Modifications to the Chairman's Mark of
The Children's Health Insurance Program Reauthorization Act of 2007

Improve funding for the territories under CHIP and Medicaid:

On Page 6 in **Section 104:**

-- Strike "would continue to be subject to the 50% match rate, but such expenditures would be matched with federal funds" on lines 4 – 6 of the second paragraph in the Explanation of Provision
-- Replace with "would be subject to the 90% federal match rate for the start-up expenses associated with such systems and the 75% federal match rate for the operation of such systems."

Delay effective date of CHIP contingency fund by one year:

On Page 16 **in Section 108.**
-- Strike "FY2008" on line 2 of the first paragraph and replace with "FY2009"
-- Strike "FY2009" on line 3 of the first paragraph and replace with "FY2010"
-- Strike "FY2008" on line 1 of the fourth paragraph and replace with "FY2009"

Technical correction to 2-year availability of allotments:

On Page 17 **in Section 109.**
-- Strike "FY2005" on line 1 of the first paragraph in the Explanation of Provision and replace with "FY2006"
-- Strike "FY2006" on line 2 of the first paragraph in the Explanation of Provision and replace with "FY2007"

Technical clarification: $100 million in grants for outreach and enrollment:

On Page 20 in **Section 201.**
-- Strike "each of" on line 4 of the first paragraph in the Explanation of Provision

Express Lane State Option:

On Page 24, before **Title III**, insert two new sections, 203 and 204, as follows:

Section 203. Option for states to rely on findings by an Express Lane agency to determine components of a child's eligibility for Medicaid or CHIP

Current Law

Medicaid law and regulations contain requirements regarding determinations of eligibility and applications for assistance. Generally, the Medicaid agency must determine the eligibility of each applicant no more than 90 days from the date of

application for disability-based applications and 45 days for all other applications. The agency must assure that eligibility for care and services under the plan is determined in a manner consistent with the best interests of the recipients.

In limited circumstances outside agencies are permitted to determine eligibility for Medicaid. For example, when a joint TANF-Medicaid application is used the state TANF agency may make the Medicaid eligibility determination, or the Secretary may enter into an agreement with a given state to allow the Social Security Administration (SSA) to determine Medicaid eligibility of aged, blind, or disabled individuals in that state.

Applicants must attest to the accuracy of the information submitted on their Medicaid applications, and sign application forms under penalty of perjury. 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 available benefits. Subsequent to initial application, states must request information from other federal and state agencies, to verify applicants' income, resources, citizenship status, and validity of Social Security number (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 also establish a Medicaid eligibility quality control (MEQC) program designed to reduce erroneous expenditures by monitoring eligibility determinations. State Medicaid overpayments made on behalf of individuals due to an error in determining eligibility may not exceed 3% of the State's total Medicaid expenditures in a given fiscal year. Erroneous excess payments that exceed the 3% error rate will not be matched with Federal Medicaid funds.

With regard to criteria for State Personnel Administration and Offices, current law requires each state plan to establish and maintain methods of personnel administration in accordance with the Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. States must assure compliance with the standards by local jurisdictions; assure that the U.S. Civil Service Commission has reviewed and determined the adequacy of state laws, regulations, and policies; obtain statements of acceptance of the standards by local agencies; submit materials to show compliance with these standards when requested by HHS; and have in effect an affirmative action plan, which includes specific action steps and timetables, to assure equal employment opportunity.

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 these circumstances, applications for SCHIP coverage must first be screened for Medicaid eligibility.

Under Medicaid presumptive eligibility rules, states are allowed to temporarily enroll children whose family income appears to be below Medicaid income standards for up to 2 months until a final formal determination of eligibility is made. Entities qualified to make presumptive eligibility determinations for children include Medicaid providers, agencies that determine eligibility for Head Start, subsidized child care, or the Special Supplemental Food Program for Women, Infants and Children (WIC). BIPA 2000 added several entities to the list of those qualified to make Medicaid presumptive eligibility determinations. These include agencies that determine eligibility for Medicaid or the State Children's health Insurance Program (SCHIP); certain elementary and secondary schools; state or tribal child support enforcement agencies; certain organizations providing food and shelter to the homeless; entities involved in enrollment under Medicaid, TANF, SCHIP, or that determine eligibility for federally funded housing assistance; or any other entity deemed by a state, as approved by the Secretary of HHS. These Medicaid presumptive eligibility rules for children also apply to SCHIP.

