

Children's Health Insurance Program (CHIP) Regulation
And Related Revisions to the Medicaid Regulation Parts 431, 433, & 435
Implementing the Balanced Budget Act of 1997
May 7, 1999

The CHIP regulation is based on policies that have been discussed by the Steering Committee, cleared by the Department, White House and OMB, and with the exception of some of the issues described in this document identified as "New Issues", have been released publicly. These policies were released in the form of a State plan application template, five sets of 108 questions and answers, and 20 "Dear State Health Official" letters. On the whole, States, the Hill, and the advocate community are well aware of our policies. The regulation text consists almost entirely of previously released public documents. However, this document identifies and describes those issues that are new, as well as those key issues that may be considered controversial.

Subpart A - Introduction; Definitions and Terms, State Plans for Child Health Insurance Programs and Outreach

Section 457.1 - Program Description

- This provision gives a general description of the Children's Health Insurance Program.

Section 457.2 - Basis and Scope of Subchapter D

- This provision describes the authority provided for in Title XXI to set forth State plan requirements, standards, procedures and conditions for obtaining FFP for providing coverage to targeted low-income children.

Section 457.10 - Definitions and Use of Terms

- This subsection provides the general definitions and terms used throughout this regulation.

Section 457.30 - Basis, Scope and Applicability of Subpart A

- This provision gives the basis for the provisions governing the administration of a State child health program, the general requirements for a State child health plan, and a description of the process for review of a State child health plan or plan amendment.

A. New Issue: We have not publicly announced our policy that amendments that implement new cost sharing charges, increase existing cost sharing charges or increase the cumulative cost sharing maximum are subject to the rules pertaining to an amendment for a restriction in benefits. We have not imposed this rule on States. To address this concern, we make the distinction that cost sharing is considered a restriction in benefits for purposes of the rules applying to amendments. This may be controversial because we have previously told Pennsylvania that cost sharing is not part of the benefit package for purposes of a grand fathered benefit package because the two issues are addressed separately in the statute.

B. New Issue: We have stated in previous guidance that in the event that the plan is not implemented as it was approved, the federal government would not match the State's prior expenditures. We are further clarifying in the preamble procedures for when a State plan amendment that does not have segregable expenditures and can be identified as beyond the scope of the approved State plan, is not approved as it was implemented. The implementation of such a plan amendment is considered a failure to conduct the State program in accordance with the approved State plan, subject to compliance procedures. In this situation, HCFA may only withhold federal matching funds after following the compliance procedures permitting the State a "reasonable opportunity for correction". This is consistent with the denial of New York's plan amendment, since the unapproved expenditures could be separated from the approved expenditures. Some may find this controversial, since we are applying separate procedures for different types of plan amendments. However, OGC has advised that this is the only policy supported by the statute.

Section 457.70 - Program Options

- This provision specifies that a State may obtain health benefits coverage through a Medicaid expansion program, a separate child health program or a combination program.

Section 457.80 - Current State Child Health Insurance Coverage and Coordination.

- This provision requires a State to describe the extent and manner in which children have creditable health coverage; the current State efforts to provide or obtain creditable health coverage for children; and the procedures to accomplish coordination between CHIP and other health insurance programs.

Section 457.90 - Outreach

- This provision requires a State to implement outreach procedures and provides examples of outreach procedures such as public education campaigns and enrollment simplification.

Section 457.110 - Enrollment Assistance and Information Requirements

- This provision requires States to make accurate, easily understood information available and to provide assistance to families in making informed health care decisions. In particular, we will be requiring States to make benefit and provider information available to children enrolled in CHIP.

New Issue: This is a new requirement to be imposed upon the States, although most States are already doing this. This provision is being implemented pursuant to the *Consumer Bill of Rights and Responsibilities*. While advocates will be in favor of this requirement, States may see it as restricting their flexibility in CHIP and imposing Medicaid managed care requirements on this program.

Section 457.120 - Public Involvement in Program Development

- This provision requires a State to describe the methods used to involve the public in the design and implementation of the program.

Section 457.130 - Civil Rights Assurance

- This provision requires a State to assure that it will comply under the plan with all civil rights requirements.

Section 457.135 - Assurance of Compliance with Other Provisions.

- This provision requires a State to assure that it will comply under Title XXI with certain provisions of Titles XIX and XI of the Social Security Act (as specified in Section 2107(e)).

Item of Potential Controversy: Our “1115 waiver” policy is mentioned in the preamble of the CHIP regulation, but we do not discuss it in great detail. The preamble simply states that we have not approved waivers of Title XXI provisions, and invite comments. This was done to be consistent with our current overall guidance on section 1115 where very little guidance has been made available so that we have flexibility to further refine, or even change our policies. Most of the

guidance on CHIP has been in the form of individual letters to States or members of Congress, in response to specific requests (e.g. Minnesota, Wisconsin, Washington and Vermont). In the past, we have wanted to preserve the Secretary's full discretion, rather than complicate matters by proposing regulations, which can be difficult to change. In addition, we did not feel prepared to determine what "1 year of program experience plus an evaluation" should mean at this point, so we have asked for comments in the preamble.

We can expect several comments from States on this issue. It is possible that some groups will be upset that we have not developed a clear policy on when we would permit waivers of Title XXI. Hill Democrats and advocates may also raise concerns because allowing States to modify parts of the Medicaid program for children (e.g. allowing cost-sharing for the Medicaid population) contradicts a fundamental principle in their drafting of language to create a two pronged CHIP program, that keeps the full protections of Medicaid in place.

Section 457.140 - Budget

- This provision requires a State to include a budget in its State plan. It specifies the requirements for the budget.

A. New Issue: We have not publicly announced our requirement that the State must submit its planned expenditures for a three year period and States have done this. While we have requested that States submit a three year budget, we have not previously required three years. This may be controversial because States may see this as burdensome.

B. Item of Potential Controversy: We have publicly announced that we will not approve State plans that have impermissible funding as the State share. The statute requires that States comply with 1903(w), relating to limitations on provider donations and taxes. This may be controversial because, in the review of State plans and plan amendments, we are using a different standard than the Medicaid program. In Medicaid, we focus less on the State's source of funding initially and take action retroactively.

Section 457.150 - HCFA Review of State Plan Material

- This provision describes HCFA's authority to review and approve or disapprove State plans and plan amendments. It specifies that the Administrator will designate an official to receive the initial submission of a State plan and an individual to coordinate review for each State that submits a State plan.

Section 457.170 - Withdrawal Process

- This provision states that the State CHIP plan or amendment can be withdrawn at any time upon written notification to HCFA.

Section 457.190 - Administrative and Judicial Review of Action on State plan material

- This provision gives States the opportunity to make a request for reconsideration of HCFA's action on a State plan or amendment (within 60 days of receipt) and provides for hearing procedures.

Subpart B - General Administration - Reviews and Audits; Withholding for Failure to Comply; Deferral and Disallowance of Claims; Reduction of Federal Medical Payments *Published in the Federal Register on March 4, 1999.*

Section 457.200 - Program reviews

- This provision describes the review process of the plan administration which includes review of policies and procedures, on-site review and case records review.

Section 457.202 - Audits

- This provision describes the OIG audit process of a State operation. It determines whether the program operates in a cost-efficient manner and that funds are properly expended. Audit reports are released to State and Department officials with OIG recommendations; and concurrence or clearance, appeals, and adjustments are considered.

Section 457.204 - Withholding of payment for failure to comply with Federal requirements

- This provision describes reasons for withholding of payment. Payments will be withheld if the State is in noncompliance with title XXI. Plans will have reasonable opportunity for correction.

Section 457.206 - Administrative appeals under the State CHIP

- This provision describes the three determinations that are subject to reconsideration upon request by a State: Compliance with Federal requirements; FFP in State CHIP expenditures; and Discretionary grants disputes.

Section 457.208 - Judicial review

- This provision sets forth the State's right to a judicial review, petition for review, and court action.

Section 457.210 - Deferral of claims for FFP

- This provision describes that the Regional Administrator or Administrator will defer a claim if they question its permissibility. A written notice will be sent identifying the type, amount, and reason for deferring.

Section 457.212 - Disallowance of claims for FFP

- This provision explains the notice of disallowance that is sent to the State that includes the date, time, and amount of the claim that was deferred. A State may request reconsideration within 30 days of the disallowance letter.

Section 457.216 - Treatment of uncashed or canceled (voided State CHIP) checks

- This provision says that if a check remains uncashed beyond 180 days from the date it was issued, it is no longer an allowable program expenditure. The State CHIP agency must refund all FFP that it received for uncashed checks and a claim may be filed if an uncashed check is cashed after the refund is made.
- This provision says that if the State has claimed and received FFP for the amount of a voided check, it must refund the amount of FFP received.

Section 457.218 - Repayment of Federal funds by installments

- This provision requires that a State repay the Federal funds by installments if the amount to be repaid exceeds 2.5 percent of the actual annual State share. This provision describes the repayment schedule and process.

Section 457.220 - Public funds as the State share of financial participation

- This provision describes how public funds may be considered as the State's share in claiming FFP if they are appropriated directly to the CHIP agency. This provision specifies that public funds are not Federal funds and not authorized by Federal law to match Federal funds.

Section 457.222 - FFP for equipment

- This provision describes how claims for financial participation in the cost of equipment under the State CHIP are determined in accordance with subpart G of 45 CFR part 95.

Section 457.224 - Conditions relating to cost sharing

- This provision specifies that no FFP is available for cost sharing amounts that beneficiaries should have paid and anything paid for individuals who are not eligible, even when services could have been provided under a State CHIP program.

Section 457.226 - Fiscal policies and accountability

- This provision requires that a State provide and maintain an accounting system, records for 3 years, and beyond 3 years if audit findings have not been resolved.

Section 457.228 - Cost allocation

- This provision requires that the State CHIP Agency have an approved cost allocation plan on file with the Department in accordance with the requirements contained in subpart E of 45 CFR part 95.

Section 457.230 - FFP for State ADP expenditures

- This provision describes that FFP is available for the design and development of mechanized claims processing and information systems for operation of certain systems.

Section 457.232 - Refunding of Federal Share of CHIP overpayments to providers and referral of allegations of waste, fraud or abuse to the Office of Inspector General

- This provision specifies that payments to the States are reduced or increased to adjust for overpayments or underpayments that have been made. Indications of waste fraud and abuse will be referred promptly to the Office of Inspector General.

Section 457.234 - State plan requirements

- This provision requires that the State must submit a written statement describing the nature and scope of the CHIP program and conform with requirements of title XXI.

Section 457.236 - Audits

- This provision requires that the agency assure appropriate audit of records on costs of provider services.

Section 457.238 - Documentation of payment rates

- This provision requires that the agency maintain documentation of payment rates.

Subpart C -State Plan Requirements: Eligibility

Section 457.300 - Scope and authority

- This provision generally describes Subpart C, which sets forth and interprets eligibility requirements pertaining to a State child health insurance plan.

Section 457.301 -Definitions and use of terms

- This provision describes the definitions and terms used for purposes of this subpart.

Section 457.305 -State plan provisions

- This provision sets forth the requirement that the State plan must include a description of standards consistent with §457.310 and §457.320 used to determine the eligibility of children for coverage under the State program.

*state
def. of
income*

Section 457.310 -Targeted low-income children

- This provision defines Targeted low-income child and the standards to be met in order to qualify as such.

Item of Potential Controversy: Title XXI prohibits the participation of children of employees of public agencies who are eligible to participate in a State health benefit plan. [Section 2110(b)(2)(B)] In cases where there is no employer premium subsidy for any State health insurance coverage option in a public agency, the children could be covered under CHIP.

The regulation will more clearly define the phrase “eligible for health benefits coverage under a State health benefits plan” to mean that a child in such a family who otherwise meets the criteria under the statute, but only has available a *nominal* amount of funds that subsidize health benefits coverage would not be considered to be eligible for State employee health benefits and would therefore, be eligible for CHIP. Since the level of funding available to purchase “health benefits coverage under a State health benefits plan” varies by county, children in some counties might be eligible for CHIP, while children in other counties might be ineligible.

Section 457.320 -Other Eligibility Standards

- This provision sets forth the eligibility standards that may or may not be used when determining eligibility for targeted low income children under the State child health insurance plan.

Section 457.330 -State plan requirement; enrollment of American Indian and Alaska Native children.

- This provision sets forth the requirement that a State must include in its plan a description of procedures to be used to ensure the provision of child health assistance to American Indian and Alaskan Native children

Section 457.340 -Application

- This provision sets forth the application procedures that a State must follow when determining eligibility for targeted low income children under the State child health insurance plan.

#10
is
or less
nominal

Section 457.350 -Eligibility Screening

- This provision sets forth the screening procedures States must follow to ensure that all applicants that are potentially eligible for Medicaid are identified and enrolled in Medicaid if found eligible.

Item of potential controversy: States are concerned that families will not complete the Medicaid application process if they are not immediately found eligible for the State Children's Health Insurance Program and that these children will remain uninsured. Many States have expressed concerns about a negative perception of public assistance programs and the barrier that causes difficulty in getting children enrolled in Medicaid.

Section 457.360 - Facilitating Medicaid Enrollment

- This provision sets for the enrollment procedures that a State must follow when determining eligibility for targeted low income children under the State child health insurance plan.

Section 457.361 - Application for and Enrollment in CHIP

- This provision sets forth the procedures States must follow to facilitate the application and enrollment process for separate child health programs. States must inform applicants about their rights and obligations under the program as well as the processes for eligibility determinations and effective dates.

Section 457.365 - Grievances and Appeals

pear

This provision requires States to provide a process for filing grievances and appeals for denial, suspension or termination of eligibility for the program.

Subpart D - State Plan Requirements: Benefits

Section 457.401 - Basis, Scope and Applicability

- This provision generally describes Subpart D which sets forth and interprets requirements for health benefits coverage and other child health assistance under a State child health insurance plan.

Section 457.402 - Child Health Assistance and Other Definitions

- This provision defines child health assistance and health benefits coverage and lists the services available for payment under a State child health plan. The majority of these definitions are consistent with those used in the Medicaid program.

Section 457.410 - Health Benefits Coverage Options

- This provision lists the four health benefits coverage options from which a State may choose to design its child health assistance program.

Item of potential controversy: The regulation makes clear that there are four possible categories of benefits coverage. It is important to note that during negotiations with States over what their benefits packages would include, it became clear that further description was needed over exactly what each benefit option should mean and what procedures are required to meet that option.

One particular area of concern has been the use of “Secretary approved” coverage. We have determined that those States choosing to use “benchmark - plus” benefit packages must do so under Secretary approved coverage. Even though this may create the appearance of broad Secretarial discretion, we believe that this discretion will be viewed positively overall, because we are allowing flexibility above and beyond a basic minimum level of coverage (the benchmark).

Section 457.420 - Benchmark Health Benefits Coverage

- This provision describes the various benchmark options from which a State may choose to design its benefit package for targeted low income children.

Section 457.430 - Benchmark equivalent health benefit coverage

- This provision describes the requirements to which the State must adhere in designing a benchmark equivalent benefit package for its targeted low income children.

Section 457.431 - Actuarial Report for Benchmark-equivalent coverage

- This provision describes the process requirements in developing an actuarial analysis comparing the actuarial value of coverage of the benchmark package to the State-designed benchmark equivalent benefit package for its targeted low-income children.

