



Center for Medicaid and State Operations

SHO # 09-015
CHIPRA #10

December 16, 2009

Re: CHIPRA Performance Bonus Payments

Dear State Health Official:

On February 4, 2009, the President signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3. The law contains provisions that directly affect both the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act (the Act) and the Medicaid program under title XIX of the Act. Under CHIPRA, States will be able to strengthen their existing programs and provide coverage to additional low-income, uninsured, children, and pregnant women. The purpose of this letter is to provide guidance on the new sections 2105(a)(3) and (4) of the Act which provides Performance Bonus Payments (Bonus Payments) for Federal fiscal year (FY) 2009 through FY 2013 to help States offset the costs of increased Medicaid child enrollment.

The Centers for Medicare & Medicaid Services (CMS) is providing initial guidance on this new provision as we release the bonus payments for FY 2009. We look forward to working with States in future years to determine if they qualify for the Bonus Payment, and will continue to encourage States to submit information to conduct a determination even if they are not certain they qualify.

Explanation of Bonus Payments (Section 2105(a)(3) and (4)) of the Act

The Performance Bonus provides added Federal funding for qualifying States that have increased Medicaid enrollment of children above a baseline level. To qualify during a Federal fiscal year, a State must be implementing during the year at least five of eight program features that simplify the application and renewal process. The goal is to encourage and assist States in reaching and enrolling more uninsured children who are eligible for Medicaid. The children that count towards the Bonus Payment are children enrolled in Medicaid who meet eligibility criteria in effect on July 1, 2008. These qualifying children include children enrolled in CHIP-funded Medicaid expansion programs.

The eight program features, which are described in more detail in Appendix I, are:

1. Continuous Eligibility
2. Liberalization of Asset (or Resource) Requirements
3. Elimination of In-Person Interviews
4. The Same Application and Renewal Process for Medicaid and CHIP
5. Automatic/Administrative Renewal

6. Presumptive Eligibility for Children
7. Express Lane
8. Premium Assistance

U.S. Commonwealths and Territories are eligible to receive Bonus Payments, to the extent that the Department of Health and Human Services has determined that there are satisfactory methods for reporting and collecting reliable data regarding the Medicaid enrollment of children in the Commonwealth or Territory. CMS is working with the individual Commonwealth and Territories to establish reliable data collection methods.

Qualifying for Receipt of Bonus Payments – Implementing the Five of Eight Program Features

To qualify for a Bonus Payment for a fiscal year, a State must be implementing at least five of the eight program features throughout the Federal fiscal year for which the Bonus Payment will be made. Because we recognize that implementation is a multi-faceted process, we intend to issue regulations to provide further guidance on the parameters under which a State will be considered to have implemented a program feature.

For FY 2009, we will consider a State to be qualified for a Bonus Payment when five of the eight program features have been operational at least as of April 1, 2009 (when this provision of CHIPRA became effective), and through the end of the Federal fiscal year on September 30, 2009. For FFY 2010, the State must undertake a process to implement at least five of the eight program features that meet the following milestones:

- Any required State legislation, if applicable, is effective on or before the start of the Federal fiscal year (October 1st) for which a Bonus Payment is being made; and
- Five of the eight program features are operational for a minimum of 6 months during the first fiscal year for which the Bonus Payment is being made; and are still in effect on September 30 of that fiscal year.

If a State is implementing a new program feature that requires a State plan amendment (SPA), it should note that the SPA should be submitted and approved in time to ensure that the program feature at issue is actually operational for the 6-month period.

CMS Procedures for Acting on Requests for Bonus Payments

The CMS will make determinations that a State is qualified for a Bonus Payment based on timely requests by States containing needed information. CMS has previously provided information directly to States regarding their requests for 2009 Bonus Payments. In future years (2010-2013), CMS will act on requests received no later than November 1 following the end of the fiscal year for which the Bonus Payment is being requested. For example, requests for Bonus Payments with respect to FY 2010 should be submitted no later than November 1, 2010, following the end of the fiscal year on September 30, 2010. The request should specify which of the eight enrollment and retention program features qualifies the State for the payment, identify the sections and pages of the approved State plan authorizing the program feature, if applicable,

and, where necessary, provide supporting documentation for a program feature that may not be addressed in the State plan.

