



Center for Medicaid, CHIP and Survey & Certification

CMCS Informational Bulletin

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SUBJECT: Recent Developments in Medicaid and CHIP Policy

This CMCS Informational Bulletin is intended to provide a series of operational policy clarifications regarding our work implementing the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 and the Affordable Care Act of 2010. We hope you will find this information helpful as you administer these critical health coverage programs.

Further Clarification on CHIPRA Performance Bonuses

In our CMCS Informational Bulletin dated March 3, 2011, we provided information regarding the criteria needed to meet the program feature --"Liberalization of Asset Tests" -- for purposes of the Fiscal Year 2011 CHIPRA Performance Bonuses. As you know, the purpose of the Performance Bonuses is to encourage States to remove barriers that prevent eligible children from enrolling in and retaining coverage. In our previous Bulletin, we indicated that in order to qualify for this program feature, States would be required to liberalize the asset test for all Medicaid categories for which being a child is a condition of eligibility (including the section 1931 family coverage group under which parents can be eligible as well as children). Although one of the most effective ways to ensure that children are enrolled in coverage is to remove the asset test for the whole family, it was brought to our attention that States may have mechanisms in place where, even if there is an asset test for the 1931 group, children's access to coverage is not impaired.

CMCS has determined that, for purposes of CHIPRA Performance Bonuses, States will not be required to remove the asset test for the 1931 eligibility group as long as the State can demonstrate that all children who are income eligible for Medicaid can be enrolled in one of the State's eligibility categories that does not include an asset test and, therefore, will not be denied eligibility due to an asset test. States may be able to qualify for this program feature if they submit documentation to show that as of April 1, 2011, children in families that do not qualify under section 1931 due to assets are placed into another eligibility category and enrolled without requiring further action on the part of the family.

We have also determined that States will not be required to liberalize the asset test for the medically needy eligibility group for children, the group of “Katie Beckett” children eligible under 1902(e)(3) of the Act, and children eligible under section 1902(a)(10)(A)(ii)(XIX), as created by the Family Opportunity Act.

To recap, for FY2011, the asset test must be eliminated or self-declaration of assets must be accepted without the family’s verification for all children enrolled in CHIP and children enrolled in Medicaid as poverty-related children, Qualified Children, AFDC-related reasonable classifications of children, non-IV-E State subsidized adoption children, optional targeted low-income children, and independent foster care adolescents.

As always, States should submit a State Plan Amendment (SPA) to eliminate the asset test for any eligibility category. These may be in State Plan Attachment 2.2-A, State Plan Attachment 2.6-A, and/or supplements to State Plan Attachment 2.6-A, as appropriate. States that choose to liberalize the asset test by using self-declaration or administrative verification of assets should submit supporting documentation of this change with their FY2011 Performance Bonus Application, but a SPA is not required.

States considering applying for a FY 2011 Performance Bonus are encouraged to contact Dena Greenblum of the Children and Adults Health Programs Group at 410-786-8684 or via email at CHIPRABonusPayments@cms.hhs.gov before April 1, 2011 to ensure that all documentation is in order. We hope this clarification will be helpful.

Coverage of Freestanding Birth Centers

We also wanted to provide States with information regarding section 2301 of the Affordable Care Act, which ensures Medicaid coverage of care provided in freestanding birth centers. Section 2301 requires States that recognize freestanding birth centers to provide coverage and separate payments for freestanding birth center facility services and services rendered by certain professionals providing services in a freestanding birth center, to the extent the State licenses or otherwise recognizes such providers under State law. This provision took effect upon enactment of the Affordable Care Act on March 23, 2010, for services furnished on or after that date, unless State legislation is required.

States will need to submit amendments to their Medicaid State plans that specify coverage and separate reimbursement of freestanding birth center facility services and professional services in order to comply with this provision. Questions regarding this information may be directed to Ms. Linda Peltz, Director of the Division of Benefits and Coverage at 410-786-3399 or via email at Linda.peltz@cms.hhs.gov. As always, CMS Regional Office staff are available to assist States in submitting the appropriate State plan changes.

