Joyce
Clements-Smith
(Phone) 3956017
Joyce_Smith@OMB@
OFE.gov.

5/8 shirley

D.C. CHIP

2 meetings w Children's Hospital

They want to sign people up on site

convene mtg of Mayor's people

contact
- Michael Barr - OMB - DC liaison
- HHS 464

meeting
H, clinic, Mayor's Ofc, HHS CHIP people

5/8 Michael Barr - Make appt for next week w Chris

Pre-meeting w/ pharmaceutical, etc.

Confirmed

DC Chip — ask Shirley

Michael Barr - D.C. guy at OMB

Children's
National Medical Center.

Serving Children and Their Families Since 1870

111 Michigan Avenue, N.W.
Washington, D.C. 20010-2970
(202) 884-5000

Anne Heather

~~Confidential~~

MEMORANDUM

TO: Melanne Verveer, Assistant to the President & Chief of Staff to the First Lady
Fax: 202-456-6244

FROM: Jacqueline D. Bowman, Vice President
Government & Public Affairs

DETERMINED TO BE AN ADMINISTRATIVE MARKING
INITIALS: RLCR DATE: 02/15/12
2012-0254-S

DATE: September 27, 1999

SUBJECT: Meeting with the Mayor of the District of Columbia (White Paper)

Thank you for taking the time to allow us to explain some of the major issues confronting Children's Hospital as we and the District Government struggle to cope with important issues that affect the lives of many of our patients and children throughout our community.

We appreciate any mention the First Lady may have an opportunity to make with respect to these issues when she meets with Mayor Williams. *A more genuinely collaborative approach by the District in working with traditional providers will move us toward actual Medicaid Program reform and improved access to care for children and adults much more quickly.*

We have attached two documents. The first focuses on Medicaid enrollment and eligibility issues. The second describes: 1) the issues surrounding the District's Medicaid expansion plan which eliminates the DSH Program, 2) the $9-$26.3 million in federal DSH funds we are already working with the Clinton Administration to obtain, and 3) the less risky approach toward expansion we're encouraging the District to adopt.

Again, thank you for your interest, and please feel free to have your staff (I have forwarded this document to Shirley Sagawa, Ruby Shamir & Chris Jennings.) contact me at 202-884-4933 if you have any questions or need additional information.

cc: Shirley Sagawa (202-456-6244)
Ruby Shamir (202-456-5690)
Chris Jennings (202-456-5557)

Attachment

Hope Great meeting you

District of Columbia Medicaid
Eligibility Determination

CNMC is the only institution of its kind in the District of Columbia and the surrounding area. The largest single provider of pediatric primary care services, Children's also provides pediatric tertiary care along with over 40 pediatric specialties and subspecialties. With over 125 years of experience, Children's is also the largest provider of pediatric services to Medicaid enrollees. This experience has earned Children's the trust of families and the wider community. Public health authorities should seek to capitalize on this asset to buttress efforts to expand access to pediatric health care services.

Enrollment/Eligibility Status Report

The District of Columbia Medical Assistance Administration estimates that approximately 8,000 children are uninsured in the District of Columbia (national estimates of the number of uninsured have been higher.) Since October of 1998, the MAA has, to its credit, adopted a short SCHIP application form and contracted for outreach services. By June, the District reported only 1,905 new SCHIP eligible enrollments. About 2,500 children previously eligible for the regular program were enrolled. Over 4,100 parents were enrolled (approximately 20,000 people are currently eligible for the regular Medicaid Program, but remain unenrolled

Eligibility Issues

- The District's Medicaid policy, planning, outreach and administration is the responsibility of the Medical Assistance Administration (MAA), but enrollment is the responsibility of the Income Maintenance Agency (IMA)
- IMA was sued (settled) for noncompliance with Medicaid requirements.
- Despite the availability of the short form, families that may apply for other forms of public assistance simultaneously continue to use the long complicated common form
- The District is not set up to accept applications electronically which would eliminate many delays and reduce the number of clients who never complete the paper process.
- HCFA requires states to post state eligibility workers at DSH hospitals, but the District continues to only post them at the public hospital.
- Although special outreach programs may be in effect, they are uneven and access to these initiatives does not appear to be open to all providers.
- Hospitals have both a mission oriented and financial incentive to expend hundreds of thousands of dollars to enroll individuals on Medicaid, but the District has no such goal/incentive for which MAA/IMA administrators can be held accountable.
- MAA staff recently encouraged hospitals to cease taking what they have termed the "extraordinary" steps that hospitals occasionally take to ensure compliance by socially and economically disadvantaged (less compliant patients & families) with procedures necessary to complete the Medicaid application/interview process.
- Federal rules require states to reimburse hospitals for eligibility/enrollment costs. Contrary to its own rules, the District pays a small portion of the costs.
- The District uses presumptive eligibility for pregnant women but refuses to adopt the policy for children

