The Children's Health and Medicare Protection Act (CHAMP ACT)

Bill Summary

I. PROTECTING CHILDREN'S HEALTH

Ensures States will have predictable funding streams that track projected children's health needs:

- Each State will receive a CHIP allotment for FY08 based on spending estimates submitted by the State to the Secretary of Health and Human Services in 2007 increased by two factors: national health care cost increases and State population growth. Annual State allotments will grow by these two factors each year.
- States will have two years to spend each year's annual allotment. In addition, every two years, State allotments will be recalibrated to ensure funding meets children's needs.
- States that experience a shortfall due to enrollment of children who are today eligible but not enrolled, will receive an enrollment adjustment equal to the federal share of State's average per capita cost per child.

Best Practices performance bonus: States that implement 4 out of 6 outreach and enrollment "best practices" and enroll new children who are currently eligible for coverage but not enrolled, would receive a "performance bonus". Best practices include:

full year enrollment
presumptive eligibility
administrative renewal
state flexibility in asset determinations
elimination of in person interviews
joint SCHIP/Medicaid application

Protecting CHIP for Children: The CHIP statute only provides for coverage of "targeted low-income children." The bill maintains current law regarding eligibility for CHIP, with one exception that States would have the option to cover pregnant women.

Child-Centered Benefits:

- Children are assured coverage of dental care under CHIP.
- Mental health care is treated equally with physical health care under benchmark benefits packages.
- States can provide such coverage through multiple delivery arrangements including an HMO, PPO, or other arrangement.
- The Secretary's authority to approve "alternate" benefits packages is limited by requiring that any alternate benefit design meet or exceed existing benchmark coverage.

Quality Measures/Commission: HHS is required to establish a pediatric health quality program working with pediatric providers, children's advocates, and other experts on children's health care to develop child-centered quality and program performance measures. A new independent Commission (CAPE), the Children's Access, Payment and Equality Commission, modeled after the Medicare Payment Advisory Commission, is established to monitor children's access to care and services, and adequacy of provider payment under both CHIP and Medicaid. The Commission will also examine issues of health disparities and underserved areas.

Protections for Safety Net Providers: Federally Qualified Health Centers (FQHCs) and rural health centers (RHCs) services are guaranteed for children in CHIP and the current payment system in Medicaid is applied.

New State Flexibility for Coverage of Children and Pregnant Women: States are allowed to cover pregnant women and older children, as well as legal immigrant children and legal immigrant pregnant women, who otherwise meet the requirements for coverage under CHIP. States are given a new option to cover family planning services without a waiver.

II. MEDICARE BENEFICIARY IMPROVEMENTS

Invests in improvements for Medicare beneficiaries that include:

- **New preventive benefits:** Provides Medicare with the authority to use the recommendations of the US Preventive Health Services Task Force to add new preventive health benefits without Congressional approval.

- **Eliminates cost-sharing for preventive benefits:** Eliminates co-insurance and waives deductible for current preventive benefits and preventive benefits added in the future through the process outlined above.

- **Mental health:** Reduces Medicare's discriminatory 50% co-payment on mental health outpatient services to the standard 20% co-payment over a period of 6 years and adds additional mental health providers to Medicare so that services are more widely available.

- **Low-Income protections:** Expands and improves the Low Income Subsidy (LIS) program for drugs and the Medicare Savings Programs (MSP), which help ensure affordable health care for seniors and people with disabilities with lower incomes.

  Expands Income Eligibility: Improves the Medicare Savings Programs by making the Q1 program, which pays premiums for low-income seniors, permanent and increasing eligibility to 150% of poverty.
  Improves Assets Tests: Increases the allowable resource amounts under both the MSP and LIS assets tests to $17,000 and increases them annually thereafter.
  Education & Outreach: Enhances outreach and education for the LIS and MSP, including simplified applications and using the Social Security Offices to educate beneficiaries about the Medicare Savings Programs, and requires translation of model MSP form in 10 languages.
  Consumer Protections. Eliminates the Part D late enrollment penalty for Low Income Subsidy eligible individuals and guarantees continuous open enrollment for LIS eligible individuals.

- **Reducing Health Disparities:** Requires CMS to collect data necessary to better track and address racial and ethnic disparities in Medicare. Creates two new demonstrations to 1) test methods for Medicare reimbursement for Limited English Proficiency services and 2) provide additional outreach and support for Medicare beneficiaries who were previously uninsured. Directs the HHS Inspector General to issue a report on Medicare provider and plan compliance with Culturally and Linguistically Appropriate Services (CLAS) standards.

- **Consumer protections:** Allows beneficiaries to change drug plans if their drug plan formulary changes during the year. Codifies the requirement that Part D plans cover all or substantially all drugs in six important therapeutic classes of drugs. Eliminates the prohibition on coverage of benzodiazepines.