The CMS intends to use the chart in Appendix III to document the determinations made for those States requesting Bonus Payments. CMS will record the relevant information from State submissions and maintain the chart for determinations that were completed. States are encouraged to populate this chart with the information required above and to submit the information to CMS with their request for a determination of qualification for a Bonus Payment.

Submitted State materials will be reviewed and evaluated by CMS. CMS intends to make the determination of whether the State requesting a payment meets the required conditions by December 1 of each year. The State should provide as much information as possible to allow CMS to accurately evaluate the State's qualification for a Bonus Payment. A list of the States making such requests and the program features that constitute the basis for the request will be posted on the CMS Web site. After CMS determines which States qualify under the "five out of eight" requirement, CMS will notify each State and publish a list of the States that qualify on the CMS Web site.

Determining Whether a State Meets the Enrollment Target and Calculation of Bonus Payments

Once CMS has determined that a State meets the five out of eight requirement, as discussed above, we will determine whether the State qualifies for a Bonus Payment based on enrollment and, if so, the amount of the State's Bonus Payment. These determinations are calculated with respect to certain State-specific "baseline" information relating to the State's Medicaid (title XIX) enrollment and per capita expenditures for children. In particular, the baseline enrollment for a State for FY 2009 is based on the monthly average unduplicated number of "qualifying children" enrolled in the State plan under Medicaid during FY 2007. This amount is then adjusted forward to the fiscal year for which the Bonus Payment is being made (that is, for example, to FY 2009 for purposes of the FY 2009 Bonus Payment) based on the percentage change (either positive or negative) in the population growth for children in the State from FY 2007 to FY 2009. An additional adjustment factor (set out in the statute, by CHIPRA) is added to arrive at the baseline enrollment level (see Appendix II for a detailed explanation).

A State will qualify for a Bonus Payment if its enrollment exceeds the baseline enrollment level for the fiscal year. Bonus payments are two-tiered based on the level of the State's enrollment increase above the baseline. The first-tier Bonus Payment amount is calculated by multiplying the State-specific per capita amount by the amount the current Medicaid child enrollment exceeds the baseline child enrollment for the fiscal year; this enrollment amount is limited to no more than 10 percent of the baseline enrollment amount for the fiscal year. The second-tier Bonus Payment amount is available for States that have increased enrollment by more than 10 percent above the baseline enrollment level for the fiscal year.

The CMS will identify, obtain, and validate the data elements needed to calculate the Bonus Payment for each qualifying State (CMS is currently working with States on the FY 2009 data calculations). Payments to qualifying States will be made by December 31 of the calendar year following the end of the fiscal year for which the criteria was implemented. The Bonus

Payments will be provided to a State through the issuance of a grant award; a State will be able to access these funds through the Payment Management System.

Additional information on the process for determination of the Bonus Payment, including the identification and validation of data elements, and associated timeframes for FY 2009 is found in Appendix II – Bonus Payments for FY 2009. CMS will use the same processes and validation of data elements in FY 2010-2013, provided the anticipated process and results are successful for FY 2009. CMS will provide additional guidance on these and other issues related to the performance bonus payments in forthcoming regulations.

States with questions about the calculation of the Bonus Payment or the process explained in Appendix II can contact Mr. Richard Strauss of the CMS Financial Management Group for additional information or assistance. Mr. Strauss' contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
Mail Stop S3-13-15
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: 410-786-2019
E-mail: Richard.Strauss@cms.hhs.gov

We look forward to working with States in this initial year of implementation and in the future. If you have questions regarding this guidance please send an e-mail to CMSOCHIPRAquestions@cms.hhs.gov or contact Ms. Maria Reed, Deputy Director, Family and Children's Health Programs Group, who may be reached at (410) 786-5647.

Sincerely,

/s/

Cindy Mann
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
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APPENDIX I – Program Features for Bonus Payment Qualification

- 1) **Continuous Eligibility in both Medicaid and CHIP** – Continuous eligibility assures coverage to a child for 12 months, regardless of changes in circumstances other than the situations identified below:
 - a) The child is no longer a resident of the State.
 - b) The death of the child.
 - c) The child reaches the age limit.
 - d) The child/representative requests disenrollment.
 - e) A child who is enrolled in a separate CHIP program files a Medicaid application, is determined eligible for Medicaid, and is enrolled in Medicaid without a coverage gap.