Section 457.440 - Existing Comprehensive State-based Coverage

- This provision identifies the three existing comprehensive state based programs (New York, Florida, and Pennsylvania) grandfathered-in according to the statute as well as the requirements for any modifications made to those existing programs.

Section 457.450 - Secretary-approved Coverage

- This provision describes ways a State may define Secretary-approved coverage for its separate State Children's Health Insurance Program. Secretary-approved coverage may include: 1) the same benefits as are provided under the Medicaid State plan, a "Medicaid look-alike" 2) a comprehensive benefit package offered under an 1115 waiver that either offers the full EPSDT benefit or that has been extended to the entire Medicaid population in the State; or 3) a benchmark plan plus any additional benefits.

Section 457.470 - Prohibited Coverage

- This provision explains that health benefit coverage is not required under the State plan for certain items or services under Title XXI.

Section 457.475 - Limitations on coverage - abortions

- This provision describes the conditions under which abortion services are permitted under Title XXI and discusses the treatment of managed care entities providing this service under a separate contract.

California

New Issue: We have received an inquiry from the State of California regarding this issue. The State has proposed to use "firewalls" rather than separate contracts for the provision of abortion services. We have prepared a letter to State Health Officials confirming that this is not permissible and that separate contracts are required. The regulation will likely be the vehicle for announcing this policy for CHIP and may raise concerns with several States.

Section 457.480 - Pre-Existing Condition Exclusions and Relation to Other Laws

- This provision describes the applicability of the preexisting condition exclusion and the parts of HIPAA, ERISA, the Mental Health Parity Act, and the Newborns and Mothers Health Protection Act that apply to CHIP.

Section 457.490 - Delivery and Utilization Control Systems

- This provision describes that the State plan must include a description of proposed methods of delivery and utilization control systems to ensure that children receive care that is appropriate and medically necessary.

Section 457.495 - Grievances and Appeals

- This provision requires States to provide enrollees the opportunity to file grievances and appeals for reductions or denial of services provided for in the benefit package.

Subpart E - State Plan Requirements: Beneficiary Financial Responsibility

Section 457.500 - Basis, Scope and Applicability

- This provision describes the statutory basis for the cost-sharing provisions for separate child health programs.

Section 457.505 - General State Plan Requirements

- This provision requires that the State plan specify the amount of cost sharing imposed, the methods (including a description of the public schedule) the State uses to inform the public of the cost sharing amounts, the procedures used to ensure that beneficiaries are not charged cost sharing for well-baby/well-child care when a State purchases family coverage or coverage from an employer sponsored group health plan.

Section 457.510 - Premiums, Enrollment fees, or Similar fees

- This provision discusses what the State should include in its plan regarding information on premiums, enrollment fees, or similar fees.

Section 457.515 - Co-payments, Coinsurance, Deductibles, or Similar Cost sharing charges

- This provision discusses what the State should include in its plan regarding information on co-payments, coinsurance, deductibles, or similar cost sharing charges.

Section 457.520 - Cost sharing for well-baby and well-child care.

- This provision requires that cost sharing not be imposed on beneficiaries for well-baby/well-child care services. This section defines all services considered well-baby/well-child care where a copayment is not allowed.

Section 457.525 - Public schedule

- This provision requires States to publish a schedule of the cost sharing charges that will be imposed on the beneficiary.

Section 457.530 - General Cost Sharing Protection for Lower Income Children

- This provision instructs States to not vary premiums, deductibles, coinsurance, co-payments or any other cost-sharing based on family income that favors children from families with higher income over children from families with lower income.

Section 457.535 - Protection to ensure Enrollment of American Indians/Alaska Natives

- This provision permits States to exclude from cost sharing children who are American Indians as defined by the Indian Health Care Improvement Act of 1976 and Alaskan Natives who are members of a Federally recognized tribe and receive services at IHS facilities and Tribal 638 facilities.

option/mandatory **New Issue:** The regulation gives States the option to waive cost sharing for these individuals. Some have argued that States should be required to exempt all AI/ANs from cost-sharing, while others are concerned about the precedent of allowing preferential treatment for certain groups. However, we feel that our long standing and unique relationship with the tribes makes this acceptable and most beneficial. We are still discussing the issue of whether to take OCR's recommendation to make this policy a mandate, as they would prefer that if we are going to single out this group of individuals, we should do so uniformly across the States.

Section 457.540 - Cost sharing Charges for Children in Families At or Below 150% of the FPL

- This provision specifies the maximum allowable cost sharing amounts for children in families with income below 150% of the FPL. The maximum cost sharing amounts are between \$1 and \$5 based on the cost of services provided; and \$15 to \$19 premium per month based on family size and \$1000/month family income.

Section 457.545 - Cost sharing for children in families above 150 percent of the FPL

- This provision stipulates that States may impose on a sliding scale, premiums, deductibles, copays, coinsurance or other cost sharing amounts up to the legislative maximum (5% of family income cap) on cost sharing for children in families with income over 150% of the FPL.

Section 457.550 - Maximum Allowable Cost Sharing Charges on Targeted Low-Income Children at or Below 150% of FPL.

- This provision lays out the requirements for imposing cost sharing. It specifies the frequency and amounts that can be charged and requires that cost-sharing charges cannot exceed 5% of a families annual income.

Section 457.555 - Cumulative Cost Sharing Maximum

- This provision proposes a cumulative cost sharing maximum on the amount of cost sharing imposed on children in families with income above 150% of the FPL (5% of the family's income), and at or below 150% of the FPL (2.5% of the family's income).

A. New Issue: New policy placing a 2.5% cumulative maximum on cost sharing for families below 150% FPL. This issue arose because the statute as written permits families with incomes below 150% FPL to pay as much cost-sharing as those above 150% FPL. After much discussion it was decided that a reasonable cap would be 2.5% of income for lower income families.

Congressional Democrats and advocates are adamant about having cost-sharing relative to the levels of poverty for this population. In addition, this proposed cap will be controversial for those States that have in place a cap that is higher than the 2.5% proposed cap because a State plan change would be needed to comply with the regulations when they become final (CO, FL, KY, UT). Since this policy has not been made public, although States know we are considering this, there has been a question as to whether States with approved plans that cover children at 150% and below will be required to lower the cost-sharing cap to 2.5%, or whether those States with cost-sharing above 2.5% may be grand fathered in, but OGC has said that legally, we could not permit grand fathering.

aw.
notice

B. Item of Potential Controversy: It has been our policy that States must have a procedure in place to track the 5% cap on family income and to ensure that families do not pay out-of-pocket for expenses once they have reached the cap. To date, the “shoe-box” approach has been the method of choice for States. This means that the State calculates the dollar amount that represents a family’s cap and then the family collects receipts for each visit/prescription and lets the State know when they reach the cap. Once this occurs, the State puts in place a mechanism to make sure beneficiaries are not billed any further by the plan or providers.

The preamble discusses the “shoe box” approach as the method of choice for tracking against the 5% cap, but solicits comments on additional ideas. There is concern in the advocate community and with some on the Hill that the “shoe box” approach places too much of the burden of tracking expenses on the beneficiary. We commissioned a study through George Washington University to develop alternatives, however the study found no viable alternatives. Instead, the study found that it is unlikely that most families will actually reach the 5% cap within the year, thus diminishing the need for a sophisticated tracking system.

C. Item of Potential Controversy: The statute does not specify whether States should use gross or net family income in calculating the 5% cap, therefore we have not provided any guidance on this issue to date. Virtually all States, however, are using gross income in making these calculations, and we have permitted this so far.

The regulation will clarify that States have the option to use either gross or net family income when calculating the cost-sharing caps. The preamble explains that States have this option, but encourages them to use net income because it is more helpful to the beneficiary as well as being more reasonable. The Hill and the advocates will raise concerns that we are giving States the option to use gross family income in calculating the caps. They will argue that it is much more difficult, even unlikely, that a family would ever reach the cap when gross income is used.

D. New Issue: Under the law, States have the option of counting beneficiary payment of services not covered by CHIP towards the beneficiary’s cumulative cost sharing maximum. However, we cannot require this under the statute. Advocates and the Hill could raise concerns that most States will not choose to do this; and the special needs population will be penalized, as they may need services not included under CHIP, and be required to pay cost-sharing for them.

Gross
vs
net

E. New Issue: While the statute does not allow us to mandate that States apply cost-sharing imposed on adults in CHIP family coverage plans toward the cumulative maximum cap, the regulation proposes that States have the option to do so. This policy has not been released publicly thus far. Advocates may argue that States should be required to count all cost-sharing imposed on a “family” when they are receiving CHIP family coverage because they are likely to reach the cap more quickly.

5% for entire family

Section 457.560 - Grievances and Appeals

- This provision requires States to give enrollees the opportunity to file grievances and appeals for disenrollment based on failure to pay cost sharing.

Section 457.570 - Due Process

- This provision requires States to establish a process that gives beneficiaries a reasonable opportunity to pay past due cost-sharing amounts as a “due process” mechanism before disenrollment from CHIP.

New Issue: The statute does not require States to have a protocol to follow prior to disenrolling a beneficiary who has failed to pay cost-sharing. We have proposed that the States have such a process to provide assistance to those beneficiaries who cannot meet their cost-sharing obligations. The preamble language points out specific examples like allowing beneficiaries a grace period prior to disenrollment, or allowing disenrollment only after the beneficiary has established a pattern of failure to make copayments.

We will also specify in the preamble that HCFA will request a copy of this written process once the proposed regulation is published. During the on-site reviews and future cost sharing amendment reviews, HCFA, for plans approved, will target and address problem areas in the State’s disenrollment process. When questions are raised regarding the disenrollment policy in future amendments, the State’s response will be a part of the State plan. States may object to this level of prescriptiveness as we have not applied a great deal of scrutiny during our initial review of the plans.

Subpart F - Financial Regulation: Allotments and Payments to States -- *Published in the Federal Register on March 4, 1999.*

Section 457.600 - Purpose and basis of this subpart

- This subpart interprets Section 2104 of the Act which specifies the total allotment amount available to each State for fiscal years 1998 through 2007 and Section 2105 of the Act which specifies the provision for making payment to States.

Section 457.602 - Applicability

- The provisions of this subpart apply to the 50 states and the District of Columbia, and the Commonwealths and Territories.

Section 457.606 - Conditions for State allotments and Federal payments for a fiscal year

- This provision requires that a State have a plan submitted in accordance with section 2106 of the Act and that the plan must be approved by October 1, 1999 for fiscal years 1998 and 1999. This provision specifies that after fiscal years 1999, the plan must be approved by end of fiscal year and an allotment is not available prior to the beginning of the fiscal year.
- Federal payments for States' CHIP expenditures under an approved health plan are limited to the amount of available funds remaining in State allotments in accordance with formulas specified in 457.608 and 457.610.

Section 457.608 - Process and calculation of State allotments for a fiscal year

- This provision describes the national total allotment amount for each Federal fiscal year. It describes the formula for allotments to the 50 States, the District of Columbia, Commonwealths, and Territories. This provision describes the formula used to calculate the national total allotment for a fiscal year.
 - The amount available for allotment is determined by subtracting certain amounts from the total appropriation specified in section 2104 9 (a) of the Act.
 - The data and methodology used for determining State allotments for a fiscal year are described in this provision.

- This provision specifies that each approved plan will receive a minimum allotment of \$2 million. If the allotment is below the \$2 million minimum and needs to be increased, the increase will be offset by reducing the State allotments for the other States in a pro rata manner.

--Final allotments are determined by HCFA based only on those States that have approved State child health plans by the end of fiscal year 1999.

Section 457.610 - Period of availability for State allotments for a fiscal year

- This provision describes that the final allotment amount for a fiscal year remains available until expended for Federal payments based on claims during a 3-year period of availability.

Section 457.614 - General payment process

- This provision requires the State to submit quarterly budget estimates and expenditures reports in order for HCFA to advance a grant to a State. In addition, States must track Federal payments claimed quarterly.

Section 457.616 - Application and tracking of payments against the fiscal year allotments

- This provision describes the categories of payments applied to reduce the State allotments for a fiscal year.

--Payments made to the State for expenditures claimed during the fiscal year under title XIX Medicaid program.

--Coordination and order of payments, and payments against multiple State CHIP fiscal year allotments.

--Principles for applying Federal payments against the allotment must apply to Medicaid expenditures based on the quarter in which the expenditures are claimed by the State. Payments must be applied in a manner that is consistent, effective, and efficient for all States.

Section 457.618 - Ten percent limit on certain Children's Health Insurance Program expenditures

- This provision describes primary expenditures (expenditures under a plan for targeted low-income children, in form of a standard benefit package), non-primary expenditures (administrative, outreach, and health initiatives), and defines the 10 percent limit calculation.
- These expenditures are subject to a 10 percent limit, based on the total computable amount of the State's allotment available in the fiscal year. The total computable amount is determined by dividing the States allotment by the State's enhanced matching rate for that fiscal year.

Section 457.622 - Rate of FFP for State expenditures

- This provision describes the enhanced Federal medical assistance percentage computation. The conditions for availability are; State must have an approved plan, allotment amounts available in the fiscal year and expenditures against a 10 percent limit. The categories for which it is available are; requirements meeting section 2103 of the Act, Initiatives for improving the health of children, and expenditures for outreach activities.
- This provision describes FFP availability in expenditures for activities defined in sections 2102 (c) (1) and 2102 (c) (2).

Section 457.624 - Limitations on certain payments for certain expenditures

- This provision sets forth the limitations on certain payments. Abortions are generally not covered but there is an exception. Purchase of family coverage has to be relative to the amounts that the State would have paid for comparable coverage.

Section 457.626 - Prevention of duplicate payments

- This provision lists the general definitions used in this section. The provision specifies that no payment will be made to a State for child health assistance under the plan to the extent that a health insurer would have been obligated to pay for services.

Section 457.628 - Other applicable Federal regulations

- This provision describes other regulations including, HHS regulations in sources of Health Care-Related Taxes and Provider-Related Donations, and non-discrimination under programs through HHS including handicap programs.

Section 457.630 - Grants procedures

- This provision describes the general provisions once HCFA has approved a State plan. Grants are awarded to cover Federal share of expenditures. A State must submit a budget request for the 4 quarters of fiscal year 1998 and 3 quarters of fiscal year 1999. The amount of the grant is based on information submitted to HCFA. This provision specifies the content of award, effect of award, and general administrative requirements.

Subpart G - Strategic Planning, Reporting and Evaluation

Section 457.700 - Basis, Scope and Applicability

- This subpart sets forth the State plan requirements for monitoring, reporting and evaluation under Title XXI.

Item of Potential Controversy: Our approach has been to work with the states to be flexible in the submission of the annual report and evaluation while trying to establish guidelines that promote a base level of comparability for annual reporting and Year 2000 evaluations -- both of which will become the basis for the Secretary's Report to Congress in 2001. In addition, a State-generated workgroup, with HCFA representation, is working to establish model templates for both future annual reporting and evaluation. States will most likely use such a template, as it will be the only model available to them, so this will help us to get some consistent information in some States.