Recommendations

Self-Attestation

Some jurisdictions have eliminated the need for families to attach documentation to the Medicaid application (Florida and Wisconsin). States have a variety of methods for verifying income. For example, it is possible to match data supplied on a Medicaid application to wage or income tax returns. Similarly, collateral databases from the public schools, WIC, school lunch or other programs could be used to verify information supplied by parents seeking Medicaid coverage for their children.

Alabama, Utah, Washington, Florida and California do not require families to document family income as part of the SCHIP application process. The family member is required to sign a statement that all of the information provided on the application is true. This and similar techniques result in a smooth, efficient and less costly process. Children can be rapidly enrolled in Medicaid and assured of access to adequate pediatric health care services.

Presumptive Eligibility

For many years several states have exercised the option under federal law to make pregnant women presumptively eligible for Medicaid services. This feature of the program permits pregnant women to receive enrollee services while the application is being processed.

A provision in the Balanced Budget Act of 1996 enacted a similar state option for children, as well. The District has adopted the process for pregnant women, but has rejected providing presumptive eligibility for children or even for especially vulnerable pediatric populations.

A specific time period (60 days) is established for presumptive eligibility, and parents must answer questions on income and employment, for example. *New York has established this process for the SHIP, and will move to presumptive eligibility for regular Medicaid in January, 2000.* Experience, to date, indicates that almost 100% of those receiving services under this process are determined to be eligible.

The District can work with providers to ensure adequate follow-up verification rather than insisting that a confused and worried parent attend to a some times intimidating application process, often while a child is in the midst of an illness.

Presumptive eligibility is consistent with the District MAA's position that very little time or data are required when using the new short application form.

District of Columbia Medicaid
Disproportionate Share Hospital Program & Medicaid Expansion

Children's National Medical Center has a mission of Care, Advocacy, Research and Education. One of our principle goals has been to ensure the broadest possible access to health care services for children, including insurance coverage. Children's has enrolled as many as 2,000 children in Medicaid, annually, and our staff is very familiar with the cracks through which children frequently fall. Children's strongly supports effective efforts to expand health insurance coverage. These initiatives must be based on concrete data, sound analysis, appropriate funding and a clear understanding of the target population and its particular health care requirements.

Medicaid Expansion and Technical Correction Status Report

Children's joined several major Medicaid hospitals, but failed to convince the District to work to correct the approximately $26.3 million mistake in the 1997 BBA cap on the federal matching portion of the District's Medicaid Disproportionate Share Hospital Program. The hospitals successfully sought Administration (Carol Thompson Coles & Jacob Lew) and Congressional (Eleanor Norton) support for a technical correction. Action is currently pending on this item before the Appropriations Committees on Labor, Health and Human Services and Education.

Simultaneously, and with no consultation with providers, MAA proposed a major Medicaid expansion that would leave 25,000 of the target population uninsured while eliminating the only public support for hospitals (even though they would likely continue to provide significant levels of uncompensated care. The District Council refused to implement the proposal this year, but gave the Mayor the authority to proceed in FY 20001. A Commission is also to submit recommendations regarding the troubled health delivery system.

Expansion Issues

- The Medicaid expansion plans prepared by the MAA and its consultants relies upon existing resources (DSH is less than 4% of DC Medicaid) that currently fund the District's safety net -- health care providers that serve the bulk of the Medicaid population and the uninsured.
- The MAA's plan will use funds currently used to subsidize services for children to fund a managed care insurance program for adults.
- The MAA's plan uses funds previously available for uncompensated care to pay for insurance coverage for coverage for 9,000 persons who already have private insurance.
- The MAA's plan requires a massive redistribution of resources but is based entirely upon enrollment assumptions, service utilization, cost, and critically essential demographic, financial and other data points that the District's Medicaid Program does not measure.
- The MAA's plan is based upon inadequate extrapolated national data.
- Expansions must be budget neutral. The MAA's administrative planning process historically underfunds program obligations (including DSH) in a manner that makes this massive plan an even greater risk for current and new enrollees as well as traditional providers
- MAA plans exceed historic administrative capacity to manage major new programs:
  1) working for HCFA approval of the extension of the 1915 waiver for the TANF population;
  2) the publication and review of new managed care contracts for the same population;
  3) coping with the potential bankruptcy/sale of the largest HMO in the TANF program;
  4) extending the 1915 Waiver to include foster care children;
  5) extending the 1915 Waiver to include special needs children now covered by an 1115 Waiver;
  6) negotiating with HCFA on a new Medicaid expansion 1115 Waiver to cover childless adults;
  7) amending the 1115 application to include a one-year 2400 person ($6 million) pilot project.