The option to provide continuous eligibility for Medicaid is described in section 1902(e)(12) of the Act. Continuous eligibility is not specifically defined under CHIP (title XXI of the Act). A State with separate CHIP programs that chooses to implement the option of continuous eligibility to qualify for a Bonus Payment must follow the procedures described in section 1902(e)(12) of the Act. CMS will address the definition of continuous eligibility under title XXI in forthcoming regulations. Pending further guidance regarding the interaction of premium payment requirements and continuous eligibility under CHIP, CMS will consider State CHIP programs that utilize 12-month continuous eligibility contingent on premium payment to be consistent with this program feature.

- 2) **Liberalization of Asset (or Resource) Requirements in Both Medicaid and CHIP** – Under this program feature, the State must either:
 - a) Impose no asset test for determining eligibility for children or;
 - b) Allow administrative verification of assets. In this case, the State: (1) permits the child or the child’s parent, or other representative, to declare and certify under penalty of perjury the required information relating to the family’s assets; and (2) takes steps to verify assets through means other than by requiring documentation from the child or the child’s parent or representative, except if there is a discrepancy, or if otherwise justified.
- 3) **Elimination of In-Person Interview Requirement in Both Medicaid and CHIP** – The State does not require an in-person application or face-to-face interview for applications and renewals of Medicaid and CHIP eligibility unless there are discrepancies or individual circumstances justifying an in-person application or face-to-face interview in a particular situation.

- 4) **Use of the Same Application and Renewal Forms and Procedures for Medicaid and CHIP** – The State uses the same or interchangeable application and renewal forms, supplemental forms, and information verification process for establishing and renewing eligibility for Medicaid and for CHIP.
 - a) Supplemental forms are forms requesting additional information needed to establish or verify one or more factors of eligibility. Examples include forms to verify employment, income, or residency. To qualify under this program feature, the same supplemental forms must be used in Medicaid and CHIP unless a Federal program rule requires differences.
 - b) The information verification process refers to the State’s procedures for verifying all factors of eligibility. For example, if a State allows self declaration of income in CHIP, it must also do so in Medicaid to qualify under this program feature. The verification process includes both the methods and the timeline for verifying eligibility. For example, to qualify under this program feature, the time frame for submitting documentation to renew eligibility (if documentation is required) must be the same in Medicaid and in CHIP.

- 5) **Automatic/Administrative Renewal in both Medicaid and CHIP** – This program feature requires a State to rely on either or both of the following procedures:
 - a) Administrative Redeterminations: The State provides a preprinted form populated with eligibility information available to the State to the child or the child’s parent or other representative, along with a notice that eligibility will be renewed and continued based on such information unless the State is provided other information that affects eligibility. A State may choose to require that the child/representative return a signed copy of the preprinted form to confirm the desire to continue coverage of the child. The State will verify eligibility through electronic and other means.
 - b) Ex Parte Redeterminations: The State makes a redetermination to the maximum extent possible based on information contained in the individual's Medicaid file or other information available to the State, before it seeks any information from the child’s parent or representative. A State can complete an ex parte renewal without sending a renewal form to the child’s parent or representative. Refer to CMS’ State Medicaid Director Letter, released on April 22, 1997, explaining Federal requirements for ex parte redeterminations available at <http://www.cms.hhs.gov/smdl/downloads/SMD042297.pdf>.

Further guidance on ex parte redeterminations will be provided in forthcoming regulations.

- 6) **Presumptive Eligibility for Children for Both Medicaid and CHIP** – Presumptive eligibility allows children who appear to be eligible for Medicaid and CHIP to enroll pending a full determination of eligibility. To qualify using this program feature, the State must implement presumptive eligibility for children in Medicaid, in accordance

with section 1920A of the Act, and also for children in CHIP, in accordance with section 2107(e)(1)(E) of the Act, if the State has a separate CHIP.