The regulation text will closely follow the CHIP statute and will not require States to provide much beyond what is prescribed in the legislation, except for the basic information outlined in the December 4 letter. The preamble provides a more in depth discussion of performance measurement and strategic objectives for encouraging States' accountability through data reporting.

While the Congress, the Administration and numerous advocacy and research groups are anxious to learn about the impact of CHIP, the States will be challenged to respond to the requirements in the law and the regulation given the severe limitations on data and the challenges of Y2K and other impediments to timely reporting. Some States have not been able to meet our deadlines for reporting their first annual report and enrollment information. Also, some of the data we are getting is not consistent with our request. While the regulation is based directly upon the Title XXI statute, which provides broad authority to require specific standardized data, some States have argued that we cannot uphold such requirements.

Section 457.710 - State plan requirements: strategic objectives and performance goals

- This provision requires that the State child health plan describe the strategic objectives, performance goals, and the performance measures the State has established.

New Issue: The preamble discusses the two general goals for the proposed monitoring provisions. Specifically, monitoring will assure State compliance with both statutory requirements under title XXI and the content of a State's title XXI plan. In addition, monitoring will allow us to track the submission of requested data related to CHIP programs, including enrollment, expenditure, program data, etc., and other efforts related to ultimately ensuring enrollment of eligible children into both CHIP and Medicaid. Expected outcomes of CHIP monitoring include: 1) identifying the need for corrective action, enforcement and improvement within State title XXI programs; 2) recognizing and sharing best practices that may lead to increased enrollment; 3) identifying States' needs for technical assistance; and 4) informing HCFA as we prepare for the Secretary's report to Congress.

The regulation text provides authority for activities such as audits to identify States' noncompliance with the statute and policies outlined in the regulation, as well as with the State plan as approved. The purpose is also to provide States with the opportunity for corrective action as necessary.

In addition, Section 457.200 of the financial regulation outlines HCFA's process for program reviews. In order to determine compliance with Federal requirements for State CHIP programs, HCFA will review State and local administration of State CHIP plans "through the analysis of State's policies and procedures, on-site reviews of selected aspects of agency operation, and examination of samples of individual case records." If it is found that a State program is out of compliance with Federal requirements, a State "must correct its practice accordingly." In addition, the Department's Office of the Inspector General (OIG) will periodically review State

operations to determine the following: 1) whether or not the program is being operated in a cost-efficient manner; and 2) whether funds are being properly expended for the purposes for which they are appropriated. OIG will release reports simultaneously to the States and the Department regarding their findings and recommendations. Section 457.204 outlines the Department's basis for withholding payments to States and additional actions for State noncompliance with Federal regulations.

Section 457.720 - State plan requirement: state assurance regarding data collection, records, and reports

- This provision requires that the State plan provide an assurance that the State will collect the data, maintain the records, and furnish the reports to the Secretary, at the times and in the standardized format that the Secretary may require.

Section 457.730 - State plan requirement: state annual reports and evaluation

- This provision requires the State plan to include a description of the State's proposal for submitting annual reports and the state evaluation.

Section 457.735 - State plan requirement: state assurance of the quality and appropriateness of care

- This provision requires that the State child health plan describe the strategy the State has adopted for assuring the quality and appropriateness of care, particularly with respect to providing well baby care, well-child care, and immunizations and assuring access to covered services, including emergency services. In this section, States must discuss the specific elements of their quality assessment and improvement strategies.

Section 457.740 - State expenditure and statistical reports

- This provision discusses State expenditure and statistical reporting requirements. States must report CHIP expenditures on a quarterly basis. States also must report the number of children under 19 years of age who are enrolled in separate CHIP, Medicaid-only, and Medicaid-expansion programs by age, countable income (poverty level determined by state-defined countable income and state-defined household size) and service delivery categories on a quarterly basis. In addition, States annually must report an unduplicated count of children by these three categories for each preceding federal fiscal year.

Section 457.750 - Annual Report

- This provision discusses the type of information that States must provide in the Annual report. The State must provide an assessment of the operation of the State in the preceding federal fiscal year including the progress made in reducing the number of uncovered low-income children and in meeting other strategic objectives and performance goals. In order to report on the progress made in reducing the number of uncovered low-income children, a State must choose a methodology to establish an initial baseline estimate of the number of low-income children.

B. Item of Potential Controversy: States have the option to decide what methodology to use for the baseline estimate of the uninsured but many appear dissatisfied with available data sources. While we have the ability to track changes in baseline at a national level, States may not be comfortable with HCFA determining their State's percent reduction of uninsured children.

To date, we have received baseline estimates from most States. As we did not impose any particular methodology on States, the methodologies used vary substantially across States. For example, most States have submitted baseline estimates using CPS data in various forms (e.g., different survey years, pooled estimates, CPS combined with other survey research, etc.) and others have used either State-based or research-based surveys. States may argue that since there are few reliable and affordable tools accessible to States to develop baseline estimates, tracking this information annually may not make sense.

Section 457.760 - State evaluation

- This provision discusses the requirement that States submit a comprehensive evaluation by March 31, 2000 that analyzes the progress and effectiveness of their State child health insurance program.

Subpart H - Substitution of Coverage

Section 457.800 - Basis, Scope and Applicability

- This provision describes Subpart H which sets forth and interprets requirements to prevent substitution of coverage under a State Children's Health Insurance Plan.

Section 457.805 - State Plan Requirements: Private Coverage Substitution

- This provision explains the requirements for describing reasonable procedures in the State plan that will ensure that no substitution of coverage under a group health plan occurs.

A. Item of Potential Controversy: This regulation text does not set forth our internal policy establishing greater scrutiny at higher levels of income, however we do discuss it in the preamble and solicit comments. We have been applying this standard when reviewing plans, but want to leave room for flexibility.

3 *B. Item of Potential Controversy:* There has been a question regarding the application of substitution provisions to the separate Medicaid group of targeted low-income children. Some States have been imposing waiting periods under Medicaid expansions and concerns have been raised that this is in conflict with the entitlement nature of Medicaid.

Section 457.810 - Premium Assistance for Employer-Sponsored Group health Plans: Required Protections Against Substitution

- This provision describes the requirements for preventing crowd-out in States utilizing employer-sponsored group health plans, including a minimum period of uninsurance (6 months), the minimum employer contribution permitted (60%), and the requirement for an evaluation of the effects of this policy on access to health coverage.

Item of Potential Controversy: Intergovernmental groups and States (e.g., NGA, APHSA) will argue the policy for employer-sponsored coverage is too prescriptive. Some Congressional staff and States believe we do not have statutory authority to impose more stringent requirements on employer-sponsored coverage. Some States have complained about difficulty in meeting the conditions for employer-sponsored coverage (e.g., 6 month waiting period and 60 percent employer contribution.).

Subpart I - Program Integrity and Beneficiary Protections

Section 457.900 - Definitions, Basis, Scope and Applicability

- Subpart I, Program Integrity and Beneficiary Protections, finds its basis in both Title XIX and Title XI of the Social Security Act, which the Title XXI statute refers to. The CHIP statute emphasizes the importance of maintaining program integrity, but does not prescribe specifically what fraud and abuse protections must be in place. This subpart requires States to have procedures in place and suggests, for purposes of consistency, the Medicaid provisions in this area as a good precedent to follow.

This subpart applies only to States implementing separate State CHIP programs. States that utilize the option to expand existing Medicaid programs must comply with the Medicaid program integrity requirements.

New Issue: This subpart provides the States with flexibility in terms of the type of fraud and abuse protections they choose to implement. However, we have not provided guidance as to our policies on program integrity thus far and we believe that most S-CHIP States have not done a great deal in this area. Therefore, this is a new policy area that may be perceived as somewhat burdensome to these States.

Section 457.902 - Definitions

- This provision describes the terms relevant to this subpart.

Section 457.910 - State Program Administration and Requirements

- The State child health plan must provide safeguards necessary to ensure that eligibility is determined and services are provided in an appropriate and efficient manner that serves the best interests of the beneficiaries.

Section 457.915 - Fraud Detection and Investigation

- The State child health plan must include procedures to ensure program integrity and detection of fraud and abuse. States are also required to have procedures for coordination between the State program integrity unit and the OIG, DOJ, FBI, etc. Although States with separate CHIP plans are not required to use the same procedures specified in the Medicaid regulations, this subsection encourages States to do so.

Section 457.920 - Accessible Means to Report Fraud and Abuse

- The State agency must facilitate communication between the State and the public in terms of reporting possible fraud or abuse, and for providing information about the issue. This subsection suggests using a toll-free number for this purpose.

Section 457.925 - Preliminary Investigation

- When a complaint or report is made, the State must conduct a preliminary investigation to determine whether further action is needed.

Section 457.930 - Full Investigation, Resolution and Reporting Requirements

- States must have procedures for investigation of fraud and abuse, and are encouraged to utilize the Medicaid procedures already provided in regulation, including collaboration with Medicaid Fraud Control Units (MFCUs)

Section 457.935 - Sanctions and Related Penalties

- Any provider that has been barred from participating in Medicare or Medicaid cannot become a CHIP provider. All corresponding Medicaid disclosure requirements and the related penalties apply.

Section 457.940 - Procurement Standards

- This provision establishes payment limitations for CHIP services by requiring that States: 1) provide for free and open competition, to the extent possible, in the bidding of contracts for Title XXI services; and/or 2) base Title XXI payment rates on public and/or private payment rates for comparable services. It also permits States to establish higher rates by justifying that such rates are necessary to ensure sufficient provider participation or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services.

New Issue: While our policy basically mirrors the Medicaid regulations that are already in place -- procurement transactions must be "conducted in a manner providing full and open competition" where appropriate, we also agreed to several additional options. The goal is to prevent situations where the State is paying excessively for services. For example, if the State is paying \$100 a day for a service that should only be \$10/day.

Section 457.945 - Certification for Contracts and Proposals

- Both MCOs and fee-for-service providers must certify the integrity of all information specified by the State.

Section 457.950 - Contract and Payment Requirements Including Certification of Payment-related Information

- The State must ensure that contracts with managed care entities (MCEs) include enrollment and other required data and the MCE must attest to the accuracy and integrity of enrollee claims and payment data. In addition, the MCE must make that data available to the State upon request.
- States using fee-for-service must establish procedures to ensure the integrity of provider claims. Fee-for-service providers must provide the State with access to enrollee and payment data upon request by the State.

Section 457.955 - Conditions Necessary to Contract as an MCE

- This provision requires States to ensure that MCEs have procedures in place to guard against fraud and abuse. States must enforce MCE compliance with all Federal and State standards and must have a mechanism for reporting fraud, abuse or violation of enrollment or payment requirements to HCFA or the Office of the Inspector General. States have authority to inspect or audit the MCE at any time, with reasonable cause.

Section 457.960 - Reporting Changes in Eligibility and Redetermining Eligibility

- This provision requires States to have procedures designed to ensure that enrollees make accurate reports in circumstances that may affect their eligibility and to conduct redeterminations upon a change in circumstances in a timely manner.

Section 457.965 - Documentation

- This provision requires States to include in each applicant's record, facts to substantiate eligibility determinations.

Section 457.970 - Eligibility and Income Verification

- States may use discretion in establishing verification methods, and are encouraged to follow the Medicaid procedures that are in place. This provision also permits States to terminate eligibility for “good cause” reasons, but with written notice of the reasons for termination.

Section 457.975 - Redetermination Intervals in Cases of Suspected Enrollment Fraud

- This provision gives States flexibility to conduct redeterminations in cases of suspected enrollment fraud at whatever frequency is determined to be in the best interest of the program.

Section 457.980 - Verification of Enrollment and Provider Services Received

- States must have methodologies in place to verify the accuracy of provider billing and must maintain systems to verify enrollment where enhanced matching is received by the State.

Section 457.985 - Enrollee Rights to Grievances and Appeals

- This provision requires States and providers to have written procedures in place to give enrollees the opportunity to file grievances, complaints, and appeals, with special emphasis on cases of denial, suspension or termination of eligibility; disenrollment for failure to pay cost sharing; and reduction or denial of services provided for in the benefit package.

In addition, States must inform beneficiaries in writing of their rights. The provision gives States the opportunity to design their own procedures, and suggests use of the Medicaid managed care practices at a minimum, including application of the “gag rule” prohibiting interference with health care professionals’ advice to enrollees; and limitations on physician incentives that have the effect of reducing or limiting services.

Section 457.990 - Privacy Protections

- States must apply the Medicaid privacy protections to separate CHIP programs. These protections include those pertaining to the protection of enrollee data, medical records and mental health history, and privacy of minors. States must follow the data

transmission and other Internet transmission protections and are encouraged to adopt HCFA's data confidentiality and security policies to safeguard data.

Section 457.995 - Overview of Beneficiary Protections

- This provision describes all of the sections of the President's directive that are addressed in the CHIP regulation. The sections addressed are as follows: §457.65, §457.110, §457.130, §457.402, §457.525, §457.735, §457.985, and §457.990.

Item of Potential Controversy: We have determined that based on the President's directive, we should include as many protections as possible in this area. This may be controversial with the States because the Title XXI statute does not specifically make reference to these protections.

Subpart J -- Waivers

Section 457.1000 - Basis and Scope

- This provision lays out the conditions under which States may obtain waivers of the 10 percent cap on administrative expenditures and to provide coverage to entire families.

Section 457.1005 - Waiver for Cost-effective Coverage through a Community-Based Health Delivery System

- This provision describes the requirements a State must follow to exceed the 10 percent limitation on administrative costs in order to provide child health assistance to targeted low-income children under the state plan through the utilization of cost-effective community-based health care delivery systems.

Section 457.1010 - Waiver for Purchase of Family Coverage

- This provision describes a waiver which allows the State to provide coverage to an entire family coverage in lieu of individual coverage. To receive payment for purchase of family coverage under the plan, the State must establish that the cost of covering the family is cost effective, meaning it will cost no more than to cover the individual child. The State must also demonstrate that such coverage shall not substitute for other health insurance coverage. When the State applies for the waiver, HCFA will approve the waiver if: 1) the State meets the requirements for substitution of private coverage described in 457.350, 2) meets the requirements for obtaining

health benefits coverage for eligible children as defined in 457.410, 3) meets the standards for imposing cost sharing on beneficiaries and 4) meet the basic requirements for cost-effectiveness. HCFA may withdraw its approval of the waiver if it determines the waiver is no longer cost effective.

Item of Potential Controversy: The only States to receive such a variance thus far are Massachusetts and Wisconsin, using the employer buy-in option. Several other States have shown interest in this option and have asked for greater flexibility. Unfortunately, the statute is very clear and the standards will be too difficult for most States to meet. We will continue to receive pressure from States looking to find more and creative ways to spend their allotments, but some on the Hill are adamant that no flexibility was intended in this area. In addition, we believe that a legislative change would be needed to go beyond the statute to grant variances that will provide more flexibility to cover adults.

Section 457.1015 - Cost Effectiveness

- This provision describes the waiver requirements for demonstrating cost effectiveness in determining whether to provide family coverage in lieu of individual coverage.

Miscellaneous Issues

Vaccines for Children

- Non-Medicaid CHIP programs may opt to obtain vaccine at the Federal discount price, plus an amount to cover the costs of administrative overhead and distribution, for the purpose of immunizing CHIP eligible children. This applies to non-Medicaid CHIP programs as well and states may want to use this existing authority given the existence of the VFC program and its potential impact on CHIP. States electing this option must retain overall responsibility for the provision of health services, under the requirements of § 457.405. However, the State may subcontract for any or all other services provided under its CHIP program, including professional services required to immunize eligible children.