Recommendations

The District of Columbia must:

Implement Administrative & Program Improvements to Maximize Enrollment

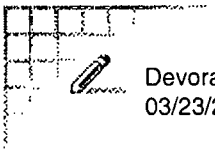
- work with providers and HMOs to obtain accurate costs for Medicaid budget projections
- incorporate electronic eligibility determination, claims submission & claims payment systems
- regularly update inpatient codes that ensure efficient, proper and prompt payment of inpatient claims and accurate patient diagnosis and discharge data collection
- regularly update physician and outpatient services codes and payment rates to reflect true costs of care, and provide incentives for delivering primary/preventive health care services.
- establish program policies clearly understood by Medicaid staff, financial intermediaries and providers that are based fully on District state plan and federal regulations.
- in conformity with federal rules, extend outstationed eligibility workers to DSH hospitals.
- extend outstationed eligibility workers to non-DSH hospitals

Seek Federal Resources to Support Local Commitment to Insure New Populations

- advocate for restoring the $26.3 million in federal DSH funds mistakenly eliminated by the 1997 BBA in order to fund new insurance coverage
- strongly consider using the DSH technical correction funds to expand Medicaid eligibility while preserving the current DSH Program to support safety net hospitals
- include the local matching funds required for drawing down the federal technical correction funds in the local Medicaid budget (for example, if the FY 2000 appropriations process yields a $9 million increase in federal DSH, then DC must provide $3.9 million)

Adopt Achievable Goals for the Most Vulnerable Populations

- use new local and appropriate federal resources to expand Medicaid enrollment in order to ensure that new enrollments are properly financed and sustainable
- phase-in coverage for the most vulnerable populations in order to measure actual enrollment take-up rates, utilization of services, and costs
- target smaller population groups by income and age (19 to 27 year-olds and/or 50-64 year-olds) in order to develop a manageable expansion program with rational utilization/cost projections that do not risk undermining the broader systems of care required by all citizens
- initially provide expanded coverage on a fee-for-service basis (historic rates) in order to properly plan and accurately project a transition to managed cared plans.



Devorah R. Adler
03/23/2000 02:01:19 PM

Record Type: Record

To: Heather H. Howard/OPD/EOP@EOP

cc:
Subject: Re: CHIP

sorry -- totally forgot!

here you go.

MEDICAID, THE CHILDREN'S HEALTH INSURANCE PROGRAM AND CHILDREN'S HEALTH INSURANCE OUTREACH

As recent studies have confirmed, children without health insurance are more likely to be sick as newborns, less likely to be immunized as preschoolers, less likely to receive medical treatment when they are injured, and less likely to receive treatment for illnesses such as acute or recurrent ear infections, asthma, and tooth decay (National Academy of Sciences, 1998). Uninsured children are also more likely to be hospitalized for conditions that could have been managed with appropriate outpatient care than insured children. (GAO, 1998). Without treatment, these diseases can have lifelong consequences (IOM, 1998; GAO, 1998). Yet, the number of uninsured children is large. The Agency for Health Care Policy and Research (1998) found that 4.7 million children are eligible but not enrolled in Medicaid. Several million more have income too high for Medicaid but too low to afford private insurance.

To help these children, the President, with bipartisan support from the Congress, signed the **Children's Health Insurance Program (CHIP)** into law. The Balanced Budget Act of 1997 allocated $24 billion over the next five years to extend health care coverage to uninsured children. CHIP enables states to insure children from working families with incomes too high to qualify for Medicaid through non-Medicaid state programs, Medicaid expansions, or a combination of both. Each state with an approved plan gets its expenditures matched with Federal funds up to a fixed state "allotment". As of May, 1999, 47 States, the District of Columbia and four U.S. Territories have implemented CHIP to date. Of these approved plans, 14 create a separate grant program, 26 expand Medicaid and 12 include a combination of a grant program and Medicaid expansions.