Dental Services in FQHCs

Section 501(d) of CHIPRA added a new section 1902(a)(72) of the Social Security Act, which provides that a State may not prevent a Federally-Qualified Health Center (FQHC) from entering into contractual relationships with private practice dental providers in the provision of FQHC services. Section 501(d) also amended section 2107(e)(1)(B) of Title XXI by applying this same requirement to CHIP. Following are several questions and answers regarding this provision.

Question 1: How does section 501(d) affect State Medicaid and CHIP programs?

Answer 1: This section removes potential barriers to FQHCs contracting with private dental providers to furnish Medicaid and/or CHIP-covered FQHC services. In the past, some State Medicaid agencies may have required dental providers who contracted with FQHCs to individually enroll in the Medicaid program. This is no longer permissible under the statute. However, States may set standards that are generally applicable to all dental providers and dental services furnished under the Medicaid and CHIP State plan, such as quality standards, but must allow FQHCs to contract with qualified providers who meet such standards.

Question 2: How will this provision be implemented?

Answer 2: Dental services furnished off-site by private dental providers who contract with FQHCs will be covered by Medicaid and CHIP as FQHC services when those dental services are of the type that would be covered if provided on-site at the FQHC. Payment for such services should be made to the FQHC in accordance with the State plan. This CHIPRA requirement will help to ensure dental access for individuals enrolled in CHIP and Medicaid.

Question 3: What is the Health Resources and Services Administration’s (HRSA) role and responsibility regarding the FQHC program?

Answer 3: FQHCs are defined in section 1905(l)(2)(B) of the Act. To qualify as an FQHC, an organization must meet one of the following criteria:

- Receive a grant under section 330 of the Public Health Service Act,
- Be designated as meeting the statutory requirements to receive a grant under section 330 (commonly known as a “Look-Alike”); or
- Be an outpatient health program or facility operated by a tribal or urban Indian organization.

HRSA is responsible for administering the FQHC program for those organizations that qualify under the section 330 grant program of the Public Health Service Act and the Look-Alike program. In this role, HRSA is responsible for assuring that section 330 grantees and Look-Alikes meet all the same statutory requirements. HRSA performs its program oversight role in a similar manner for both types of entities.

Questions or concerns regarding HRSA's program requirements, including those regarding FQHC contract arrangements with providers, should be referred directly to oppdgeneral@hrsa.gov or to Ms. Tonya Bowers, Director, Office of Policy and Program Development, Bureau of Primary Health Care, HRSA, who may be reached at (301) 594-4300.

Model Interstate Coordination Process for Medicaid and CHIP

Section 213 of CHIPRA also required that by August 4, 2010, CMS develop a model process designed to coordinate Medicaid and CHIP enrollment, retention and access to care for children who frequently change their State of residence. The Secretary is required to submit a Report to Congress describing additional steps or authority needed to make such further improvements to coordinate the enrollment, retention and coverage under CHIP and Medicaid for such children.

In July 2010, CMCS released a proposed model process for interstate coordination based on consideration of comments received in response to the notice published in the *Federal Register* on December 18, 2009, information included in the 2006 Report to Congress entitled "*Studies Regarding Barriers to Participation of Farm Workers in Health Programs*," and information gathered from States and the CMS Tribal Technical Advisory Group. This process has not been finalized and we are very interested in States' and other stakeholders' feedback on the proposed model.

Proposed Model for Interstate Coordination

Host State Activities

The Host State is the State where a Medicaid or CHIP eligible individual arrives seeking coverage of medical care. Upon such a request, the Host State will confirm eligibility in the Home State, and upon receipt of confirmation, issue a Guest Card to the individual and notify the Home State of the individual's guest status and current address. The Host State will enroll the individual through its Medicaid Management Information Systems (MMIS) with a guest status, including a code that identifies the Home State. The individual will be able to use the Guest Card to access any services covered by the Host State, subject to the Host State's limitations and requirements, from any provider enrolled with the Host State. The Guest will be exempt from enrollment in any managed care plans or benchmark plans.