- 7) **Express Lane Eligibility in both Medicaid and CHIP** – This program feature allows a State to utilize the Express Lane option for eligibility determinations or redeterminations in accordance with section 203 of CHIPRA and section 1902(e)(13) of the Act, and also for CHIP eligibility determinations or redeterminations in accordance with section 2107(e)(1)(B) of the Act, if the State has a separate CHIP program. CMS is issuing separate guidance on the Express Lane option.
- 8) **Premium Assistance Subsidies for Medicaid or CHIP** – A State can qualify under this program feature if it has implemented premium assistance:
 - a) In CHIP in accordance with section 2105(c)(10) of the Act, as added by section 301(a)(1) of CHIPRA; or
 - b) In Medicaid in accordance with section 1906A of the Act, as added by section 301(b) of CHIPRA.

Appendix II - Calculation of the Bonus Payment

The following describes the data elements, processes, and methodologies (including a preliminary finalizing payment adjustment process) for calculating the CHIP Performance Bonus Payments (Bonus Payments) for a fiscal year. Bonus Payments for a Federal fiscal year must be made by December 31 following the end of such fiscal year.

A. DATA ELEMENTS FOR BONUS PAYMENTS

The amount of the total Bonus Payment payable to a State eligible for such payment for a fiscal year may be comprised of 2 components, "First Tier" and "Second Tier", based on the number of "Qualifying Children" enrollees and the Medicaid Per Capita expenditures for the fiscal year for which the Bonus Payment is being made. Refer to items 1 through 4 below for further clarification of the elements of the Bonus Payment calculation.

The following provides details and discusses the data elements used in the calculation of the Bonus Payment for a State:

1. Baseline Enrollment of "Qualifying Children."

The calculation of the Bonus Payment requires establishing for each State eligible for such payment a "baseline number of child enrollees" for the fiscal year for which the Bonus Payment is being determined. In general, as referenced in statute, Baseline Enrollment refers to the monthly average unduplicated number of "qualifying children" enrolled in title XIX; and, for FY 2009, the Baseline Enrollment must be established using such data for FY 2007.

Section 2105(a)(3)(F) of the Act defines "qualifying children" as "children who meet the eligibility criteria (including income, categorical eligibility, age, and immigration status criteria) under title XIX, and including those eligible pursuant to a waiver under section 1115 of the Act (see section 4 below for a further discussion of qualifying children). As required under section 2105(a)(3)(C)(iii) of the Act, enrollment data from FY 2007 are the basis for the Baseline Enrollment for FY 2009; such data for FY 2007 were obtained from the Medicaid Statistical Information System (MSIS). In particular, the Baseline Enrollment for each State was established using all of the "MSIS Coding Categories" for which States report individuals under the "Basis-Of-Eligibility" (BOE) of child in their Medicaid programs. The purpose and intention was to capture every individual considered and reported by each State to be eligible as a "child" under the unique provisions of its Medicaid (title XIX) program.

The enrollment number from MSIS includes all individuals identified and reported eligible as a child under title XIX, including individuals under the "Medicaid Expansion" option under section 1905(u) of the Act. That is, "Medicaid Expansion" children are covered under section 1905(u) of title XIX of the Act and, as such, are considered as children covered under title XIX (Medicaid), even if the Federal share (at the enhanced Federal medical assistance percentage (FMAP)) of the expenditures for such individuals

are applied against such States' (those with Medicaid Expansions) available CHIP allotments.

The MSIS "BOE codes" associated with "Child" used for developing the FY 2009 Baseline Enrollment using the FY 2007 Baseline Enrollment are as follows:

- "4 Child (not Child of Unemployed Adult, not Foster Care Child)"
- "6 Child of Unemployed Adult (optional)"
- "8 Foster Care Child"

As indicated above, the FY 2009 Baseline Enrollment for a State is based on the FY 2007 enrollment data for the State. Section 2105(a)(3)(C)(iii)(I) of the Act requires that, in order to determine the FY 2009 Baseline Enrollment, the Baseline Enrollment from FY 2007 be adjusted by the application of a growth factor. In particular, as specified by the statute, based on estimates obtained from the Bureau of the Census, the FY 2007 enrollment data are adjusted by the application of a child population growth factor for each State to reflect the percentage change (either positive or negative) in the population of children from 2007 to 2008, and then from 2008 to 2009.