Explanation of Provision

The provision would create a three year demonstration program that would allow up to 10 states to use Express Lane at Medicaid and CHIP enrollment and renewal. The demonstration would provide $44 million for systems upgrades and implementation (not coverage costs) and $5 million for an independent evaluation of the demonstration at the end of three years and a report on the demonstration's effectiveness to Congress. The report would be due one year after completion of the demonstration.

The Demonstration would allow states the option to rely on a finding made by an Express Lane Agency within the preceding 12 months to determine whether a child under age 19 (or at state option age 20, or 21) 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 (including the waiver of requirements of this title).

If a finding from an Express Lane agency results in a child not being found eligible for Medicaid or CHIP, the State would be required to determine Medicaid or CHIP eligibility using its regular procedures. The provision does not relieve states of their obligation to determine eligibility for medical assistance under Medicaid, or prohibit state options intended to increase enrollment of eligible children under Medicaid or CHIP. In addition, the provision requires states to inform the families (especially those whose children are enrolled in CHIP) that they may qualify for lower premium payments or more comprehensive health coverage under Medicaid if the family's income were directly evaluated for an eligibility determination by the State Medicaid agency, and at the family's option they can seek a regular Medicaid eligibility determination.

The provision would allow States to rely on an Express Lane Agency finding that a child is a qualified alien as long as the Agency complies with guidance and regulatory procedures issued by the Secretary of Homeland Security for eligibility determinations of qualified aliens, and verifications of immigration status (that meet the requirements of Section 301 of this bill).

States that opt to use an Express Lane Agency to determine eligibility for Medicaid or CHIP may meet the CHIP screen and enroll requirements by using any of the following requirements: (1) establishing a threshold percentage of the Federal poverty level that is 30 percentage points (or such other higher number of percentage points) as the state determines reflects the income methodologies of the program administered by the Express Lane Agency and the Medicaid State plan, (2) providing that the child satisfies all income requirements for Medicaid eligibility, or (3) providing that such child has a family income that exceeds the Medicaid income eligibility threshold that serves as the lower income eligibility threshold for CHIP.

The provision would allow states to provide for presumptive eligibility under CHIP for a child who, based on an eligibility determination of an income finding from an Express Lane agency, would qualify for child health assistance under CHIP. During the period of presumptive eligibility, the State may determine the child's eligibility for CHIP based on telephone contact with family members, access to data available in electronic or paper format, or other means that minimize to the maximum extent feasible the burden on the family.

A State may initiate a Medicaid eligibility determination (and determine program eligibility) without a program application based on data obtained from sources other than the child (or the child's family), but such child can only be automatically enrolled in Medicaid (or CHIP) if the family affirmatively consented to being enrolled through affirmation and signature on an Express Lane agency application. The provision requires the State to have procedures in place to inform the individual of the services that will be covered, appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations created by the enrollment (if applicable), and the actions the individual must take to maintain enrollment and renew coverage. For children who consent to enrollment in the State plan, the provision would allow the State to waive signature requirements on behalf of such child.

States that participate in the Express Lane Eligibility Demonstration would not be required to direct a child (or a child's family) to submit information or documentation previously submitted by the child or family to an Express Lane agency that the State relies on for its Medicaid eligibility determination. A participating state may rely on information from an Express Lane agency when evaluating a child's eligibility for Medicaid or SCHIP without a separate, independent confirmation of the information at the time of enrollment.

An Express Lane agency must be a public agency determined by the State agency to be capable of making the determinations described in the provisions of this section and

is identified in the state plan under this title or Title XXI. Express Lane Agencies would include: (1) a public agency that determines eligibility for assistance under a State program funded under part A of title IV, a program funded under Part D of title IV a State child health plan under title XXI, the Food Stamp Act of 1977, the Head Start Act, the Richard B. Russell National School Lunch Act, the Child Nutrition Act of 1966, or the Child Care and Development Block Grant, the Steward B. McKinney Homeless Assistance Act, the United States Housing Act of 1937, the Native American Housing Assistance and Self-Determination Act of 1996, (2) a state specified governmental agency that has fiscal liability or legal responsibility for the accuracy of the eligibility determination findings, and (3) a public agency that is subject to an interagency agreement limiting the disclosure and use of such information for eligibility determination purposes.

Programs run through Title XX (SSBG) are not eligible Express Lane agencies. Private for-profit organizations are not eligible Express Lane agencies. Current law applies regarding the ability of Medicaid to contract with non-profit and for-profit agencies to administer the Medicaid application process with clarifying language that nothing in this demonstration exempts states from the merit-based system for Medicaid employees. A rule of construction would also clarify that states may not use the Express Lane option as a means of avoiding current merit-based employment requirements for Medicaid determinations.