CHIP builds on **Medicaid**, a joint Federal-state program that provides health insurance for most poor children. All states extend Medicaid eligibility to children under the age of 6 in families

with incomes below 133 percent of the poverty level; children between 6 and 15 in families with incomes below 100 percent of the poverty level; and, by 2002, children between the ages of 16 and 18 in families below 100 percent of the poverty level. Many States have taken advantage of options that allow them to cover children in families with higher incomes. The President's initiative to reduce the number of uninsured children also included policies to increase enrollment of poor children in Medicaid.

IMPORTANCE OF OUTREACH

While Medicaid and CHIP have the potential to cover many of the 11 million uninsured children in America, the programs will not succeed without an aggressive, broad-based outreach effort. Experience with Medicaid has shown that many families do not know about their children's eligibility. A 1998 study by the Southern Institute for Children and Families demonstrated that 55% of families did not understand that even if they are no longer eligible for welfare because they have started working, their children are often still eligible for Medicaid, and that 57% of adults did not understand that even if a child's parents live together, the child can still get Medicaid. In addition, many families associate Medicaid with a family that cannot provide for itself, and do not want to be labeled as welfare recipients, even if the law entitles their children to benefits. Low-income working families who have never been eligible for traditional public assistance programs – but who are now eligible for CHIP – may not realize that they are currently eligible for benefits. In some states, the application process can be long, arduous, and beyond the ability of many families to complete. Cultural barriers, like difficulties in language comprehension, also pose a barrier for some families.

To reduce these barriers, the President has launched a public-private children's health insurance outreach initiative. The centerpiece of this effort is the Interagency Task Force on Children's Health Insurance Outreach. On February 18, 1998, the President issued an Executive Memorandum to The Departments of Agriculture, Education, Housing and Urban Development, Health and Human Services, Interior, Labor, Treasury, and the Social Security Administration requesting that they develop options to participate in his public-private initiative to enroll uninsured children in Federal-State insurance programs. Federal departments can play a critical role in children's health insurance outreach. A number of these Federal employee directly administers programs that assist low to middle income families; others work through state-based or tribal programs. Virtually all of these employees work with private grantees, contractors, and technical assistance providers.

The Departments responded on June 26, 1998 with a list of over 150 activities that: (1) identify all employees and grantees who work with families; (2) develop an educational strategy to ensure that employees and grantees are educated about the availability of Medicaid and CHIP; (3) develop an Agency-specific plan as part of the Administration-wide outreach plan, and (4) identify any legislative or statutory barriers which affect the identification and enrollment of uninsured children in Federal-State insurance programs. Many children eligible for Medicaid or CHIP are currently in contact with one or more Federal programs, making these programs appropriate places for reaching out to uninsured children. Most children are enrolled in school, child care, or Head Start. Many participate in school breakfast and lunch programs. Others are enrolled in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

and the Federal Food Stamp Program. They attend public health clinics for immunizations and school nurses for injuries. Their parents interact with the IRS, job programs, or housing assistance. Some uninsured children are American Indians and benefit from Bureau of Indian Affairs and/or Indian Health Service programs. In addition to this vast workforce, Federal agencies also have a network of private sector counterparts and partners who can get involved in children's health insurance outreach.

As part of these efforts, the President, the First Lady, and Secretary Shalala launched the Insure Kids Now Campaign, designed to enroll eligible but uninsured children in Medicaid and the new Children's Health Insurance Program (CHIP). This campaign engages a broad-based, bipartisan, public-private coalition to use a variety of means to educate and assist families in insuring their children. Initial activities include the launch of a nationwide, toll-free number set up by the National Governors' Association in partnership with the Administration and Bell Atlantic to provide families with essential information about Medicaid and CHIP; placing the toll-free number on corporate products; airing public service announcements on TV and radio; and enlisting grass-roots organizations to get the word out. The Administration will continue to work through public and private actions to improve children's health coverage.

CHIP - reallocation →
Carol McCall wants to do a event

Chip - after 3 years -
States have 3 years to spend their $ -
Then it's redistributed - use - lose
after 3 years -
create an incentive to use it

← move a fast in Congress to Δ to $ 5 years

Want Hillary to stand up + say shall fight Next effort.

do a event Monday - so need to know tomorrow.