As provided under section 2105(a)(3)(iii)(II) of the Act, the baseline number of child enrollees for a State for fiscal years after FY 2009 is determined by the application of a growth factor to the previous fiscal year's Baseline Enrollment, which is based on the child population growth for the State as estimated by the Bureau of the Census.

The details of the Bonus Payment calculation methodology are discussed in more detail in section C below.

2. Current Enrollment of Qualifying Children.

This data element is the "monthly average unduplicated number of qualifying children" for a State for the current fiscal year (e.g., FY 2009) for which the Bonus Payment is being determined, and which is compared to the Baseline Enrollment level for such fiscal year (item 1. above) in order to calculate the Bonus Payment for such fiscal year. Because of timing, such data is not available directly from the MSIS (that is, such data would not be available by December 31 following the end of the fiscal year). Therefore, this current enrollment data element needs to be obtained directly from a State prior to December 31 in order to make the Bonus Payments by that date. In order to provide current enrollment, a State should use the same State institutional data sources that are used for reporting under MSIS and for child enrollment reporting by States (that is, the Statistical Enrollment Data System, including the States' Medicaid Management Information Systems and other State data sources.

The FY 2007 Baseline Enrollment data obtained from MSIS may not represent an exact one-to-one mapping for each of the above statutory eligibility categories. However, as discussed in section 1 above, the Baseline Enrollment data represents all individuals identified and reported by each State with a BOE of "child." We believe this approach appropriately addresses the intent of the statute in a way that is operationally feasible.

The CMS will work with States to obtain the current enrollment level of qualifying children for each State, consistent with the statutory definition, the reporting mechanisms, and validation process for such data in the State and/or Nationally.

With respect to the FY 2009 current Baseline Enrollment, which CMS requested that States provide for purposes of determining the FY 2009 Bonus Payments, the MSIS data are not available on a current basis. The current enrollment data must also reflect conditions and requirements not effective or applicable in FY 2007. For example, the definition of qualifying children must “not include children for whom the State has made an election to provide medical assistance under paragraph (4) of section 1903(v)” of the Act (section 2105(a)(3)(F)(iii) of the Act); this election under section 1903(v)(4) of the Act was made available under section 214(a)(2) of CHIPRA; therefore, the provision was not available in FY 2007.

Furthermore, as indicated in section 2105(a)(3)(F) of the Act, and as further discussed in section 4 below, the definition of “qualifying children” refers to children who meet the “eligibility criteria ... in effect as of July 1, 2008 for enrollment under title XIX, taking into account criteria applied as of such date under title XIX pursuant to a waiver under section 1115.” That is, in providing the current enrollment, the State should include individuals who are considered to be eligible as “children” under the indicated statutory citations above, but should exclude the individuals indicated above who are children for which the State has made an election under section 1903(v)(4) of the Act, or children who may be eligible under groups or criteria which were not available or in effect under the State’s Medicaid (title XIX) program on July 1, 2008.

3. Projected Per Capita State Medicaid Expenditures.

The amount of a Bonus Payment for a State for a fiscal year is determined by multiplying the excess amount of the current enrollment for the fiscal year over the Baseline Enrollment for the fiscal year by the projected per capita State Medicaid expenditures for the fiscal year. Under section 2105(a)(3)(D) of the Act, the projected per capita State Medicaid expenditures amount:

“is equal to the average per capita expenditures (including both State and Federal financial participation) for children ... but not including children eligible for assistance by virtue of the receipt of benefits under title XVI, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased by the annual increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the respective subsequent fiscal year ends and multiplied by a State matching percentage ... for the fiscal year involved”.

The per capita Medicaid expenditure data element for each State, which includes only those expenditures which are directly associated with children, must reflect expenditures for a State from the “most recent fiscal year” for which such data is available and must exclude expenditures for children eligible for Medicaid on the basis of receipt of benefits under title XVI of the Act (that is, the Supplemental Security Income (SSI) program, which provides benefits to blind and disabled individuals).