In addition, the provision would require such agencies to notify the child's family (1) of the information that will be disclosed under this provision, (2) that the information will be used solely for the purposes of determining eligibility under Medicaid and CHIP, (3) that the family may elect not to have the information disclosed for such purposes. The Express Lane agency must also enter into or be subject to an interagency agreement to limit the disclosure and use of such information.

As part of the demonstration, signatures under penalty of perjury would not be required on a Medicaid application form attesting to any element of the application for which eligibility is based on information received from a source other than an applicant. The provision would provide that any signature requirement for a Medicaid application may be satisfied through an electronic signature.

States participating in the Demonstration will have to code which children are enrolled in Medicaid or CHIP by way of Express Lane for the duration of the demonstration. States must take a statistically valid sample, approved by CMS, of the children enrolled via Express Lane annually for full Medicaid eligibility review to determine eligibility error rate. States submit the error rate to CMS and if the error rate exceeds 3% either of the first two years, the state must show CMS what corrective actions are in place to improve upon their error rate and will be required to reimburse erroneous excess payments that exceed the allowable error rate of 3%. However, CMS does not have the authority to apply the error rate derived from the Express Lane sample to the entire Express Lane or Medicaid child population, or to take other punitive action against a state based on the error rate. States that participate in the Express Lane

demonstration will continue to be subject to existing requirements under Medicaid requiring states to reimburse erroneous excess payments that exceed the allowable error rate of 3% consistent with 1903(u).

Section 204. Authorization of certain information disclosure to simplify health coverage determinations

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 available benefits. Subsequent to initial application, states must request information from other federal and state agencies, to verify applicants' income, resources, citizenship status, and validity of Social Security number (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 also establish a Medicaid eligibility quality control (MEQC) program designed to reduce erroneous expenditures by monitoring eligibility determinations.

Explanation of Provision

The provision would authorize federal or State agencies or private entities with potential data sources relevant for the determination of eligibility under Medicaid (e.g., eligibility files, vital records about births, etc.) to share such information with the Medicaid agency if: (1) the child (or such child's parent, guardian, or caretaker relative) has provided advanced consent to disclosure, and has not objected to disclosure, (2) such data are used solely for the purpose of identifying, enrolling, and verifying potential eligibility for Medicaid medical assistance, and (3) an interagency agreement prevents the unauthorized use, disclosure, or modification of such data, and otherwise meets federal standards for safeguarding privacy and data security, and requires the State agency to use such data for the purposes of child enrollment in Medicaid. The provision would impose criminal penalties for persons who engage in unauthorized activities with such data.

For purposes of the Express Lane Demonstration only, the provision would also authorize the Medicaid and CHIP programs to receive data directly relevant to eligibility determinations and determining the correct amount of benefits under such program 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.

Technical Correction: Verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP

On Page 25 in **Section 301:**
-- Between "with" and "90" on line 5 on the second paragraph under Explanation of Provision, insert "an opportunity to cure the invalid determination with the Social Security Administration, followed by"

Additional State option for providing premium assistance

On Page 30 in **Section 401**, before the first full paragraph, insert the following:

Each state has the option to establish an employer/family premium assistance purchasing pool for employers with less than 250 employees who have at least one CHIP-eligible employee (pregnant woman) or child.

The state, or a state designated entity, will identify and offer access to not less than two privately delivered health products that meet the CHIP benefits benchmark.

States that provide ESI coverage to parents of targeted low-income children, would be permitted to offer a premium assistance subsidy to eligible parents in the same manner as that State offers such subsidy to eligible child(ren). The amount of the premium subsidy would be increased to take into account the cost of enrollment of the parent in the ESI coverage, or at state option, the cost of the enrollment of the child's family (if the states determines that it is cost-effective).

Child health quality improvement activities for children enrolled in Medicaid or CHIP

On Page 35 in **Section 501.**
-- Insert "including services to promote healthy birth and prevent and treat premature birth," after "acute conditions," in line 8 of the last paragraph on the page

On Page 38 in Subsection (d)
-- Strike "or" in line 7 of the first paragraph
-- Insert prior to the period at the end of line 8 ", or (4) demonstrate the impact of the model electronic health record format for children on improving pediatric health, including the effects of chronic childhood health conditions, and pediatric health care quality as well as reducing health care costs"

On Page 38:
--Insert new subsection (e) as follows:

Current Law

Greater awareness of the obesity crisis and its long-term social and economic implications has encouraged policy makers to fund an array of programs aimed at promoting physical activity and appropriate nutrition. While many of these have been state-based efforts, the federal government has actively funded obesity research as well as health promotion campaigns and public health surveillance systems.