Because the Immunization Program of the State Health Department is the CDC grantee, and has sole authority to order and distribute vaccine purchased under the CDC discount contracts, a State CHIP program which opts to obtain these vaccines must negotiate a memorandum of agreement with the Immunization Program to order vaccines and distribute the directly to CHIP providers, and must agree to reimburse the Immunization Program for the cost of each dose of vaccine, including a pro rata share of administrative overhead and distribution costs. Providers who receive vaccine

must agree to comply with reporting and other requirements of the State immunization program, in order to assure that vaccine distributed is accounted for appropriately.

If HCFA establishes that the State has retained overall responsibility for the provision of services and if the State Immunization program has established one price per dose which includes all charges for vaccine, the Immunization Program's administrative overhead and distribution of vaccine, the 10% cap on direct services and administrative costs will not apply.

Item of Potential Controversy: This issue has been and will continue to be controversial with States and the advocate community. The Hill has also taken a strong position on this issue, in favor of our policy.

Disproportionate Share Hospitals (DSH)

- Title XXI includes a provision that requires States to receive enhanced match for disproportionate share hospital payments under CHIP. We mention this in our letter to the States on financial issues released on December 8, 1997. Although States have the ability to use the CHIP money this way, to date no State has done so.

Because of the concern about this both within HCFA and for some on the Hill, we asked OGC to try to determine whether we have the authority to prohibit States from using CHIP funds for DSH. The General Counsel has told us that this is not possible without a legislative change. We plan on providing technical assistance to Senate Finance Committee staff who are drafting legislation to change this provision.

The CHIP regulation does not address this issue specifically, however it is discussed in the preamble. It notes that we understand that there may be a general concern about the use of title XXI allotment dollars for payment to disproportionate share hospitals and are seeking a legislative change to address this discrepancy. However, until Congress can address this issue in legislation, the law does not allow HCFA to issue a policy that disallows claims for DSH payments related to CHIP Medicaid expansion groups.

Item of Potential Controversy: Some may see the current policy on use of CHIP funds in this way as inappropriate. However, although no State has taken advantage of it, States may oppose a legislative change in policy on the grounds that it limits flexibility and the ability to spend CHIP dollars as they wish. The advocates may oppose a change in policy as well, arguing that States need increased DSH funding to cover uncompensated care costs. On the other hand, the advocates share our

concern that all CHIP dollars will not be going toward the provision of health care services for children.

Related Revisions to Medicaid Regulations - Parts 431, 433, and 435

Section 433.11 - Enhanced FMAP Rate for Children

- We have made changes to Part 430 of the regulations necessary to incorporate the policies pertaining to FFP that are explained in the CHIP financial regulatory package which is in final clearance.

Item of Potential Controversy: We have proposed (as does the CHIP financial proposed regulation) to make FFP available at the enhanced rate for all Medicaid expansions for children. We considered limiting the availability of enhanced FFP to the new optional group of optional targeted low income children. However, we decided to make enhanced FFP available to States for any expansion for children. That is, enhanced FFP is available for services provided to any child who would not be eligible for Medicaid under the rules in effect on March 31, 1997 and who does not have creditable health insurance, regardless of the eligibility group involved.

This grants flexibility to States and encourages coverage of the maximum number of children. For example, States may expand a group of children whose eligibility is related to the poverty level (e.g., children under age 6 with income at or below 133 percent of the poverty level) and receive enhanced match for those children who do not have insurance and would not have been eligible prior to the expansion. This enables States to expand coverage to children whether or not they have creditable health insurance rather than limiting the expansion to children without insurance as under the new optional targeted low income children's group. (Regular FFP would be available for the children with health insurance and enhanced FFP for those without insurance, all in the same eligibility group.)

We have also required that States maintain a valid method of identifying services provided on behalf of those children who have no insurance and would not be eligible prior to the expansion. Only regular Medicaid FFP will be available if they are unable to separate the children eligible under the old rules from those eligible under the expansion.

Section 435.229 - Optional Targeted Low Income Children

- These proposed regulations add the new optional group of optional targeted low income children to the existing optional groups. In general, all regular Medicaid rules apply to this group.

Section 435.910 - Use of Social Security Number

- These proposed regulations explain that a Medicaid identification number other than a Social Security Number may be given to an individual who, because of well established religious objections, refuses to obtain a Social Security Number.

Section 435.1001 - FFP for Administration

- This provision states that FFP is available for administrative functions such as Medicaid eligibility determinations and redeterminations, and determining presumptive eligibility for children.

Section 435.1002 - FFP for Services

- This provision makes FFP available for services provided to presumptively eligible children.

Section 435.1100 - Presumptive Eligibility for Children

- The statute requires that we adapt the language from an already published notice of proposed rulemaking pertaining to presumptive eligibility for pregnant women to implement the new provision related to presumptive eligibility for children. At this point, the majority of States have not yet taken advantage of this option, so we do not have an indication of the overall reaction we will get.

A. Item of Potential Controversy: We have proposed to allow States to establish reasonable methods of limiting the number of periods of presumptive eligibility which will be authorized for a child in a given time frame. The statute is silent on this issue. (Pregnant women were limited to one period of presumptive eligibility per pregnancy.) We stated that because family income and circumstances can change from month to month, we believe it is unreasonable to limit a child to one period of presumptive eligibility in a lifetime. However, it is also unreasonable to provide a child with unlimited periods of presumptive eligibility. The latter would allow continuous coverage of children who never file an application for regular Medicaid and are never determined eligible. It might also result in a parent not seeking

preventive care or establishing a medical home for the child but rather seeking care on an ad hoc basis knowing that the child will be found presumptively eligible.

B. Item of Potential Controversy: We have proposed to require that States provide all services, including EPSDT, to presumptively eligible children. The statute is silent on this issue. (Services provided to presumptively eligible pregnant women are limited by statute.) We considered allowing States to limit the services provided (e.g., provide ambulatory care only). However, we believe that most children will be found retroactively eligible for regular Medicaid and entitled to all services during that period. Therefore, adequate medical care should not be delayed pending the decision on the regular Medicaid application. Another issue that may raise controversy is the fact that once a child is determined to be presumptively eligible, the statute requires that any services provided to that child will be counted against the State's allotment until the final determination of eligibility is completed. So, if the child never follows through with the full application, States can, in effect, be penalized, thus creating a disincentive to use presumptive eligibility.

NationalThe New York Times
ON THE WEB[Home](#)[Site Index](#)[Site Search](#)[Forums](#)[Archives](#)[Marketplace](#)

May 9, 1999

Many States Slow to Use Child Health Plan

Related Articles

- [Issue in Depth: Health Care](#)

Forum

- [Join a Discussion on Health Care Reform](#)
-

By ROBERT PEAR

WASHINGTON -- States are using less than 20 percent of the federal money that Congress made available, with much fanfare, for a big new program to subsidize health insurance for children in low-income families.

Some states say they cannot find enough eligible uninsured children to use all the money they are entitled to receive. Critics say many states have been slow to reach out to eligible children and sign them up.

The program's slow start and the accumulation of unspent money are tempting Republicans in Congress to take back some of the money and use it for other purposes -- an idea vehemently opposed by Democrats, by advocates for children and by governors of both parties.

Sen. John D. Rockefeller IV, the West Virginia Democrat who helped create the Children's Health Insurance Program in 1997, said, "The Appropriations Committee is looking at the unused money for other projects." He objects to such a shift.

Elaina J. Fox, a spokeswoman for West Virginia's new child health program, said, "A majority of states will probably not be able to utilize their full allotments" of federal money.

Governors are enthusiastic about the program, and tens of thousands of children have clearly benefited. But Rep. Diana DeGette, D-Colo., said some states, including her own, had "an abysmal record" of finding uninsured children and enrolling them in the new program.

Congress provided \$39 billion for the program over 10 years, including \$4.2 billion a year in 1998 and 1999. Federal officials said states had used \$260 million through December 1998 and \$115

million in the first three months of this year. The Congressional Budget Office estimates that states will use a total of \$800 million this year.

States say they have enrolled one million youngsters in the new program. But federal officials and health policy experts say the numbers are somewhat misleading.

Nearly 30 percent of the million children are in New York State, and 176,000 of the New York children were already in a state-financed program, Child Health Plus, often described by federal officials as a model for the nation.

Moreover, Frank C. Ullman, a health policy expert at the Urban Institute here, said, "The decrease in **Medicaid** enrollment in many states is greater than the increase in coverage through the new Children's Health Insurance Program." So it is unclear, he added, whether there has been a net reduction in the number of uninsured children -- one of the main goals for President Clinton and Congress.

The number of children without health insurance has been creeping up in recent years and is now at least 10.7 million, the Census Bureau says.

Under federal law, children eligible for **Medicaid** may not be enrolled in the new Children's Health Insurance Program. **Medicaid** is intended for families with somewhat lower incomes. States are supposed to screen children and enroll them in **Medicaid** if they qualify for it.

But states have a strong financial incentive to put children into the new program, rather than in **Medicaid**, because the federal government pays a larger share of the costs -- 65 percent, rather than 50 percent, in high-income states like New York, New Jersey and Connecticut.

The children's health plan was forged in a bipartisan agreement between the president and Congress. When he signed the legislation in August 1997, Clinton said it would extend insurance coverage "to up to five million children." He called it "the largest expansion in health care for children" in three decades.

Bruce D. Lesley, director of congressional relations at the National Association of Children's Hospitals, said: "The results to date have been mixed. Some states like South Carolina have done an unbelievably good job of enrolling children in the new health insurance program. Other states like Virginia are not doing so well. In these states, parents who need to know about the new program have no idea that it exists."

South Carolina simplified its enrollment process, disseminated applications at drug stores, day care centers, schools, churches and Indian reservations and signed up 40,400 children for the new program. By reaching out to low-income families, the state also found 46,000 other children who were eligible for its pre-existing **Medicaid** program.

No one ~~is~~ is more committed
to the success of this prog
than FOTOS & FLOTUS. We
will continue to work w/ Governors,
the providers & children's adv
in strongly opposing any
move to redirect resources
away from these essential
prog.

By contrast, Amy M. Atkinson, a spokeswoman for the Virginia Department of Medical Assistance Services, said her state had enrolled 8,599 children in the new insurance program, including only 71 in Richmond, through May 3.

Sen. Charles S. Robb, D-Va., said, "My state has not been as quick off the mark as others have."

Edward J. Rogan, a spokesman for the New Jersey Department of Human Services, said the state had enrolled 30,232 children in its new health program, known as Kid Care, and expected to spend \$19 million of its \$88 million federal allotment this year.

Connecticut has enrolled 8,000 children and expects to spend \$5.4 million of its \$35 million federal allotment this year, said David Dearborn, a spokesman for the Connecticut Department of Social Services. As a side benefit, he said, in reaching out to low-income families, the state has found several thousand children eligible for its **Medicaid** program.

Auditors in some states said some children enrolled in the new program were probably ineligible and should have been enrolled instead in the regular **Medicaid** program.

In welfare, a separate program, states have also allowed substantial amounts of federal money to go unspent. They say they are keeping it for a rainy day, in case the economy sputters.

But that concern does not explain delays in spending money on health insurance for children. Officials in many states said they had only recently begun to enroll children because they first had to design new health programs, get federal approval, prepare application forms, set up toll-free telephone lines, print posters and run advertising to publicize the availability of the new benefits.

Judith A. Arnold, deputy commissioner of the New York Health Department, said, "Congress should be patient with states that seem to be moving slowly."

The federal government has approved children's health plans for every state except Tennessee, Washington and Wyoming.

State officials told Congress in 1997 that they needed the maximum latitude to design their own programs because they knew best how to meet the health needs of uninsured children.

But in a curious way, the law penalized states that had already expanded **Medicaid** eligibility by increasing the permissible income for families seeking coverage. Such states included Minnesota, Vermont and Washington.

In Washington State, for example, **Medicaid** covers children whose family incomes are up to twice the official poverty level (up to \$27,760 a year for a family of three). Since those children are eligible for **Medicaid**, they may not enroll in the new Children's Health Insurance Program.

app administer this prog.
we have been & will continue
to strongly inc. states to
undertake app & succ outreach
activ. for both trad MC as
well as the CCHP prog for
mil of unins. kids

Q:

A: projecting for 99

First, much more sig increase
in state exp this year, project
that trend will continue full
expectation even more the
ftr year. Takes time to
establish & implement these
new prog & there has been varying
levels of success @ state
level to complete
necessary work.

Under federal law, Washington may use its share of the new federal money -- \$46 million a year -- for children of families with incomes up to 2.5 times the poverty level.

But Thomas W. Bedell, acting director of the **Medicaid** program in Washington State, said: "We won't be able to spend our full allotment of federal money. We have only 10,000 uninsured children with family incomes from 200 to 250 percent of the poverty level. We estimate that we can spend only \$7.5 million of our federal money in the next year and a half."

Likewise, Gov. Howard Dean of Vermont, a Democrat, said the law penalized "states like Vermont that have served as national leaders in expanding health care coverage."

Ullman of the Urban Institute said: "In theory, there's enough money to cover five million children a year in the initial years of the new Children's Health Insurance Program. But only 3.2 million uninsured children live in families with the proper income to qualify."

[Home](#) | [Site Index](#) | [Site Search](#) | [Forums](#) | [Archives](#) | [Marketplace](#)

[Quick News](#) | [Page One Plus](#) | [International](#) | [National/N.Y.](#) | [Business](#) | [Technology](#) |
[Science](#) | [Sports](#) | [Weather](#) | [Editorial](#) | [Op-Ed](#) | [Arts](#) | [Automobiles](#) | [Books](#) | [Diversions](#)
| [Job Market](#) | [Real Estate](#) | [Travel](#)

[Help/Feedback](#) | [Classifieds](#) | [Services](#) | [New York Today](#)

[Copyright 1999 The New York Times Company](#)

Q: conc about reports may be
for the population

We ~~are~~ we have reviewed
no conclusive reports that
there are significant Hs of
low income children elig for MC
being enrolled in CHIP. We
have been consistent & clear
that the statute explicitly
~~prohibits~~ ^{req} that a State ~~must~~ may
not enroll ^{that} MC eligible kids in
EFMAP CHIP prog. We strongly
believe that any abuse
of practice in this regard
would sig undermine
the pub of the Congress
conf. that States can

CROWD OUT AND MEDICAID

Issue: Should we reconsider our policy of applying crowd out requirements to Medicaid expansions under Title XXI, the Children's Health Insurance Program (CHIP)?

Background: One of the fundamental principles under Title XXI is that CHIP coverage should not supplant existing public or private coverage. Title XXI requires that States ensure that coverage provided under CHIP does not substitute for — or crowd out — coverage under either private group health plans or Medicaid. In reviewing State plans, we have a 3-tiered policy based on income for assessing whether State CHIP plans meet the crowd out requirements. States at 150 percent of poverty or below, must monitor crowd out. States between 150 and 200 percent of poverty must monitor crowd out and, if they find crowd out has occurred at an unacceptable level, they must implement a procedure to limit crowd out (e.g., a waiting period for insurance). States above 200 percent of poverty must implement a specific procedure to limit substitution. Although this policy currently is internal, we are planning to describe it in the CHIP regulation.