Per Capita Growth Factor. As indicated, when the available per capita expenditure data is from a fiscal year prior to the fiscal year for which the Bonus Payment is being determined, a growth factor is applied to increase the per capita to the fiscal year for which the Bonus Payment is being determined. In developing this data element for each State for the most recent fiscal year available for the State, the same MSIS expenditure and enrollment data and the same BOE codes for children (as discussed in section 1 above) were used. This growth factor is based on the percentage increase in per capita National Health Expenditures (NHE); this information is available from CMS.

State matching percentage. The final per capita amount for a fiscal year is determined by multiplying the per capita for the fiscal year (including both State and Federal share amounts, and after application of the growth factor) by the State matching percentage. The State matching percentage is equal to 100 percent minus the FMAP, as defined in section 1905(b) of the Act, for the current fiscal year for which the Bonus Payment is being determined for each State

4. Qualifying children.

With the exceptions noted below, qualifying children include all children enrolled in Medicaid who meet State eligibility criteria in effect on July 1, 2008, including children covered through CHIP-funded Medicaid expansions and children covered under section 1115 demonstrations.

More specifically, qualified children are defined as those enrolled in one of the following eligibility groups as well as children enrolled under a title XIX demonstration:

- 1902(a)(10)(A)(i)(I) and 1931(b): low-income families
- 1902(a)(10)(A)(i)(III) and 1905(a)(i): Qualified Children
- 1902(a)(10)(A)(i)(IV) and 1902(l)(1)(B): poverty-level related children under age 1
- 1902(a)(10)(A)(i)(VI) and 1902(l)(1)(C): poverty-level related children aged 1 up to age 6
- 1902(a)(10)(A)(i)(VII) and 1902(l)(1)(D): poverty-level related children aged 6 up to age 19
- 1902(a)(10)(A)(ii)(I) and 1905(a)(i): reasonable categories of AFDC-related children
- 1902(a)(10)(A)(ii)(II) and 1905(a)(i): children who would meet the AFDC requirements if work-related child care costs were paid from earnings rather than by State agency
- 1902(a)(10)(A)(ii)(III) and 1905(a)(i): children who would meet the AFDC requirements if they were as broad as allowed under Federal law

- 1902(a)(10)(A)(ii)(VIII): non-IV-E State subsidized adoption children
- 1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(B): poverty-level related children under age 1
- 1902(a)(10)(A)(ii)(XIV): optional targeted low-income children
- 1902(a)(10)(A)(ii)(XVII): independent foster care adolescents
- 1902(a)(10)(A)(ii)(XIX): Family Opportunity Act children (certain disabled children)
- 1902(a)(10)(C)(i)(III) and 1905(a)(i): medically needy children
- 1902(e)(3): TEFRA children (disabled children receiving home and community-based services)
- 1920A: presumptive eligibility for children (only if the child is determined to be eligible for medical assistance under title XIX)

The term Qualifying Children does not include any children for whom the State has made an election to provide medical assistance under paragraph (4) of section 1903(v) of the Act. Section 214(a)(2) of CHIPRA amended section 1903(v) to provide States the option of covering children under Medicaid who are lawfully residing in the U.S. without regard to the 5-year waiting period. Section 2105(a)(3)(F)(iii) specifies that such children cannot be counted for purposes of the Bonus Payment calculation.

Section 115 of CHIPRA provides an option for States to claim expenditures for Medicaid expansion children under the regular Medicaid FMAP rather than the CHIP enhanced FMAP. However, such children shall be disregarded for purposes of the Bonus Payment calculations in determining the current enrollment number for the first 3 fiscal years of such election; furthermore, the Baseline Enrollment numbers would also be affected for fiscal years occurring after this 3-fiscal-year period .