Title III of the Public Health Service Act (42 USC) obliges the Secretary of Health and Human Services to "conduct… encourage, cooperate with, and render assistance to other appropriate public authorities, scientific institutions, and scientists in the conduct of, and promote the coordination of, research, investigations, experiments, and demonstrations, and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and impairments". In carrying out these responsibilities, the Secretary is authorized to make grants-in-aid to universities, hospitals, laboratories, other public or private institutions, and to individuals for research projects.

The National Academy of Sciences (NAS) recently noted that the fundamental problem plaguing national programs seeking to address the obesity crisis is that these efforts "remain fragmented and small-scale". Moreover, obesity prevention programs remain largely uncoordinated. Although many federal agencies are involved in overseeing different types of obesity-related programs, including the Centers for Disease Control and Prevention (CDC), the Department of Agriculture, the National Institutes of Health, and Department of Health and Human Services, NAS concluded that the lack of a dedicated funding stream for obesity prevention and inadequate coordination between federal agencies has led to inefficient uses of resources or unnecessary redundancies in programmatic efforts.

Another problem is that many federal funding streams available to support healthy lifestyles among children have been very narrowly focused on small target populations or they have only addressed obesity indirectly. Examples of the former include efforts which have exclusively targeted low-income families (usually, Medicaid recipients); by contrast, health education courses aimed at American Indians with Type 2 diabetes exemplify the types of federally-funded efforts which have indirectly served as obesity prevention programs but which have reached very limited numbers of individuals in the aggregate.

Explanation of Provision

The Secretary, in consultation with the Administrator of the Centers for Medicare and Medicaid Services, shall conduct a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity by awarding grants to eligible entities to carry out such a project. The model will (1) identify behavioral risk factors for obesity among children; (2) identify needed clinical preventive and screening benefits among those children identified as target individuals on the basis of such risk factors; (3) provide ongoing support to such target individuals and their families to reduce risk factors and promote the appropriate use of preventive and screening benefits;

and (4) be designed to improve health outcomes, satisfaction, quality of life, and appropriate use of items and services for which medical assistance is available under CHIP and Medicaid.

Eligible entities include a city, county, or Indian tribe; a local or tribal educational agency; an accredited university, college, or community college; a federally-qualified health center; a local health department; a health care provider; a community-based organization; or any other entity determined appropriate by the Secretary, including a consortium or partnership.

An eligible entity awarded a grant under this provision shall use the funds to (1) carry out community-based activities related to reducing childhood obesity, (2) carry out age-appropriate school-based activities that are designed to reduce childhood obesity, (3) carry out educational, counseling, promotional, and training activities through the local health care delivery systems, and (4) provide, through qualified health professionals, training and supervision for community health workers to engage in educational efforts related to obesity.

Not later than 3 years after the Secretary implements the demonstration project under this subsection, the Secretary shall submit to Congress a report that describes the project, evaluates the effectiveness and cost effectiveness of the project, evaluates beneficiary satisfaction under the project, and includes any other information the Secretary deems appropriate. $25 million is authorized for this purpose.

--Reorder existing subsections (e), (f), (g), and (h)

New Mental and Dental Health Provisions

On Page 48, before Title VII, insert two new sections, 607 and 608, as follows:

Section 607. Mental Health Parity in CHIP Plans

Current Law

In 1996, Congress passed the Mental Health Parity Act (MHPA) that established new federal standards for mental health coverage offered by group health plans, most of which are employment-based. Under provisions included in the 1997 Balanced Budget Act (P.L. 105-33), Medicaid managed care plans and SCHIP programs must comply with the requirements of MHPA.

Medicaid expansions under SCHIP follow Medicaid rules. Thus, when such expansions provide for enrollment in Medicaid managed care plans, the MHPA applies. Separate state programs under SCHIP follow SCHIP rules that have broader application than the Medicaid rules. In separate state SCHIP programs, to the extent that a health insurance issuer offers group health insurance coverage, which can include, but is not limited to managed care, the MHPA applies.