The Office of General Counsel (OGC) advised the Department that we had a policy choice over whether to extend this crowd out policy for separate State CHIP plans to CHIP Medicaid expansions. The legal link exists because the Medicaid definition of "optional targeted low-income child" refers back to the definition in Title XXI of a "targeted low-income child." Part of that definition requires that the child must be "determined eligible by the State for child health assistance under the plan." OGC says that we can read this language as permitting States to impose additional eligibility requirements for the "optional targeted low-income child" category in Medicaid. We tried to limit the ability of States to impose additional eligibility criteria by saying in the regulation that they "must be consistent with Title XXI."

We chose to apply the CHIP crowd out policy to Medicaid expansions using the "optional targeted low-income children" category established under Title XXI **when pressed by OMB and the White House.** Our rationale was that we wanted to treat separate State CHIP plans and CHIP Medicaid expansions in an equitable manner, and we believed that the crowd out provisions were a very integral part of the statute. We also were consciously trying to avoid the criticism that we were favoring Medicaid over separate State programs.

The most common strategy used in States with Medicaid expansions is a waiting period. Although we have asked all States to have a protection in place, we did not specifically require a waiting period for those States with Medicaid expansions.

Democratic staff and Advocates concerns

The Democratic Committee staff argue vigorously that the intent of the drafters was that the crowd out requirements only would apply to separate State CHIP programs -- not CHIP Medicaid expansions. They say that the Republican Committee staff on the Hill at the time of CHIP enactment agreed with them. They also point out that in meetings and in one of our questions and answers we have stated that "...all Medicaid rules apply to CHIP Medicaid expansions." **Medicaid is an entitlement and they are concerned about waiting periods contradicting this basic premise.**

A number of advocates also have raised concern with the crowd out policy in Medicaid. In addition to opposing this policy, they argue that the rationale that HCFA relies on to support these crowd out provisions opens the door for eligibility restrictions well beyond crowd out, **particularly when future amendments are in place.** Title XXI permits States broad discretion to impose eligibility criteria in their separate State programs. Once HCFA permits States to adopt additional eligibility criteria in their Medicaid programs, there appears to be no statutory basis for HCFA to prevent States from further limiting Medicaid eligibility.

OPTIONS

Option #1: Maintain current policy of requiring crowd out provisions in CHIP Medicaid expansions. (Note: If this option is chosen, we will need to have further discussions about the rationale for allowing this policy. We could use the legal rationale described above that is currently in the draft regulation or another rationale favored by advocates.)

Pros:

- We have approved all 26 CHIP Medicaid expansions and 12 combination plans using this policy of requiring crowd out protections in Medicaid.
- States are getting pressured from their legislatures and elsewhere to have protections against crowd out. We did not pressure States to impose eligibility waiting periods as anti-crowd out measures in CHIP Medicaid expansions -- their initial plans included these provisions.
- All CHIP plans -- separate State and Medicaid expansions -- will be treated equitably.

Cons:

- Our "friends" on the Hill are very opposed; they argue that this was not Congressional intent. They feel this policy destroys the entitlement nature of Medicaid.
- The advocates argue that our current policy opens up the door for eligibility restrictions that we may not favor such as enrollment caps, Medicaid time-limits, service area restrictions and other types of policies.

Option #2: Reverse current policy; do not permit States to impose crowd out restrictions in CHIP Medicaid expansions.

Pros:

- Medicaid would be preserved. There would be no risk of States imposing new eligibility restrictions in Medicaid.

Cons:

- This would be a major reversal of policy. We would have to ask all 26 States with approved CHIP Medicaid expansions and the 12 States with combination plans to change their plans to come into compliance with the new policy. Some may not want to amend their plans, and our only alternative would be a compliance action. States may not be compelled given our lack of willingness to take compliance actions against States.
- Republicans on the Hill felt strongly about the issue of crowd out. They may be very opposed to this weakening of our stance against crowd out.

Option #3: Do not require States to impose crowd out restrictions in CHIP Medicaid expansions, but allow States to apply for a Section 1115 waiver if they would like to impose crowd out restrictions such as an eligibility waiting period.

Pros:

- We would retain control over the types of anti-crowd out strategies States could impose through the Section 1115 waiver process.
- We would not run the danger of creating new and troubling legal precedents.
- Waivers are time-limited and would require an evaluation. This is appropriate in the context of crowd out where there are important questions yet to be answered.

Cons:

- This would be a major reversal of policy. We would have to ask all 26 States with CHIP Medicaid expansions and 12 States with combination plans to amend their plans. It would be difficult to tell States that their current crowd out policies are no longer allowed, but if they want to continue them they can request a waiver and we will permit it.
- There is a significant amount of political sensitivity about using Section 1115 authority in CHIP.

Report to the President
Interagency Task Force on Children's Health Insurance Outreach

Submitted by the
Secretary of Health and Human Services

In Collaboration With

The Secretary of Agriculture
The Attorney General
The Secretary of Commerce
The Secretary of Education
The Commissioner of the Environmental Protection Agency
The Secretary of Housing and Urban Development
The Secretary of the Interior
The Secretary of Labor
The Commissioner of Social Security
The Secretary of Treasury

Jeanne-

this is my first try @ a rewrite
pls note: a lot of this is cut & paste
from press releases in order to
update the original report. I also
recycled lang from the orig report directly
when nothing had changed.
Let me know what you think.
TJ.

OVERVIEW: REPORT OF THE TASK FORCE ON CHILDREN'S HEALTH INSURANCE OUTREACH

This report outlines the progress that the Departments of Agriculture, Education, Housing and Urban Development, Health and Human Services, Interior, Labor, Treasury, and the Social Security Administration have made towards executing a series of multi-agency proposals to educate families and facilitate the enrollment of children in Medicaid and the new Children's Health Insurance Program (CHIP). It is clear that the activities initiated by these Departments to date have made an important contribution to reducing the number of uninsured children in America.

The report also provides a list of new activities and new Federal partners to promote children's health insurance outreach nationwide. These new activities could be implemented in the time frames described, should the President approve of the proposals.

BACKGROUND

2 paragraphs
On February 18, 1998, the President issued an Executive Memorandum to eight Federal Departments operating programs to assist working families requesting that they develop options to participate in his public-private initiative to enroll uninsured children in Federal-State insurance programs. The Departments of Agriculture, Education, Housing and Urban Development, Health and Human Services, Interior, Labor, Treasury, and the Social Security Administration responded on June 26, 1998 with a list of 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. *1 sentence is added last para*

This report summarizes the successful implementation of these activities and the addition of three new partners – the Departments of Justice and Commerce and the Environmental Protection Agency – to sustain a complementary and aggressive outreach effort that is consistent with the overall initiative to cover uninsured children.

IMPORTANCE OF CHILDREN'S HEALTH INSURANCE *programs*

These new Federal activities are an important step towards the President's goal of improving the health and development of American children. 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. In its first release of state enrollment data, the Department of Health and Human Services (HHS) reported that approximately 982,000 children enrolled in CHIP in the 43 states with programs operating during 1998. This indicates that states met the HHS enrollment estimates for 1998, that states are well on their way to enrolling their target of 2.5 million children by 2000, and that we have made significant progress towards the President's goal of reducing the number of uninsured children in the United States by 5 million.

① What is

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. According to the NGA, 26 states have opted for strategies such as "continuous eligibility" and 12 states use "presumptive eligibility" -- both of which were included in the Balanced Budget Act of 1997 to increase traditional Medicaid enrollment. ~~It is important to note that the initial enrollment estimate from HHS represents only those children for whom the State receives CHIP funding. It does not include children being enrolled through the regular Medicaid program. The number of children enrolled in Medicaid also should have been impacted in 1998 because of increased outreach efforts and the requirement to screen children applying for CHIP and, if found eligible, enroll them in Medicaid.~~

②

IMPORTANCE OF OUTREACH

While Medicaid and CHIP have the potential to cover many of the ~~4.7~~ ^{over ten} 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

⑤ Progress to date

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~~. 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. *Need sentences of CHIP - families who have never been eligible*

To encourage full participation in these programs, the President has launched a children's health insurance outreach initiative. The FY 2000 budget includes over \$1 billion to give states the funds and flexibility to find and enroll hard-to-reach children. These new funds will enable States to simplify enrollment systems, launch ad campaigns, educate community volunteers, outstation eligibility workers, and conduct outreach campaigns to identify and enroll uninsured children in both Medicaid and CHIP. *reduce these barriers* *public-private* *put last*

In addition, in February 1999, 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). Building on prior efforts, this campaign will engage 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 launching 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. *Centerpiece of this effort is INSURE NOW, TR, private. IN 1998...*

WHAT IS OUTREACH?

Children's health insurance outreach is a dynamic process in which broad networks of concerned Americans work together to identify, educate and enroll uninsured children in Medicaid or CHIP. These networks include people in the public and private sectors and at the Federal, State and local levels. Activities that could increase enrollment in health insurance programs include advertising on billboards, television and radio; sending messages in simple language and in multiple languages; using toll free hotlines to answer questions and enroll individuals; spreading the word through community health advocates, children's agencies, parents networks and religious groups; and targeting uninsured children where they spend most of their time: in schools, child care settings and Head Start sites. Outreach also involves Federal and State efforts to streamline the application and enrollment process by shortening forms, accepting mail-in applications, reducing processing time, and placing eligibility workers in convenient locations. Use of a joint application form for different programs can also enhance coordination of resources across programs serving the same children. Outreach activities are not new. All states, to greater or lesser degrees currently conduct outreach for uninsured children (NGA, 1998). States may *Do we need this? if yes, (a) shorten; (b) move barriers to right after paragraph.*

receive Federal matching payments for outreach for Medicaid and CHIP. In addition, private organizations like foundations, children's advocacy groups, health care providers, and businesses have also sponsored some projects to educate and enroll children in health insurance. These groups have access to and communicate with families in different, potentially more effective ways. National experts agree that in order for the CHIP and Medicaid programs to reach their full potential, the public and private sectors must join together in an effective outreach effort.

THE FEDERAL GOVERNMENT'S CONTRIBUTION TO OUTREACH

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.

process oriented

As part of the President's continuing commitment to improving children's health, he directed 8 Federal departments that operate programs assisting low income families to find innovative and effective ways to reach out to uninsured children. In a report to the President in June 1998, the Task Force proposed more than 150 initiatives to educate government workers and families about new, low cost or free health insurance programs for children, and to coordinate efforts across departments and agencies, and partner with private sector groups. Over the past year, as they have begun to implement their initiatives, the Departments of Agriculture, Education, Housing and Urban Development, Health and Human Services, Interior, Labor, Treasury, and the Social Security Administration have taken a leadership role in children's health insurance outreach efforts. Their achievements include activities to: (1) educating the 1.2 million Federal workers, State workers and grantees about children's health insurance outreach; (2) educating families about their children's potential eligibility for health insurance; and (3) coordinating efforts across Departments and with private sector groups.

Educating Federal Workers, State Workers, and Grantees

do you want a new app as to why this is important?

Please insert specific examples of the completed activities. In a separate paragraph, please insert specific examples of the new activities the original 8 agencies have proposed in order to build off their achievements.

or can I recycle?

Educating Families

Please insert specific examples of the completed activities. In a separate paragraph, please

insert specific examples of the new activities the original 8 agencies have proposed in order to build off their achievements.

Coordinating Efforts

Please insert specific examples of the completed activities. In a separate paragraph, please insert specific examples of the new activities the original 8 agencies have proposed in order to build off their achievements.

NEW PARTNERS

Please insert a paragraph about the importance of our new partners. How do they come in contact with the target population? What are their proposed activities (presented in the same format as the completed activities)?

CONCLUSION

Insuring America's children is a national priority. Children who miss school because they are sick or who cannot see well because they lack glasses may not develop to their full potential. Two programs offer millions of uninsured children health coverage: Medicaid and the new Children's Health Insurance Program. Enrolling uninsured children in these programs will take an aggressive, sustained, public-private, Federal, State, and local effort. As demonstrated by the activities described in this report, Federal Departments have begun to make an important contribution toward this outreach effort. We look forward to working with the President on the continued implementation of this initiative.

 Laura Efurd

10/08/99 02:58:37 PM

Record Type: Record

To: Barbara D. Woolley/WHO/EOP@EOP
cc:
bcc:
Subject: Re: chip 

Here's what I have so far:

Public Education Network

Has provided Insure Kids Now to the 2000 members participating in their listserve; the Insure Kids Now toll free number is displayed on their website; sent information on Insure Kids Now to the Participants in the Comprehensive School Health Initiative; and sent Insure Kids Now information to 45 local education funds which represent 5 million children primarily in urban and disadvantaged school districts.

On ideas -- Arnie suggests another gathering of groups at the White House to reinvigorate effort. Concerned that there is an additional 1 million children uninsured. Need to have a sustained effort on this. Very willing to participate.

Still waiting to hear from National Collaboration on Youth & trying to locate National Child Care Association contact.
Barbara D. Woolley

  Barbara D. Woolley
10/05/99 05:30:46 PM

Record Type: Record

To: Jackson T. Dunn/WHO/EOP@EOP, Maureen T. Shea/WHO/EOP@EOP, Deborah B. Mohile/WHO/EOP@EOP, Laura Efurd/WHO/EOP@EOP
cc: Christine A. Stanek/WHO/EOP@EOP
Subject: Re: chip

next week, tuesday, the president will speak to the American Academy of Pediatrics on Children's Health Insurance. We are trying to get an update on what the groups did. I have put in your mailbox/chair the groups commitments made 6 months ago. Can you call the group and ask for the following information per devorah adler's email. If they have any visuals, please get copies. I would also like to put together a list of contacts, so please forward name, org and phone number. With the long weekend, we will need the information due thursday, oct. 7. Thanks. Any questions, call me.

Burson-Marsteller

1801 K Street, N.W.
Suite 1000-4
Washington, D.C. 20006 1301

www.bm.com

E. Linwood Tipton (IDFA)
said it's okay to say
that

October 7, 1999

suiza foods participated in the
chip program

Ms. Barbara Woolley
Special Assistant to the President
Office of Public Liaison
The White House
1600 Pennsylvania Ave
Washington, DC

Dear Ms. Woolley:

Thank you for the opportunity to present the activities and efforts undertaken by Wyeth-Lederle Vaccines on behalf of the Children's Health Insurance Program (CHIP). Wyeth's efforts, some of which you may recall, include:

- *Formation of the CHIP Working Group* – We have assembled representatives of some of the nation's top children's health advocacy groups -- including the American Academy of Pediatrics, Healthy Mothers, Healthy Babies, the National Education Association, and the Children's Defense Fund -- to discuss ways to help ensure CHIP's success. This group of dedicated advocates has already led to some tangible results, including the First National Children's Health Survey and a CHIP Outreach Tool Kit designed to help community-based organizations communicate CHIP-messages to parents.
- *The First National Children's Health Survey* – Researchers affiliated with NYU's Wagner School of Public Service and Wirthlin Worldwide last year conducted a survey underwritten by Wyeth that sought to evaluate children's health priorities, assess awareness and opinions of CHIP, and test the effectiveness of current outreach efforts. This survey of parents, pediatricians, and advocates yielded several interesting results including that only 17 percent of parents surveyed said they were aware of the program. We have used this data as the basis for our work to enhance CHIP outreach activities.
- *The CHIP Communications Handbook* – Flowing, in part, from the findings of the First National Children's Survey and in collaboration with the CHIP Working Group, the CHIP Communications Handbook has been created. This Handbook will help local advocates and outreach workers have a more positive impact in their CHIP awareness and enrollment initiatives. Completed earlier this year, the Handbook includes sections on "best practices", important assessment tools to better evaluate current communications strategies, various advocacy materials, and a concise resource directory.