B. PROCESS FOR ADJUSTMENT TO BONUS PAYMENTS

As discussed in section A above, CMS developed data, and States provided data, for determining the FY 2009 Bonus Payments using the most recent data available for States. In particular, because of the timing relating to availability of the current FY 2009 child enrollment numbers, such data may not have been finalized or finally validated. Furthermore, because of the potential for determinations of retroactive eligibility of children for FY 2009, the FY 2009 data used in calculating the Bonus Payments may not include all children whose eligibility would ultimately be attributed to the fiscal year. Accordingly, CMS intends to establish a process for adjusting the data used in determining and making the FY 2009 Bonus Payments that are required by statute to be made by December 31, 2009, and for future fiscal years. This Bonus Payment adjustment process, to be established, is intended to ensure that the appropriate data are used for calculating the fiscal year Bonus Payments. Information about the Bonus Payment adjustment process will be provided to States as soon as possible.

C. BONUS PAYMENT CALCULATION

The Bonus Payment for a fiscal year is comprised of two components: Bonus Payment for the first Tier 1 Enrollment levels (**BP₁**) and the Bonus Payment for the second Tier 2 Enrollment levels (**BP₂**) as follows:

$$\mathbf{BP}_1 \text{ (Bonus Payment for Tier 1 Enrollment)} = .15 \times T_1 \times PC_{FY}$$

$$\mathbf{BP}_2 \text{ (Bonus Payment for Tier 2 Enrollment)} = .625 \times T_2 \times PC_{FY}$$

$$T_1 \text{ (Tier 1 enrollment level)} =$$

Minimum of:

$$CE_{FY} - BE_{FY}$$

$$.1 \times BE_{FY}$$

$$T_2 \text{ (Tier 2 enrollment level)} =$$

$$CE_{FY} - 1.1 \times BE_{FY}$$

BE_{FY} = Baseline Enrollee level (monthly average number of unduplicated qualifying children) for the fiscal year for which the Bonus Payment is being determined; this is based on the historical FY 2007 levels for qualifying children to which the growth factor is applied.

CE_{FY} = Current Enrollment level (monthly average number of unduplicated qualifying children) for the fiscal year for which the Bonus Payment is being determined.

BE_{09} (Baseline Enrollment for FY 2009) would be determined as:

$$BE_{09} = BE_{07} \times [(1 + (CPG_{07-08}) + .04) \times (1 + (CPG_{08-09}) + .04)]$$

BE_{07} = Baseline Enrollment for FY 2007

CPG_{07-08} = Child Population Growth percentage increase from 2007 to 2008

CPG_{08-09} = Child Population Growth percentage increase from 2008 to 2009

For fiscal years 2010–2012, the Baseline Enrollment (BE_{10-12}) would be the Baseline Enrollment for the previous fiscal year (BE_{FY-1}) increased by the population growth for children for the State for the calendar year in which the fiscal year begins to the succeeding calendar year plus 3.5 percentage points:

$$BE_{10-12} = BE_{FY-1} \times [1 + (CPG_{CY-1 \text{ to } CY}) + .035]$$

For example, for FY 2010 (BE_{10}):

$$BE_{10} = BE_{09} \times [1 + (CPG_{09-10}) + .035]$$

For fiscal years 2013–2015, the Baseline Enrollment (BE_{13-15}) would be the Baseline Enrollment for the previous fiscal year (BE_{FY-1}) increased by the population growth for children for the State for the calendar year in which the fiscal year begins to the succeeding calendar year plus 3.0 percentage points:

$$BE_{13-15} = BE_{FY-1} \times [1 + (CPG_{CY-1 \text{ to } CY}) + .03]$$

Finally, for fiscal years after FY 2015, the Baseline Enrollment (BE_{16}) would be the Baseline Enrollment for the previous fiscal year (BE_{FY-1}) increased by the population growth for children for the State for the calendar year in which the fiscal year begins to the succeeding calendar year plus 2.0 percentage points:

$$BE_{16} = BE_{15} \times [1 + (CPG_{CY-1 \text{ to } CY}) + .02]$$

PC_{FY} = Per Capita Medicaid Expenditures for the fiscal year for which the Bonus Payment is being determined. This is based on the per capita for the most recent fiscal year for which data is available and to which a growth factor is applied, as appropriate, to increase the most recent available fiscal year per capita amount to the current fiscal year for which the Bonus Payment is being made. For example, if the most recent per capita amount available was from FY 2007 (PC_{07}), the per capita for FY 2009 (PC_{09}) would be:

$$PC_{09} = [(100\% - FMAP_{09}) \times PC_{07} \times (1 + NHE_{07-08}) \times (1 + NHE_{08-09})]$$