III. MEDICARE PHYSICIAN PAYMENT REFORM

Stabilizes physician reimbursement by eliminating the impending 2008 and 2009 fee cuts (projected to be -10 percent and -5 percent, respectively) and putting in place a positive 0.5 percent update in both 2008 and 2009.

Establishes parameters for fixing the physician reimbursement system by making changes to the existing system, such as removing several broken components of the SGR and investing new resources into primary care and preventive services. Further, the bill establishes mechanisms to provide feedback to physicians on how their practice patterns compare with their peers and gives CMS additional tools to assure that Medicare's prices are accurate. The bill also initiates a nationwide demonstration project to test the practice of providing a medical home for patients in which their personal

physician is paid to coordinate their care. Combined, these policies lay the foundation for a future reimbursement system that promotes quality of care and maximizes efficiency.

IV. MEDICARE ADVANTAGE REFORM

Equitable Payments to Medicare Advantage (MA) Plans:

Equitable payment transition: Phases out MA overpayments over four years to 100% of FFS in 2011. Phase-out is based on a blend of the current county benchmarks adjusted for the applicable year and 100% of county FFS costs in the projected year. There is no change in 2008; in 2009 the benchmarks will be a blend of 2/3 current benchmark and 1/3 100% of FFS for the county, in 2010 the blend moves to 1/3 current benchmark and 2/3 FFS, and starting in 2011 benchmarks will be 100% of FFS.

Enrollment limitations: Plans that fail to bid below the phased down benchmarks in their counties during the transition to equitable payment will be prohibited from enrolling new members in that year.

Repeals MA Stabilization Fund: Completes the full repeal of the regional PPO stabilization fund created in the Medicare Modernization Act to provide incentive payments to certain types of private plans.

Beneficiary Protections: Develops a Federal/State system to regulate private plan marketing and other activities, improve beneficiary protections, and provide more information about plan spending on health care services. Prohibits private plans from charging higher cost-sharing than FFS Medicare. Requires plans to meet minimum requirements regarding level of spending on medical benefits (versus administrative costs, overhead or profit).

Quality Improvements: Requires all private plans to report quality data to CMS in order to measure quality of care. Develops new data to assess disparities in health care for racial and ethnic minorities. Reinstates annual report on plan efforts to reduce disparities.

Extends Authority for Special Needs Plans (SNPs): Extends Dual Medicare-Medicaid SNPs and Institutional SNPs for three years with new requirements to assure that they are enrolling their target populations.

V. RURAL HEALTH IMPROVEMENTS

Preserves payment equity for rural Medicare fee-for-service providers. The bill extends otherwise expiring provisions in law that, if left unchanged, would negatively affect rural beneficiaries' access to physicians, hospitals, home health, ambulance services, and lab services.

VI. MEDICARE PART A

Taking into account recommendations from the non-partisan Medicare Payment Advisory Commission, the bill refines payments for a variety of institutional providers including skilled nursing facilities, rehabilitation facilities, long-term care hospitals, cancer hospitals and rural and small urban hospitals.

VII. MEDICARE PART B

Updates Medicare coverage policy for a range of providers. Improvements include: continuing the therapy cap exceptions process and planning for an improved payment system; improving coverage for speech language pathologists, nurse midwives, marriage and family therapists, mental health counselors; and assuring access to clinical social workers for beneficiaries in nursing homes. Ends the ability of physicians to refer to hospitals in which they have ownership. Reduces rental period for oxygen equipment, and eliminates first month purchase of wheelchairs. Provides patient-education services for pre-dialysis beneficiaries, puts quality programs in place, and modernizes the ESRD payment system.

VIII. OTHER MEDICARE PROVISIONS:

Establishes a comparative effectiveness program to provide the information doctors and patients need to choose the best treatments, leading to better health outcomes and value nationwide. Requires the Medicare agency to design a program to require adoption of an interoperable open source health information technology system for all Medicare providers. Ends a provision from the Medicare Modernization Act designed to arbitrarily limit Medicare's funding.

IX. MEDICAID

Protections for Children With Disabilities: Maintains access to school-based services and rehabilitation services for children with severe disabilities is maintained.

Transition from Welfare to Work: Extends for two years the Transitional Medical Assistance program (TMA), which is scheduled to sunset at the end of September.

Option for Family Planning: Provides States a new option to offer family planning services to women.

Adult day health care: Protects beneficiaries who currently receive adult day health care from having that care terminated.

Puerto Rico: Increases resources for Puerto Rico and the U.S. Territories for Medicaid and provides additional funding for data programs in those areas.

Medicaid Drug Rebate: Increases the rebate provided from drug manufacturers to the Medicaid program by 5%.

X. REVENUES

Establishes a new $ .45 Federal tax on tobacco products.

Exempts fuel excise taxes for ambulance fuel.