CHIP Efforts, Page Two

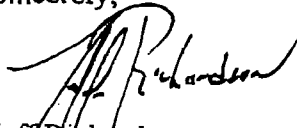
- *Beyond Enrollment: Are SCHIP Plans Linking Children to Quality Health Care?*
This report, supported by a research and educational grant from Wyeth-Lederle, was co-authored by Jack A. Meyer, President of the Washington, DC-based New Directions for Policy (NDP), and his colleague Nancy S. Bagby. Reviewing the then-19 state CHIP plans submitted to HCFA, the report was among the first to point out the vital importance of both the availability of care and the need to ensure that parents are actually *accessing* the care after they have enrolled.

We are very pleased to have collaborated over past year or so with the following key group of national children's supporters: American Nurses Association, Association of State and Territorial Health Officials, Children's Defense Fund, Delta Sigma Theta Sorority, Inc., Every Child By Two, Hope for Kids, National Assembly of National Voluntary Health and Social Welfare Organizations, National Council of La Raza, National Education Association/Health Information Network, National Health Council, and the National Healthy Mothers, Healthy Babies Coalition.

So as you can see, CHIP has been a priority issue for Wyeth-Lederle Vaccines. Working together to advance CHIP -- physicians, advocacy organizations, federal, state, and local governments, and private sector companies -- we can accomplish so much more for our nation's children.

Thank you.

Sincerely,



Jeff Richardson
Managing Director

Fax Attachments



October 7, 1999

TO: Barbara Woolley
Office of Public Liaison
The White House

FROM: Katrina Norfleet Brown
Director of Communications & Membership

RE: Children's Health Insurance Program (CHIP)

In response to your request for information on what AMCHP is doing to help spread the word about CHIP, I've outlined our activities below:

1. Created and maintain a direct link to the Insure Kids Now web site (with toll free number) on our home page at www.amchp.org.
2. Issued press release titled, "State Maternal and Child Health Programs Help Insure Kids Now" to general media. (February 23, 1999)
3. Published front page story on Insure Kids Now campaign in the March/April edition of our bimonthly *Updates* newsletter; continue to use *Updates* to provide information on state CHIP programs.
4. Published *Adolescents and the State Children's Health Insurance Program (CHIP): Healthy Options for Meeting the Needs of Adolescents* (Sept. 1999) in partnership with the National Adolescent Health Information Center and the Policy Information and Analysis Center for Middle Childhood and Adolescence, the University of California, San Francisco. AMCHP and its partners will hold a briefing later this fall announcing this resource in an effort to draw attention to the opportunities presented by CHIP to assure coverage to the adolescent population.
5. Provide ongoing representation and participation on the communications and marketing committee of "Covering Kids," a national health access initiative for low-income uninsured

• A M C H P •

October 1999



American Dental Hygienists' Association
1000 North 17th Street
Washington, D.C. 20001
Phone: (202) 462-1000
Fax: (202) 462-1001
Web: www.adha.org

OFFICERS

Lisa B. Potter, RDH, President
Karla J. Girts, BSDH, RDH, President-Elect
Ann E. Naber, RDH, Vice President
Jamie B. Menees, RDH, BS, Treasurer
Beverly P. Whitford, RDH, BS, Immediate Past President

TRUSTEES

Marie Jones-Bridges, RDH, District I
Susan Callahan Barnard, RDH, MS, District II
Irene Mary Connolly, RDH, MS, District III
Tammi O. Byrd, RDH, District IV
Barb Forrest, RDH, District V
Raychene Michaels, RDH, BS, District VI
Carrie D. Benson, RDH, District VII
Diann Bomkamp, RDH, BSDH, District VIII
Doris Baker, RDH, MA, District IX
Stephanie Bassenberger James, RDH, MS, District X
Mary Turner, RDH, MS, District XI
Gayle Chang, RDH, B.Ed., District XII

EXECUTIVE DIRECTOR

Stanley B. Peck

ADHA Distributes 11,000 Free Toothbrushes With the CHIP Tag Line and Toll-Free Number

In August, the American Dental Hygienists' Association (ADHA) distributed 11,000 free toothbrushes provided by the John O. Butler Company to ADHA state constituents across the country. Each toothbrush was imprinted with the *Insure Kids Now* toll-free number and tag line. These toothbrushes are being distributed to school children in targeted areas across the country.

In other CHIP outreach and enrollment action, ADHA published information on the *Insure Kids Now* campaign including the toll-free number and tag line in the March 1999 edition of *Access* magazine. Featured was a tear-out flyer setting forth the toll-free number along with a sidebar providing background information urging dental hygienists to work to get kids the oral health benefits for which they are eligible. This magazine reaches 80,000 dental hygienists in each of the 50 states.

Information about the *Insure Kids Now* campaign was also made available to each of the registrants at ADHA's annual meeting in June.

ADHA will continue its efforts in partnership with the Administration to ensure that CHIP and Medicaid-eligible children receive the health insurance coverage to which they are entitled.

Enclosed are samples of the toothbrushes and a copy of the explanatory sidebar and the tear-out flyer that was featured in the March issue of *Access*.

For additional information contact ADHA's Washington Counsel Karen Sealander of McDermott, Will & Emery at 202-756-8024.

Enclosures

Let's Work Together To Get Kids The Oral Health Benefits For Which They Are Eligible

The Balanced Budget Act of 1997 created a new state Children's Health Insurance Program (CHIP). Like the Medicaid program, CHIP is designed to provide health insurance coverage to uninsured disadvantaged children. The Medicaid program and the vast majority of state CHIP initiatives include oral health coverage. However, an enormous number of children are eligible for but are not enrolled in these programs.

The White House is embarking upon a major outreach effort and has asked ADHA to participate. Below is a tear-out flyer that gives consumers the toll-free number (1-877-KIDS-NOW) for CHIP and Medicaid enrollment information and urges parents to "insure kids now." Although it is a national number, calls are automatically routed—based on the state from which the call

is placed—to that state's agency responsible for enrolling children in Medicaid and CHIP.

We urge that you tear out this announcement and utilize it in publications, flyers, or brochures, or distribute it to community health centers, schools, or any other place where disadvantaged children and their parents might see it and be able to take a copy.

Coordinate your activities with your state dental hygiene association and/or your local dental hygiene component. Feel free to put the flyer in your publications or on your letterhead. Let's all work together so as many children as possible benefit from the oral health coverage in Medicaid and CHIP.

Call Jan Starr (1-800-243-ADHA, ext. 8942) in governmental affairs with any questions.

Insure Kids Now

☼ ☼ ☼ ☼ ☼ ☼

1-877-KIDS-NOW

You love your children and work hard to help them grow up strong and healthy. But like many parents, you haven't been able to give them health insurance. Now you can do something about it because there's a new nationwide effort called INSURE KIDS NOW. Call our toll-free number. Don't let your kids go another day without health coverage.

**Low-cost or free health insurance for kids
is here now.**

American Hospital Association Medicaid/CHIP Outreach Activities

- **National "Back to School" Campaign sponsored by public/private partnership.** The American Hospital Association partnered with the United Way of America and eight other nationally based private sector organizations and three federal agencies for a two-week campaign enroll kids in CHIP and Medicaid. The campaign, scheduled for September 19 – October 2, involved over 25 communities across the country
- **Insure Kids Now September 25 sign-up Day at D.C. Metropolitan Area McDonalds**
The American Hospital Association partnered with WJLA-TV, HCFA March of Dimes and McDonald's for a Medicaid/CHIP sign-up day on Saturday, September 25. Sixteen area McDonalds from D.C., MD. VA., WV hosted Medicaid/CHIP enrollment and outreach activities with over 2000 individuals and families receiving information on how to enroll. In total 330 McDonald's restaurants participated in the information campaign. Sponsored TV ads ran for the month of September with callers directed to a toll-free number. Over 1,000 calls were received. WJLA-TV hosted a phone bank and 200 calls were received during the 90-minute news program.
- **Insure Kids Now Posters** Insure Kids Now posters are going out to every hospital (over 5,000) during the month of October to celebrate national child health month over. The poster has the national toll-free number that callers can dial from anywhere in the country. Callers are routed to their local state program.

American Hospital Association

500 North Dearborn Street
Chicago, Illinois 60610-4001

1-800-626-3329

202-626-3329

1-800-626-3329

10/6/99



SpanglerT@ADA.ORG

10/06/99 05:02:00 PM

Record Type: Record

To: Barbara D. Woolley@eop

cc:

Subject: CHIP Activities

Barbara: In response to your fax on CHIP outreach activities -- the American Dental Association has done the following:

"White House Creates National Toll-free Number for CHIP" was the headline for a page one article in the member-wide circulation ADA News on March 8, 1999.

At a later date, under a headline "Medicaid and Kids", the CHIP story ran as a special state report in the ADA monthly, State Legislative Report, and referenced the March 8 ADA News article.

It ran at least twice on the ADA ONLINE (the ADA's web site) in March and September.

In each instance the toll-free number was listed.



pschneider@nacds.org

10/08/99 08:23:40 AM

CHIP

Record Type: Record

To: Barbara D. Woolley/WHO/EOP

cc:

Subject: Re: CHIP

Thanks again for helping the tour at 11 a.m. today. My friends are M/M Mark Dorian and their three children...Hanna, Emily and Sarah. They have been instructed to be at the water fountain by the East visitors gate and to await someone calling their name.

NACDS in Partnership with Johnson & Johnson distributed over 35,000 posters to chain pharmacies across the United states displaying information about the CHIP program, and posted the general referral number for enrollment information. Pharmacists also were given background information to help answer questions from the public. Additionally, chain pharmacies with other healthcare groups have launched focused campaigns in selected states to increase awareness of the program. (a campaign currently is underway in Virginia).

Nat'l As
National Assoc of Chain
Drug Stores



Pediatric Health
Committed to Kids



Randall E. Kaye, MD
Director—Team Leader
Pediatric Health Team

October 7, 1999

Barbara Woolley
Special Assistant to the President
The White House
Office of Public Liaison
1600 Pennsylvania Avenue
Washington DC 20007

Dear Ms. Woolley:

Pfizer Pediatric Health promoted the "Kids-Now" hotline by placing it on the back cover of our PDR Pediatric Resource Guide, 1999 edition. We are distributing 25,000 guides to pediatricians' offices around the country. Additionally in collaboration with Kmart we have distributed the guide for use in all of their pharmacies.

Regards,

Randall Kaye, M.D.
Director, Team Leader

REK/jb

March of Dimes SCHIP and Medicaid Outreach Activities

1. The March of Dimes promoted SCHIP and Medicaid and the Insure Kids Now toll-free phone number during WalkAmerica, the Foundation's largest fundraising event that takes place during early spring. Banners advertising the toll-free hotline were displayed at over 1000 WalkAmerica sites across the country, reaching the more than 1 million volunteers, 20,000 corporate donors, and radio and television audiences in every major media market (*photos attached*). The Foundation continues to display the Insure Kids Now banners during other organization activities, including education forums and legislative events.
2. On October 23, 1999, the March of Dimes will hold an in-store outreach and enrollment event at Kmart stores across the nation. During this special "Volunteer Days" grassroots initiative, March of Dimes volunteers, including members of our college-age Youth Council, will help families apply for coverage under SCHIP and Medicaid. (The participation of our college and high school age volunteers is, in part, an initiative designed to meet the Foundation's America's Promise commitment to step up involvement of youth in our high-priority national initiatives). The Foundation has also implemented an ongoing SCHIP/Medicaid promotion in Kmart's 1,200 in-store pharmacies. Flyers are available at the pharmacies and distributed with all prescriptions (*copy attached*).
3. The March of Dimes' Board of Trustees has designated implementation of SCHIP and Medicaid expansions as one of three mission priorities for 1999 and 2000. Accordingly, March of Dimes chapters in every state are engaging in a variety of activities to promote SCHIP and Medicaid, ranging from serving on state committees that devise outreach strategies (Illinois), to outreach efforts targeted to segments of the population often overlooked in broad mass media campaigns (e.g. South Carolina chapters have used their connections to the Hispanic community to conduct targeted outreach).
4. During the past 10 months, the seven March of Dimes chapters in Texas held 17 educational forums for policymakers, business leaders, parents, health professionals and community activists across the state. These forums were designed to promote awareness of the SCHIP program while Phase I of the Texas SCHIP program was being implemented and while debate over Phase II was taking place in the Legislature.
5. The March of Dimes has made use of its extensive direct mail network to promote children's health coverage. In particular, SCHIP was featured in a direct mail newsletter sent to over 1.5 million individual donors and through local chapter and WalkAmerica newsletters which are sent to an additional 500,000 volunteers and corporate supporters (*copy attached*).
6. The Foundation has engaged in back-to-school outreach activities in conjunction with the Department of Justice and other national partners in the "Back to School Campaign." The March of Dimes has promoted Medicaid and SCHIP and has

distributed application materials at various school-based outreach events in communities across the country, including Atlanta, Chicago and Washington, D.C.

7. The March of Dimes has funded and helped implement a television advertising campaign that began airing in the Washington, D.C. metropolitan area on October 7, 1998, as part of "National Child Health Month." The ads ran again in September 1999 in conjunction with March of Dimes SCHIP and Medicaid outreach events at McDonald's restaurants in the D.C. metropolitan area. The March of Dimes collaborated with the Health Care Financing Administration; the American Hospital Association; McDonald's; Safeway Food Stores; and WJLA-TV, the Washington, DC area ABC network affiliate, to carry out this campaign.



October 8, 1999

Ms. Barbara Wooley
White House
Washington, DC

Dear Barbara:

As you requested, here is a summary of the ways that Safeway Food & Drug cooperated with the children's health initiative to spread the word on the availability of low-cost or free health insurance for kids.

In addition to the "Insure Kids Now" campaign materials, Safeway's Eastern Division also participated with a local campaign promoted on WJLA-TV Channel 7 in Washington, DC. We ran ads on three separate occasions (see copy attached) in our Savings Guide, which, at the time, was mailed to approximately 2.3 million households in the Washington-Baltimore area each month (so that's 3 x 2.3 or 6.9 million households).

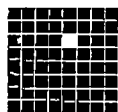
The artwork we received for "Insure Kids Now" was not the appropriate dimensions for our paper bags, so at my cost I had it redesigned by a graphics firm and duplicated for six of our divisions. Here is what they're doing:

Eastern Division	Metropolitan areas of Washington, D.C. and Baltimore, MD (125 stores) 1.6 million bags during November and December 1999
Phoenix Division	State of Arizona and one store in New Mexico (85 stores) 3.2 million bags during March 2000
Nor Cal Division	Northern California, Nevada, Hawaii (242 stores) 1.2 million bags during December 1999
Denver Division	Colorado, South Dakota, Nebraska, Wyoming, New Mexico (121 stores) 500,000 bags in November
Portland Division	Oregon and Washington (106 stores) 2.6 million bags in November
Total	13 states (plus DC), 679 stores and 9.1 million bags

I hope this is what you need for your summary.