Under MHPA, Medicaid and SCHIP plans may define what constitutes mental health benefits (if any). The MHPA prohibits group plans from imposing annual and lifetime dollar limits on mental health coverage that are more restrictive than those applicable to medical and surgical coverage. Full parity is not required, that is, group plans may still impose more restrictive treatment limits (e.g., with respect to total number of outpatient visits or inpatient days) or cost-sharing requirements on mental health coverage compared to their medical and surgical services.

Under Medicaid managed care, state Medicaid agencies contract with managed care organizations (MCOs) to provide a specified set of benefits to enrolled beneficiaries. These MCOs may be paid under a variety of arrangements, but are frequently reimbursed on the basis of a pre-determined monthly fee (called a capitation rate) for each enrolled beneficiary. The contracted benefits may include all, some, or none of the mandatory and optional mental health services covered under the state Medicaid plan. When Medicaid managed care plans do not include all covered mental health benefits, these additional services are sometimes "carved out" to a separate, specialized behavioral health managed care entity (usually subject to its own prepaid capitation rates), or may be provided in the fee-for-service setting, in which Medicaid providers are paid directly by the state Medicaid agency for each covered service delivered to a Medicaid beneficiary. All prepaid Medicaid managed care contracts that cover medical/surgical benefits and mental health benefits must comply with the MHPA without exemptions. The MHPA does not apply to fee-for-service arrangements because state Medicaid agencies do not meet the definition of a group health plan.

With respect to covered benefits, separate SCHIP programs tend to look more like private insurance models than like Medicaid. That is, these programs are more likely to cover traditional benefits (e.g., inpatient hospital services, physician services) that would be found in employer-based health insurance plans than certain service categories that are largely unique to Medicaid (e.g., EPSDT, residential treatment facilities, intermediate care facilities for the mentally retarded or ICF/MRs, and institutions for mental disease or IMDs). Most separate SCHIP programs also provide services through managed care plans, although this situation varies by state.. Again, all or some covered mental health services may be included in MCO contracts, or carved out to specialized behavioral health managed care plans, or may be provided on a fee-for-service basis.

Under CHIP, states may provide coverage under their Medicaid programs (MXP), create a new separate SCHIP program (SSP), or both. Under SSPs, 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 benefit plans). Benchmark plans include (1) the standard Blue Cross/Blue Shield preferred provider option under FEHBP, (2) the coverage generally available to state employees, and (3) the coverage offered by the largest commercial HMO in the state.

Benchmark-equivalent plans must cover basic benefits (i.e., inpatient and outpatient hospital services, physician services, lab/x-ray, and well-child care including immunizations), and must include at least 75% of the actuarial value of coverage under the selected benchmark plan for specific additional benefits (i.e., prescription drugs, mental health services, vision care and hearing services).

Explanation of Provision

This section prohibits discriminatory limits on mental health care in separate CHIP plans by directing that any financial requirements or treatment limitations that apply to mental health or substance abuse services must be no more restrictive than the financial requirements or treatment limits that apply to other medical services. It also eliminates a current law provision that authorizes states to reduce the mental health coverage provided to 75 percent of the coverage provided in CHIP benchmark plans.

Section 608. Dental Health Grants

Current Law

Under SCHIP, states may provide coverage under their Medicaid programs (MXP), create a new separate SCHIP program (SSP), or both. Under SSPs, 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 benefit plans). Benchmark plans include (1) the standard Blue Cross/Blue Shield preferred provider option under FEHBP, (2) the coverage generally available to state employees, and (3) the coverage offered by the largest commercial HMO in the state.

Benchmark-equivalent plans must cover basic benefits (i.e., inpatient and outpatient hospital services, physician services, lab/x-ray, and well-child care including immunizations), and must include at least 75% of the actuarial value of coverage under the selected benchmark plan for specific additional benefits (i.e., prescription drugs, mental health services, vision care and hearing services).

SCHIP regulations specify that, regardless of the type of SCHIP health benefits coverage, states must provide coverage of well-baby and well-child care (as defined by the state), age-appropriate immunizations based on recommendations of the Advisory Committee on Immunization Practices (ACIP), and emergency services.

Explanation of Provision

This section provides up to $200 million in federal grants for states to improve the availability of dental services and strengthen dental coverage for children covered under CHIP. States that receive grants would be required to maintain prior levels of spending for dental services provided under CHIP.

Section 801. Effective date

Page 49
-- Insert “except with respect to section 301” after “bill” in the first sentence
-- Add a new last sentence, “With respect to section 301, the effective date will be October 1, 2008.”