$FMAP_{09}$ = Federal medical assistance percentage (as determined under section 1905(b) of the Act) for FY 2009

NHE_{07-08} = Percentage growth in per capita national health expenditures from 2007 to 2008

NHE_{08-09} = Percentage growth in per capita national health expenditures from 2008 to 2009

Appendix III – Sample Request for Bonus Payment

**State Request for Children’s Health Insurance Program (CHIP) Performance Bonus Payment
Federal Fiscal Year 20XX**

State: (fill-in)

Contact: (fill-in)

Telephone: (xxx-xxx-xxxx) Email: (fill-in)

Date: MM/DD/YYYY

The following provides the State’s certification regarding eligibility for a CHIP Performance Bonus Payment for Federal fiscal year 20XX with respect to each of the indicated Qualifying Criteria in accordance with the provisions of section 2105(a)(3) and (4) of the Social Security Act. This template represents this State's request for a determination of eligibility for a CHIP Performance Bonus Payment for FY 20XX under the provisions of section 2105(a)(3) and (4) of the Social Security Act.

A. Qualifying Criteria	B. Criteria Met (Y/N)	C. State Plan Information	D. Additional Information	E. Program Limitations	F. Effective Date
Continuous Eligibility Title XIX Title XXI					
Liberalization of Asset (or Resource) Requirements Title XIX Title XXI					
Elimination of In-Person Interview Title XIX Title XXI					
Use of Same Application and Renewal Form and Procedures for Medicaid and CHIP Title XIX Title XXI					
Automatic/Administrative Renewal					

A. Qualifying Criteria	B. Criteria Met (Y/N)	C. State Plan Information	D. Additional Information	E. Program Limitations	F. Effective Date
Title XIX Title XXI					
Presumptive Eligibility for Children Title XIX Title XXI					
Express Lane Title XIX Title XXI					
Premium Assistance Subsidies Title XIX or Title XXI					

Template Instructions for Line Entries in Each Column

- A. **Qualifying Criteria** – Lines 1 through 8 in Column A list the eight program features identified in section 2105(a)(4) of CHIPRA. With respect to each of these program features, in Columns B through F each State must identify information for **both** its title XIX and XXI programs for all programs except Premium Assistance Subsidies. A State may qualify as having met that program feature if it offers a Premium Assistance Subsidy under section 2105(c)(10) of CHIPRA or section 1906A of the Act, and need only provide information on the appropriate title XIX or title XXI program.
- B. **Criteria Met** – In Column B, each State should indicate a “Y” or “N” with respect to each of the program features in Column A for which it believes it meets the respective criteria for that program feature. A State must meet the criteria for at least 5 of 8 of the program features to qualify for a bonus payment.
- C. **State Plan Information** – In Column C, each State must indicate the location (section and page number) within its approved State plan(s), if the program feature is authorized through the respective title XIX or title XXI approved State plan. States may also submit copies of the State plan page with the template as supporting documentation. An example would be the location of the section of the Medicaid- and CHIP-approved State plan that provides authorization for continuous eligibility.
- D. **Additional Information** – In Column D, each State should identify the supporting documentation it submitted to demonstrate it has met the requirements for each program feature in Column A for which it is providing information. This is needed for program features not captured within the State’s title XIX- and title XX- approved State plan. Examples of the types of additional information a State should submit are: program application(s) for eligibility in Medicaid and CHIP, redetermination forms, income and asset instruction forms, process descriptions including time frames used to receive and process information for Medicaid and CHIP, and instruction manuals provided to eligibility intake/determination employees regarding State policy for the program feature.
- E. **Program Limitations** – In Column E, each State should identify any limitations associated with the program feature referenced in Column A. In particular, the State should identify any categories or groups of children to which the program feature does not apply (such as age limitations) or any income level to which the program feature does not apply (income limitations). States should identify any other type of program feature limitation that would limit the availability of the program feature only to certain beneficiaries.
- F. **Effective Date** – In Column F, each State should indicate the date the program feature became operational in each of the applicable programs, Medicaid or CHIP.