or Medicaid population. • The law allows temporary enrollment in CHIP pending “screen and enroll” with CHIP 	<p>Express Lane agencies currently serve children at 185% of FPL or below, so most children would be Medi-Cal eligible rather than HFP eligible. Current express lane eligibility through the school lunch program is conducted only for new applications, not renewals. Other alternative Express Lane entities include the Food Stamp Program, the Women, Infants and Children (WIC) Program, and the Franchise Tax Board.</p>	<p>DHCS will conduct a cost benefit analysis to see if the potential high administrative costs for implementing the Express Lane option would be an effective avenue for increasing the enrollment of eligible uninsured children and increasing the retention of existing subscribers. The administrative costs include any forms redesign to explain Express Lane eligibility to applicants and beneficiaries and provide for an opt-out of Medicaid consideration; system redesign to track which applicants and beneficiaries had an aspect of eligibility determined by an Express Lane process; data matching between DHCS and the Express Lane Eligibility entity; and preparation and submission of reports to CMS on</p>

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<p>matching funds during this period. The law does not allow information from an Express Lane agency to be used to verify someone’s citizenship status or nationality.</p>		<p>Express Lane eligibility results.</p> <p>MRMIB will coordinate with DHCS if DHCS decides to implement this option.</p>
<p>Outreach Funding (SEC 201).</p>		<p>Effective date is April 1, 2009.</p>
<p>Allocates \$100 million for FFYs 2009 through 2013 for outreach and enrollment grants designed to increase enrollment in CHIP and Medicaid. 10% is set aside for outreach to Indians. The outreach campaigns are to be geared to rural areas and racial and ethnic populations. Funds can go to states, local governments and “other organizations</p> <ul style="list-style-type: none"> • Ten percent of the funding will be dedicated to a national enrollment campaign and ten percent to outreach grants targeting Native American children. The HHS Secretary will distribute the remaining (80%) of the funds to state and local governments and other organizations to conduct outreach campaigns. No entity shall be required to provide any matching funds as a condition for receiving the grant. 	<p>California was impaired in its ability to apply for funding given its inability to assure that all eligible children would be enrolled.</p>	<p>On September 30, 2009, CMS issued grant awards for outreach activities. Two California-based organizations received a total of \$717,044 in outreach grant funds for a two-year period (2010 and 2011). Also, two other national organizations were awarded a multi-state CHIPRA outreach grant that includes California, for a total of four.</p> <ul style="list-style-type: none"> • MRMIB and DHCS are collaborating with the CHIPRA grant awardees to develop a data sharing MOU to track the number of applications submitted by grantees and how many children are enrolled into either HFP or Medi-Cal.

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Summary of CHIPRA Provision	Impact on HFP	Important Dates and Action Items
Increased Outreach and Enrollment of Indians (SEC 202).		
Encourages states to take steps to provide for enrollment on or near Indian Reservations. Non-application of 10% limit on outreach and certain other expenditures.	California is limited in its ability to respond until such time as outreach and CAA funding is re-established.	

CHIPRA Impacts and Implementation Mandates

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Summary of CHIPRA Provision	Impact on HFP	Important Dates and Action Items
<p>Information Required for Inclusion in State Annual Report (SEC 401 & 402).</p>		<p>Effective date is April 1, 2009.</p>
<p>Requires a state to include in its annual report information on eligibility criteria, enrollment, retention, measures such as 12 month continuous eligibility, self-declaration, presumptive eligibility, denials, re-determination of eligibility, access to services and networks of care and care coordination using CAHPS survey, and premium assistance.</p> <p>The HHS Secretary will specify a standardized format. The law also provides \$5 million to improve "MSIS," the data system used by states to report on enrollment and eligibility in CHIP and Medicaid.</p> <p>Requires that states conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys annually and report results in their annual report. Allows a transition period of up to 3 reporting periods to transition to the reporting of such information.</p>	<p>CMS has provided states with a draft guidance letter on data required to be reported in the annual report. That draft indicates that CMS will set up a workgroup of CHIP states to develop questions that will provide meaningful information to address the new data requirements that include eligibility, enrollment and retention, CAHPS results and efforts to reduce the number of uninsured children as well as the voluntary reporting of the initial set of child health care quality measures.</p>	

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<p>Payment Error Rate Measurement (PERM) (SEC 601).</p>		<p>Law requires CMS to release regulations in August 2009.</p>
<p>Outlines requirements and timeline (within 6 months after CHIPRA enactment) for new Final Rule on PERM regulations (the regulations which require states to report on errors in claim payments and eligibility determinations). Also, the law states an enhanced FMAP rate of no less than 90% for PERM expenditures.</p> <p>States in the first application cycle under the interim Final Rule may elect to accept any PERM error rate already determined or instead be treated as if FFY 2010 or 2011 were the first fiscal year for which PERM requirements apply to the state.</p>	<p>CA was in the first cycle of audits and already received its results, which were exemplary.</p> <p>CA wants changes in PERM rules to establish different requirements for high performers.</p>	<p>CMS provided states with draft regulations on 07/13/09. MRMIB submitted comments on 9/22/09. CMS has not yet promulgated final regulations. MRMIB identified the following concerns:</p> <ul style="list-style-type: none"> • New PERM rules should allow states to utilize any existing state quality assurance programs in place as the mechanism to comply with PERM audits. This would provide an efficient, cost effective mechanism without having to develop duplicative services. • High performing PERM states should be rewarded with longer intervals between the required PERM audits. Lower performing states should be audited more frequently than those that have demonstrated they have implemented strong program control mechanisms, as evidenced

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Summary of CHIPRA Provision	Impact on HFP	Important Dates and Action Items
		by their high PERM scores (low error rates). MRMIB also collaborated with other states on written comments submitted to CMS by the National Academy for State Health Policy regarding the draft PERM regulations.

For a complete copy of the Children's Health Insurance Program Reauthorization Act (CHIPRA):

1. Go to <http://thomas.loc.gov/>
2. Search HR 2 (bill number)
3. Click on **Latest Major Action:** Became Public Law No: 111-3 [GPO: [Text](#), [PDF](#)]
4. Click on Continue to GPO site

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