Sincerely,

Gregory A. TenEyck
Director of Public Affairs



American College of Emergency Physicians

To: Erica
Barbara Woolley

Fax: (202) 456-6218
(202) 456-2930

From: Laura Gore

Date: October 8, 1999

Pages: 2, including cover sheet.

Here is ACEP's blurb about CHIP. I'm sort of at a disadvantage, because I haven't been involved in promoting this program, and the people who are — are on their way to ACEP's annual meeting in Las Vegas. Our members (e.g., Dr. Al Sacchetti and Dr. John Brennan, especially) who have been involved in meetings and strategizing how to get the word out, also are on their way to Las Vegas. However, I did some research, and this is what I came up with.

American College of Emergency Physicians

The American College of Emergency Physicians (ACEP) has actively promoted the Children's Health Insurance Program through its more than 20,000 members in various ways including issuing a press release, posting information about the program on ACEP's website, and promoting the toll-free number through its state chapters. ACEP also has regularly updated its members on the program through its internal publications, and several ACEP Chapters have promoted CHIP extensively, especially Pennsylvania, New Jersey, and Florida.

fax

Please call me if you need additional information.



YMCA

We build strong kids,
strong families, strong communities.

October 8, 1999

TO: Barbara Woolley
Office of Public Liaison, The White House
FROM: Eden Fisher Durbin *g. durbin*
Public Policy department, YMCA of the USA
RE: Children's Health Insurance Program (CHIP)

I am pleased to update you on our progress in getting out the word about CHIP to our 17 million members. The YMCA of the USA is passionately committed to spreading the word about CHIP to the families and communities we serve. By promoting CHIP, Ys are helping fulfill their mission of building strong kids, families and communities.

As I mentioned on the phone, our national executive director, David R. Mercer, and the chairman of the YMCA of the USA board, Tom Henderson, will be in Washington on Tuesday, October 12. They are available to participate in any CHIP events you may plan.

The YMCA of the USA met all three commitments made in February:

- We featured CHIP in our *Hotfax* publication, a national fax alert that goes to over 4,000 YMCA staff and volunteers (attached).
- Many YMCAs promoted CHIP at their annual Healthy Kids Day. Healthy Kids Day is a national day for YMCAs to highlight kids' health issues.
- CHIP materials were distributed and the program mentioned in appropriate speeches at national YMCA conferences, including the YMCA Multi-Cultural Conference and the YMCA City Agenda Conference, where keynote speaker Secretary Richard Riley discussed CHIP.

In addition, the Public Policy department is planning many more ways to spread the word about CHIP:

- The YMCA of the USA will incorporate CHIP into its new nationwide City Agenda. The City Agenda supports YMCA work in urban areas. City Agenda programs target low-income communities, focusing on middle-school age children and teenagers.
- CHIP will be featured on the soon to be re-launched www.ymca.net web site. In addition to providing general information and links, we will feature CHIP in our new e-mail newsletters.
- *Member News* is a four-color glossy poster hung in YMCA lobbies and locker rooms nationwide. Our 17 million members read *Member News* each month. An early 2000 edition will highlight CHIP (example attached).
- *Discovery YMCA* is a quarterly magazine that reaches approximately 100,000 YMCA volunteers, donors and friends. An article in one of next year's issues will address CHIP (example attached).
- On November 22 the YMCA of the USA will release *The Nation's Report Card: Assessing Risks to the American Family*. One section covers health issues and will include CHIP (example attached).
- Healthy Kids Day 2000 information packets will include information on CHIP.

The YMCA of the USA will continue to encourage YMCAs to find creative and effective ways to let their members know about CHIP. Here is an example of how one local YMCA in Silver Spring, Md., incorporates CHIP into every youth and family program:

- For Healthy Kids Day, the YMCA set up a table at their community fair and signed up families for CHIP in Spanish, English and Vietnamese.
- The YMCA provides wrap-around health and mental health services for four public schools through the "Linkages to Learning" program. Part of every case manager's job is to sign up eligible kids for CHIP.
- At the YMCA Carroll Avenue and Quebec Terrace Community Center, operating in a low-income apartment complex, youth and family bilingual counselors sign up families for CHIP. The Y is also part of the Quebec Terrace Action Group, dedicated to increasing the number of neighborhood kids signed up for CHIP.
- Teachers at the YMCA's Head Start program visit every child's home. During the visit the teacher will establish if there is a need for health insurance and, if so, help the families with the paperwork.
- In addition, the Silver Spring YMCA works with other agencies to raise awareness about CHIP, including the health department, the schools, and the community action agency.



October 6, 1999

Ms. Barbara Wooley
Office of Public Liaison
The White House

Dear Barbara:

Per your request, the following is a list of several programs Kmart Corporation has implemented in support of the Insure Kids Now campaign.

- Insure Kids Now brochures distributed through all Kmart Pharmacies nationwide (attached)
- Public Service Announcements aired in all Kmart locations. September – December
- Insure Kids Now message printed on checkout bags. September (attached)
- Tri-State Focus launched in September with March of Dimes and Children's Defense Fund in New York, New Jersey and Connecticut. Included in this effort are 50 in-store health fairs, which will provide answers regarding the program to interested parents. September 15 – November 8 (in store materials and press kit attached)
- Article in our internal Kmart Headliners newsletter that is distributed to all associates.

It's our pleasure to help spread the word about this important program. If you need additional information, please contact Cathy Polley, Director Pharmacy Government and Trade Relations at (248) 643-1262.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Dale Apley', with a large, sweeping flourish at the end.

Dale Apley

cc: Cathy Polley

The following religious organizations have worked with the CHIP program by distributing brochures and communicating via email:

Union of American Hebrew Congregations

United Synagogue of Conservative Judaism

United Jewish Communities (formerly Council of Jewish Federations)

**Update on the Schering-Plough Corporation's Efforts to Promote
CHIP-NJ KidCare**

- ◆ Approximately 400 children in the City of Elizabeth, New Jersey, have been enrolled in NJ KidCare as a result of a recent grant made by Schering-Plough. The NJ KidCare project, which began in August, 1999, hopes to enroll 3,000 children. Based on the initial enrollment numbers, this goal should be reached.
- ◆ Schering-Plough's asthma/allergy Web site for school nurses (www.schoolasthma.com) prominently promotes CHIP information for **all 50 states**. Attached is an illustration of the CHIP state-specific information available to all school nurses who have access to the Internet. The Web site also provides an Internet hyperlink to the applications for the state-specific CHIP programs. School nurses can provide the application directly to parents of uninsured children. An official launch of the Web site featuring the CHIP/KidCare information will be attended by Governor Christine Todd Whitman and will take place in Elizabeth on November 2, 1999. Schering-Plough will provide the 150 school nurses who attend the event with re-engineered laptop computers that are Internet compatible.
- ◆ Schering-Plough is collaborating with America's Promise to solicit hardware to equip school nurses throughout the country with Internet accessibility for the above-stated uses.
- ◆ Schering-Plough expects to launch this Web site in as many states as possible.

● Maureen T. Shea

10/07/99 05:19:41 PM

Record Type: Record

To: Barbara D. Woolley/WHO/EOP@EOP

cc:

Subject: Re: chip 

Catholic Charities USA

Contact: Lisa Smith 703-549-1390 X160

As promised: A major drive with seven Catholic Hospital systems and their 1,500 local Catholic Charities, including advocacy handbooks and awareness kits sent to each for their use in spreading the word both within their own systems and in their communities. Also did trainings in eight states with Catholic Charities staff.

Evangelical Lutheran Church in America/ Division of Church and Society

Contact: Sally Camp 804-355-9185

As promised: Have on website with link, included in article on women and children in poverty as well as in children's initiative booklet distributed to their 11,000 congregations

National Council of Catholic Women

Contact: Annette Kane 682-0334 X105

As promised: Included in magazine which reaches 11,000 nationwide.

National Council of Churches of Christ

Contact: Mary Cooper 544-2350

As promised: Distributed information to their 33 members communications representing 52 million US Christians

United Methodist Church - General Board of Church and Society

As promised: Distributed to their 700 members nationwide and include in workshops.

NETWORK

As promised: Distributed in their magazine which reaches 10,000 nationwide.

Woman's Missionary Union

As promised: Distributed to their leadership of 300 nationwide.

October 7, 1999

Ms. Barbara Woolley
Special Assistant to the President
Office of Public Liaison
The White House
1600 Pennsylvania Ave
Washington, DC

Dear Ms. Woolley:

Thank you for the opportunity to present the activities and efforts undertaken by Wyeth-Lederle Vaccines on behalf of the Children's Health Insurance Program (CHIP).

Wyeth's efforts, some of which you may recall, include:

- *Formation of the CHIP Working Group* -- We have assembled representatives of some of the nation's top children's health advocacy groups -- including the American Academy of Pediatrics, Healthy Mothers, Healthy Babies, the National Education Association, and the Children's Defense Fund -- to discuss ways to help ensure CHIP's success. This group of dedicated advocates has already led to some tangible results, including the First National Children's Health Survey and a CHIP Outreach Tool Kit designed to help community-based organizations communicate CHIP-messages to parents.
- *The First National Children's Health Survey* -- Researchers affiliated with NYU's Wagner School of Public Service and Wirthlin Worldwide last year conducted a survey underwritten by Wyeth that sought to evaluate children's health priorities, assess awareness and opinions of CHIP, and test the effectiveness of current outreach efforts. This survey of parents, pediatricians, and advocates yielded several interesting results including that only 17 percent of parents surveyed said they were aware of the program. We have used this data as the basis for our work to enhance CHIP outreach activities.
- *The CHIP Communications Handbook* -- Flowing, in part, from the findings of the First National Children's Survey and in collaboration with the CHIP Working Group, the CHIP Communications Handbook has been created. This Handbook will help local advocates and outreach workers have a more positive impact in their CHIP awareness and enrollment initiatives. Completed earlier this year, the Handbooks includes sections on "best practices", important assessment tools to better evaluate current communications strategies, various advocacy materials, and a concise resource directory.

CHIP Efforts, Page Two

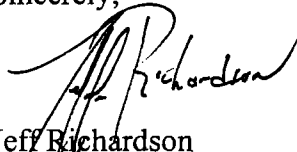
- *Beyond Enrollment: Are SCHIP Plans Linking Children to Quality Health Care?*
This report, supported by a research and educational grant from Wyeth-Lederle, was co-authored by Jack A. Meyer, President of the Washington, DC-based New Directions for Policy (NDP), and his colleague Nancy S. Bagby. Reviewing the then-19 state CHIP plans submitted to HCFA, the report was among the first to point out the vital importance of both the availability of care and the need to ensure that parents are actually *accessing* the care after they have enrolled.

We are very pleased to have collaborated over past year or so with the following key group of national children's supporters: American Nurses Association, Association of State and Territorial Health Officials, Children's Defense Fund, Delta Sigma Theta Sorority, Inc., Every Child By Two, Hope for Kids, National Assembly of National Voluntary Health and Social Welfare Organizations, National Council of La Raza, National Education Association/Health Information Network, National Health Council, and the National Healthy Mothers, Healthy Babies Coalition.

So as you can see, CHIP has been a priority issue for Wyeth-Lederle Vaccines. Working together to advance CHIP -- physicians, advocacy organizations, federal, state, and local governments, and private sector companies -- we can accomplish so much more for our nation's children.

Thank you.

Sincerely,



Jeff Richardson
Managing Director

Fax Attachments

**AMERICAN MEDICAL RESPONSE****MEMORANDUM****DATE:** October 8, 1999**TO:** Barbara Woolley**FROM:** Steve Murphy *sm***SUBJECT:** CHIP Update

Barbara,

American Medical Response has conducted EMS oriented community awareness days around the country, several of which have included promotional information on the CHIP program. We have developed a customized CHIP logo that will include the national 1-877-KIDS-NOW for use on our various community outreach materials throughout the country. We are in the process of developing a standardized flyer for national distribution to our operating locations for their use as envelope stuffers, give-aways, etc.

Steve

Future Contact Information –

HOPE for Kids 1999 Program Summary

Accomplishments in 1999

HOPE for Kids, a program of HOPE *worldwide*, has provided health education outreach to 1,164,784 children in 107 cities across 38 states this year. Activities include health fairs, door-to-door outreach campaigns, mentoring and training classes, and arts and entertainment programs. Areas of health education include immunizations, lead poison prevention, HIV/AIDS, asthma, hypertension, diabetes, and children's health insurance. In fact, HOPE for Kids volunteers have educated the families of 138,570 uninsured children and helped to enroll 6,758 of them. HOPE for Kids partners with hundreds of agencies and organizations across the nation to provide proper health insurance applications for Medicaid or CHIP. Through a grant from the Corporation for National Service, HOPE for Kids has hired AmeriCorps Fellows in eight selected cities (Chicago, Dallas, New York City, Miami, Los Angeles, Philadelphia, Boston and San Francisco). These AmeriCorps Fellows follow up with uninsured children and assist them in completing their Medicaid or Children's Health Insurance applications.

At the Presidents' Summit for America's Future in 1997, HOPE for Kids pledged that 150,000 volunteers would work 1 million volunteer hours to affect 3 million children with health education information in 100 cities by the end of the year 2000. This year HOPE for Kids has already surpassed these goals.

Future Activities

Each December, all HOPE for Kids programs nationwide participate in a Holiday Toy Drive to provide toys for disadvantaged inner-city children. In 1998, more than 89,000 children received gifts through our program. This year is expected to be even greater.

Challenges Encountered

HOPE for Kids has been very successful in its efforts to reach needy and uninsured children. However, we have faced several challenges in accomplishing our goals, including the following:

- Many families do not have an adequate understanding of what health insurance is available to them.
- Families believe that if they are taken off welfare they do not qualify for Medicaid or CHIP.
- In some states the Medicaid and CHIP applications are still too lengthy and some families give up before completing the application.
- More funding support should be given to assist organizations like HOPE for Kids with outreach, education, enrollment and follow up.

HOPE for Kids
Outreach Results
January 1 - September 30, 1999

Region <u>Totals</u>	Total Children <u>Affected</u>	Uninsured Children <u>Affected</u>	# Children Who Applied <u>for Medicaid/CHIP</u>
Central US Region	198,166	22,237	111
East Coast Region	415,156	35,750	2,624
Gulf Coast Region	61,866	8,885	3,333
Los Angeles Region	113,234	32,778	91
Mid Atlantic Region	135,430	10,800	564
New England Region	43,144	3,534	0
Northwest Region	19,885	1,552	0
Pacific Rim Region	52,788	1,538	28
Southwest Region	125,125	21,496	7
National Totals:	<u>1,164,784</u>	<u>138,570</u>	<u>6,758</u>

CHILES

HOPE FOR KIDS

HOPE worldwide

9737540757

04:59

04/1995

The Children's Defense Fund is engaged in numerous outreach and enrollment activities in states where we have CDF offices - California, Mississippi, Minnesota, New York, Ohio and Texas.