→ working on ~~redrive~~ redoing the formula

New York University
A private university in the public service

Faculty of Arts and Science
Department of Psychology
Doctoral Program in Clinical Psychology

6 Washington Place, Suite 468
New York, NY 10003-6634
Telephone: (212) 998-7979
FAX: ~~(212) 995-4292~~

Susan M. Andersen
Professor of Psychology
(Social Psychology and Clinical Psychology)
Tel: (212) 998-7799
e-mail: andersen@psych.nyu.edu
Private Fax: (212) 982-1441
March 2, 2000

Ms. Melanne Verveer
Chief of Staff to the First Lady
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20050

Dear Melanne:

Thought you might want to know I had a useful phone meeting with Pam Johnson the other day (of the National Partnership for Reinventing Government) about **CHIP and its implementation**.

She's now crunching the numbers I mentioned in my February 28th letter (or is having someone do so) -- the **number of children in poverty** in each State (eligible for CHIP) **divided by** the **number of children in poverty actually enrolled** (or not enrolled). These are the figures needed in each State, if we are to have the **program evaluation** data we need. Before this, I'd taken a close look at the **boost4kids.gov** website (in development), which is excellent, so she and I could talk at length about what it presents. The raw numbers above are on the website but are **not calculated as I'm suggesting** and are **not presented for the crucial post-welfare-reform years**. In any event, *if* the modal percentage of children in poverty *not* enrolled in CHIP is about 25% in each State, and the percentage of low-income Americans without health insurance also hovers around 25%, this suggests the *possibility* that implementation is sufficiently problematic that there is no boost for kids relative to adults (although the low-income uninsured figures may combine adults with kids).*

With regard to implementation, of course, I suggested it would be **worth studying the legislation to determine whether or not it currently has "teeth" with regard to outcome accountability**. If it does not, something could perhaps be built into the new legislation that will extend this program to parents of these kids. If States are receiving these funds in the same amount (proportional to population) regardless of whether or not they use the funds for making sure these kids are insured, this is not optimal. Decentralization should not mean forgetting the national purposes and vision for which the funds were allocated. Indeed, **it would be valuable to create a systematic incentive system whereby States are offered bonuses for finding implementation strategies that work**.

The **school lunch outreach program** of course offers demonstrable advantages and is excellent, but it cannot identify children in poverty who have no siblings currently in school, which must include numerous children 5 years old and under, as well as numerous adolescents who have dropped out or do not regularly attend. As you know, the health provider of first resort for people in poverty is the emergency room of their local hospital.

For this reason, **I proposed that a new implementation plan** be developed and brought to scale, which could be called something like **Enroll-ER** (or Emerge-Enroll or something comparable), in

which emergency rooms are empowered with easy enrollment procedures to make sure these children are enrolled and **their families know**. Obviously hospitals would rather be paid for their services, and they therefore have an incentive to participate. Pam indicated that a few States have actually experimented with something like this, that it's a good idea, and could conceivably be brought to scale – although exactly *how* best to encourage this in the context of devolution remains to be seen.

Just f.y.i.; thought you'd be interested.

Hope all's well.

As ever,

*P.S. One might ask what the "acceptable" percentage is of children eligible for CHIP but not enrolled in each State. Clearly there will never be a perfect hit rate. If it is a moral imperative for our nation that children in poverty have health care coverage, it would certainly *not* be acceptable if 25% of such children remained uninsured in practice even if eligible in principle. If 10% were uninformed of their eligibility or informed but still not enrolled, would this be acceptable? I'd think the figure should be closer to 5% or lower (i.e., nearly statistically negligible, though still not negligible in human terms). Just a thought.

Cc: Pam Johnson

Accelerating Enrollment of Uninsured Children Eligible for Medicaid and S-CHIP ($5.5 billion over 10 years, an additional 400,000 uninsured children covered). Enrollment in S-CHIP doubled to 2 million children in 1999. Despite this encouraging trend, millions of children remain eligible but unenrolled in both S-CHIP and Medicaid. The Administration's budget includes ideas advocated by the Vice President that would give states needed tools to increase coverage by:

- **Allowing School Lunch Programs to Share Information with Medicaid ($345 million over 10 years).** Since 60 percent of uninsured children are in the school lunch program, sharing eligibility information can efficiently help outreach efforts.

- **Expanding Sites Authorized to Enroll Children in S-CHIP and Medicaid ($1.2 billion over 10 years).** This includes schools, child care resource and referral centers, homeless programs, and other sites.

- **Requiring States to Make their Medicaid and S-CHIP Enrollment Equally Simple ($4.0 billion over 10 years).** Most states have carried over their S-CHIP simplification strategies like eliminating assets tests and using mail-in applications into the Medicaid program. This proposal would have all states do so to make enrollment easier for both programs.