Home State Activities

The Home State must confirm eligibility for the Host State, and upon notification from the Host State of individual's guest status, change mailing address for the individual on the eligibility file and place the individual in a suspense status. The individual should be disenrolled from any managed care plans or benchmark plans, unless the benchmark plan will provide coverage in the Host State. The Home State remains responsible for eligibility for the individual while out of State, including performing redeterminations at scheduled intervals.

Federal Financial Participation (FFP)

The Host State will be reimbursed at 100 percent for services provided to Guests. CMS will adjust the federal matching payment to the Home State by an amount equal to the Home State's share of services that were provided to its beneficiaries as Guests.

Eligibility Verification

The timely and efficient exchange of eligibility data is fundamental to this model. There are several ways in which eligibility can be verified and data can be exchanged, however, these methods vary widely with respect to their efficiency and reliability. As could be expected, the methods that can be implemented most quickly and inexpensively will most likely prove to be the least efficient, and those that require greater investment of resources will be more efficient and reliable. The Report to Congress will explore a range of potential eligibility verification methods.

As we develop the Report to Congress, CMCS encourages stakeholders to provide feedback regarding the viability of the model coordination process, especially:

- Suggestions for improvement of the proposal;
- Identification of CMS policy decisions that must be made in order to put the process in place, such as:
 - o the length of time allowed for an individual to be a “guest” in another State
 - o whether to require Host States to cover all benefits available under the State plan or just mandatory benefits, and
 - o whether to allow all eligible individuals to be a “guest” in another State or if this policy should only apply to mandatory groups; and
- Identification of implementation issues or major impediments, including statutory, regulatory, and/or systems changes that may be needed both for CMS and the States.

The full proposal is available at

<http://www.cms.gov/CHIPRA/Downloads/InterstateCoordination.pdf>

Please contact Rebecca Bruno of the Division of Eligibility, Enrollment and Outreach at (410) 786-5568 or via email at Rebecca.Bruno@cms.hhs.gov with feedback and suggestions.

\$55 Million Awarded in Grants to Further Children’s Quality Measurement

On March 1, 2011, the Agency for HealthCare Research and Quality (AHRQ) awarded cooperative grants to seven AHRQ-CMS *CHIPRA Centers of Excellence in Pediatric Quality Measures*. These Centers are part of the CHIPRA required Pediatric Quality Measures Program (PQMP) and will: (1) test and refine the initial core set of measures to make them more broadly applicable to Medicaid, CHIP, and other programs; and (2) develop additional quality measures that address dimensions of care where standardized measures do not currently exist. The measures developed by the Pediatric Quality Measures Program will be considered for the improved CHIPRA core measure set which will be made publically available by January 1, 2013.

The *Centers of Excellence* awardees are:

1. Gary Freed - Quality Measurement, Evaluation, Testing, Review, and Implementation Consortium, University of Michigan-Ann Arbor (Ann Arbor, MI)
2. Lawrence Kleinman - Mount Sinai Collaboration for Advancing Pediatric Quality Measures, Mount Sinai School of Medicine (New York, NY)

3. Mark Schuster - Children's Hospital Boston Center of Excellence for Quality Measurement/Harvard Medical School (Boston, MA)
4. Jeffrey Silber - Children's Hospital of Philadelphia Center of Excellence/University of Pennsylvania School of Medicine (Philadelphia, PA)
5. Sarah Hudson Scholle - National Collaborative for Innovation in Quality Measurement – National Committee for Quality Assurance (Washington, D.C.)
6. Rita Mangione-Smith - Center of Excellence on Quality of Care Measures for Children with Complex Needs – Seattle Children's Institute (Seattle, WA)
7. Ramesh Sachdeva – Pediatric Measurement Center of Excellence, Medical College of Wisconsin/National Outcomes Center (Milwaukee, WI)

A total of \$55 million will be awarded to the *Centers of Excellence* over a period of four years. For additional information on the CHIPRA AHRQ-CMS *Centers of Excellence*, visit: <http://www.ahrq.gov/chipra/pqmpfact.htm>

We hope you will find this information helpful. Thank you for your commitment to these critical health coverage programs.