In California, we have worked with community-based organizations throughout the state to create linkages where information on ideas and best practices can be shared between communities on Healthy Families and Medi-CAL outreach. We have also been successful in informing policy makers on the state level as to what is working with the programs and what needs to be fixed (long waits on toll free lines, community-based organizations not getting their application assitor checks from the state, and other problems that have arisen).

In Minnesota we are the lead agency for the Robert Wood Johnson Covering Kids grant. We are overseeing three pilot projects through this grant - one is through the parent walk in center in Minneapolis public schools.

In New York we have piloted two major outreach projects. One is a partnership that includes CDF-NY, Martha Stewart Living Omnimedia, and the Kmart Corporation which launched a three month campaign in early September in New York, New Jersey, and Connecticut that provides information to families needing health insurance for their children. Our goal is to ensure all eligible families learn about and enroll their children in the State Child Health Insurance Program. "Child Health Now!" features in-store informal displays and a public service media campaign by Martha Stewart. As part of this effort health fairs will be held at over 100 stores in the tri-state area over the three month campaign.

The second pilot is the Student Outreach Project (SHOUT). This project was launched last spring at Columbia University to train students to be application assitors and pair them with local community-based organizations that work with eligible families. This semester CDF is working to expand the program to 10 campuses throughout the country, as well as expanding our work in the New York area to Medical Schools. In the Spring of 1999 we also held a one day training for community-based organizations and area colleges on SHOUT and community based involvement in outreach and enrollment efforts in New York City.



A Children's Health Insurance Public Awareness and Outreach Campaign

The Children's Defense Fund-NY, Martha Stewart Living Omnimedia and the Kmart Corporation are launching a three month campaign, beginning in September, in New York, New Jersey and Connecticut that provides information to families needing health insurance for their children. Our goal is to ensure that all eligible families learn about and enroll their children in the State Child Health Insurance Program. Child Health Now! features in-store informational displays and a public service media campaign featuring Martha Stewart.

The Facts

There are more than 11 million uninsured children, under 19 years of age, in the United States. Ninety percent of these children live in families where one or more parents work. Locally, there are more than 1 million uninsured children living in New York, New Jersey and Connecticut.

Children without health coverage are less likely to have:

- A regular source of primary care
- Made a doctors visit in the last year
- Received necessary dental or vision care
- Received all of their recommended vaccinations.

Often times, medical conditions go untreated, impeding a child's ability to grow up healthy.

In August of 1997, President Clinton signed into law the biggest investment in children's health since the enactment of Medicaid in 1965. The new federal program called the State-Child Health Insurance Program (S-CHIP), allocated \$48 billion to states over the next 10 years for the sole purpose of providing health insurance to uninsured children. With the funding available in the tri-state area we can provide health insurance for the majority of our children.

Many of these families are eligible for public health insurance programs and are simply not enrolled. The reasons for poor enrollment vary. Many families are simply unaware that these programs exist or that their children might qualify. Working families may assume that because they have jobs they are not eligible. Sometimes families are just unable to maneuver through the complicated application process. Immigrant families often face additional enrollment problems such as language barriers and a distrust or fear of government programs.

Our Plan

Public Awareness

Media

- The Child Health Now! partnership has developed a public service campaign, designed by Martha Stewart Living Omnimedia, featuring Martha Stewart. The campaign includes television, radio, print and in-store displays which will debut in September.

In-store Promotion

- Beginning in mid-September, all Kmart stores in the tri-state area will feature special displays promoting the availability of free or low cost health insurance for children and the national Insure Kids Now hotline. Display elements will include posters, banners, door decals, messages on shopping bags and educational fliers describing how families can apply for health insurance. Stores will also broadcast the radio public service announcements featuring Martha Stewart.

Mobilization

- Beginning in October, several dozen Kmart stores will host "Child Health Now! Fairs" during which parents can speak with representatives of community based organizations about enrollment in children's health insurance.

A PARTNERSHIP OF CHILDREN'S DEFENSE FUND, MARTHA STEWART LIVING OMNIMEDIA AND KMART CORPORATION

420 Lexington Avenue, Suite 655, New York, NY 10170

Tel: 212-512-7400 Fax: 212-512-0865 www.childhealthnow.org

10.
SEP 28 99 9:19 NO.002 P.01

Date: 9/28

FAX



Health Division



Office of Management and Budget
Executive Office of the President
Washington, DC 20503

To: *Devorah Adler*
Fax:

From: *Kate Kivichyuk*

Number of Pages (excluding cover): *17*

Subject: *CHIP / Medicaid Technicals*

Voice Numbers:

Health Division (Front Office)	202/395-4922
Health & Human Services Branch	202/395-4925
Health Programs & Services Branch	202/395-4926
Health Financing Branch	202/395-4930

Fax Numbers:

Health Division (Front Office)	202/395-3910
Health Division (Room 7001)	202/395-7840
Health Division (Room 7002)	202/395-5648

1 **SEC. ____ STABILIZING THE SCHIP ALLOTMENT FORMULA.**

2 (a) IN GENERAL.—Section 2104(b) of the Social Se-
3 curity Act (42 U.S.C. 1397dd(b)) is amended—

4 (1) in paragraph (2)(A)—

5 (A) in clause (i), by striking “through
6 2000” and inserting “and 1999”; and

7 (B) in clause (ii), by striking “2001” and
8 inserting “2000”;

9 (2) by amending paragraph (4) to read as fol-
10 lows:

11 “(4) FLOORS AND CEILINGS IN STATE ALLOT-
12 MENTS.—

13 “(A) DOLLAR FLOOR.—In no case shall
14 the amount of the allotment under this sub-
15 section for one of the 50 States or the District
16 of Columbia for a year be less than \$2,000,000.

17 “(B) FLOORS AND CEILINGS ON CHANGES
18 IN ALLOTMENT PROPORTIONS.—Subject to sub-
19 paragraph (A), in no case shall the proportion
20 of the allotment under this subsection for one
21 of the 50 States or the District of Columbia for
22 fiscal year 2000 and each fiscal year
23 thereafter—

24 “(i) decrease by more than 10 percent
25 of the proportion for such State from the
26 preceding fiscal year;

1 “(ii) decrease by more than 30 per-
2 cent of the proportion for such State for
3 fiscal year 1999; or

4 “(iii) increase by more than 45 per-
5 cent of the proportion for such State for
6 fiscal year 1999.

7 “(C) RECONCILIATION.—To the extent
8 that the application of any of the preceding
9 subparagraphs results in the sum of the propor-
10 tions of such allotments—

11 “(i) exceeding 1.0, the Secretary shall
12 limit the maximum percentage increase in
13 the fiscal year (compared to the previous
14 fiscal year) in the proportion of allotments
15 under this paragraph for all such States in
16 a manner so that such sum equals 1.0; or

17 “(ii) being less than 1.0, the propor-
18 tion of such allotments (as computed be-
19 fore the application of floors under sub-
20 paragraphs (A) and (B)) for any State or
21 the District of Columbia under this sub-
22 section shall be increased in a pro rata
23 manner (but not to exceed the ceiling es-
24 tablished under subparagraph (B)(iii)) so

1 that (after the application of such floors
2 and ceiling) such sum equals 1.0.

3 “(D) CONSTRUCTION.—Subparagraphs (B)
4 and (C) shall not be construed as applying to
5 amounts of allotments redistributed under sub-
6 section (f).”; and

7 (3) in paragraphs (2)(B) and (3)(B), by strik-
8 ing “the fiscal year” each place it appears and in-
9 serting “the calendar year in which such fiscal year
10 begins”.

11 (d) EFFECTIVE DATE.—The amendments made by
12 this section apply to allotments determined under title
13 XXI of the Social Security Act (42 U.S.C. 1397aa et seq.)
14 for fiscal year 2000 and each fiscal year thereafter.

O:\ERN\ERN99.278

DISCUSSION DRAFT

S.L.C.

9/13

1 SEC. __. MEDICAID-RELATED BBA TECHNICALS.

2 (a) CROSS-REFERENCE CORRECTIONS.—

3 (1) Section 1902(a)(10)(A)(ii)(XIV) of the So-
4 cial Security Act (42 U.S.C.
5 1396a(a)(10)(A)(ii)(XIV)) is amended by striking
6 "1905(u)(2)(C)" and inserting "1905(u)(2)(B)".

7 (2) Section 1903(f)(4) of such Act (42 U.S.C.
8 1396b(f)(4)) is amended, in the matter preceding
9 subparagraph (A), by striking "1905(p)(1), or
10 1905(u)" and inserting "1902(a)(10)(A)(ii)(XIII),
11 1902(a)(10)(A)(ii)(XIV), or 1905(p)(1)".

12 (3) Section 1905(a)(15) of such Act (42 U.S.C.
13 1396d(a)(15)) is amended by striking
14 "1902(a)(31)(A)" and inserting "1902(a)(31)".

15 (b) ELIMINATION OF DUPLICATIVE REQUIREMENTS
16 FOR EXTERNAL QUALITY REVIEW OF MEDICAID MAN-
17 AGED CARE ORGANIZATIONS.—

18 (1) Section 1902(a)(30) of the Social Security
19 Act (42 U.S.C. 1396a(a)(30)) is amended—

20 (A) in subparagraph (A), by adding "and"
21 at the end;

22 (B) in subparagraph (B)(ii), by striking ";
23 and" and inserting a semicolon; and

24 (C) by striking subparagraph (C).

25 (2) The amendments made by paragraph (1)
26 apply as of such date as the Secretary of Health and

1 Human Services certifies [to Congress] that it is
2 fully implementing section 1932(c)(2) of the Social
3 Security Act (42 U.S.C. 1396u-2(c)(2)).

4 (c) MAKING ENHANCED MATCH UNDER SCHIP
5 PROGRAM (INAPPLICABLE TO MEDICAID DSH PAY-
6 MENTS.—

7 (1) The last sentence of section 1905(b) of the
8 Social Security Act (42 U.S.C. 1396d(b)) is amend-
9 ed by inserting "(other than expenditures under sec-
10 tion 1923)" after "with respect to expenditures".

11 (2) The amendment made by paragraph (1)
12 takes effect on [October 1, 1999], and applies to
13 expenditures made on or after such date.

14 (d) MAKING DEFERMENT OF THE EFFECTIVE DATE
15 FOR OUTPATIENT DRUG AGREEMENTS OPTIONAL FOR
16 STATES.—[review drafting]

17 (1) Section 1927(a)(1) of the Social Security
18 Act (42 U.S.C. 1396r-8(a)(1)) is amended by strik-
19 ing "shall not be effective until" and inserting "shall
20 become effective as of the date on which the agree-
21 ment is entered into or, at State option, on any date
22 thereafter on or before".

23 (2) The amendment made by paragraph (1) ap-
24 plies to agreements entered into on or after the date
25 of enactment of this Act.

O:\ERN\ERN99.278

DISCUSSION DRAFT

S.L.C.

3

1 (e) AUTHORITY TO TRANSFER FUNDS FROM SCHIP
2 APPROPRIATION TO HCFA MEDICAID ACCOUNT.—Sec-
3 tion 2104 of the Social Security Act (42 U.S.C. 1397dd)
4 is amended by adding at the end the following new sub-
5 section:

6 “(g) AUTHORITY TO TRANSFER FUNDS.—From the
7 amount appropriated for a fiscal year (beginning with fis-
8 cal year [2000]) under subsection (a), the Secretary shall
9 transfer to the appropriations account for Grants to
10 States for Medicaid the amount necessary to pay for ex-
11 penditures under title XIX to carry out the purposes of
12 this title.”.

13 SEC. ____ INCREASE IN DISPROPORTIONATE SHARE HOS-
14 PITAL ALLOTMENT FOR CERTAIN STATES
15 AND THE DISTRICT OF COLUMBIA.

16 The table included in section 1928(f)(2) of the Social
17 Security Act (42 U.S.C. 1396r-4(f)(2)) is amended under
18 each of the columns for FY 00, FY 01, and FY 02—

19 (1) at the line for the District of Columbia, by
20 striking “28” and inserting “32”;

21 (2) at the line for Minnesota, by striking “16”
22 and inserting “33”;

23 (3) at the line for New Mexico, by striking “5”
24 and inserting “9”; and

1 (4) at the line for Wyoming, by striking "0"
2 and inserting ".191".

3 SEC. __. MAKING MEDICAID DSH TRANSITION RULE PER-
4 MANENT.

5 (a) IN GENERAL.—Section 4721(e) of the Balanced
6 Budget Act of 1997 (42 U.S.C. 1396r-4 note) is
7 amended—

8 (1) in the matter before paragraph (1), by
9 striking "1923(g)(2)(A)" and "1396r-4(g)(2)(A)"
10 and inserting "1923(g)(2)" and "1396r-4(g)(2)",
11 respectively;

12 (2) in paragraphs (1) and (2)—

13 (A) by striking ", and before July 1,
14 1999"; and

15 (B) by striking "in such section" and in-
16 serting "in subparagraph (A) of such section";
17 and

18 (3) by striking "and" at the end of paragraph
19 (1), by striking the period at the end of paragraph
20 (2) and inserting "; and", and by adding at the end
21 the following new paragraph:

22 "(3) effective for State fiscal years that begin
23 on or after July 1, 1999, 'or (b)(1)(B)' were in-
24 serted in section 1923(g)(2)(B)(ii)(I) after
25 '(b)(1)(A)'."

O:\ERN\ERN99.275

DISCUSSION DRAFT

S.L.C.

5

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall be effective as if included in the enact-
3 ment of the Balanced Budget Act of 1997.

4 SEC. ____ INCREASED ALLOTMENTS FOR TERRITORIES
5 UNDER THE STATE CHILDREN'S HEALTH IN-
6 SURANCE PROGRAM.

7 Section 2104(c)(4)(B) of the Social Security Act (42
8 U.S.C. 1397dd(c)(4)(B)) is amended by inserting "
9 \$34,200,000 for each of fiscal years 2000 and 2001,
10 \$25,200,000 for each of fiscal years 2002 through 2004,
11 \$32,400,000 for each of fiscal years 2005 and 2006, and
12 \$40,000,000 for fiscal year 2007" before the period.

13 SEC. ____ REMOVAL OF FISCAL YEAR LIMITATION ON CER-
14 TAIN TRANSITIONAL ADMINISTRATIVE COSTS
15 ASSISTANCE.

16 Section 1931(h) of the Social Security Act (42 U.S.C.
17 1396u-1(h)) is amended—

18 (1) in paragraph (3), by striking "and ending
19 with fiscal year 2000"; and

20 (2) by striking paragraph (4).

21 SEC. ____ MODIFICATION OF CHIP ALLOTMENT FORMULA.

22 (a) ACCELERATION OF UNINSURED AND LOW-IN-
23 COME BLEND.—Section 2104(b)(2)(A) of the Social Secu-
24 rity Act (42 U.S.C. 1397dd(b)(2)(A)) is amended—

O:\ERN\ERN99.275

DISCUSSION DRAFT

S.L.O.

6

1 (1) in clause (i), by striking "through 2000"
2 and inserting "and 1999";

3 (2) in clause (ii)—

4 (A) by striking "2001" and inserting
5 "2000";

6 (B) in subclause (I), by striking "75 per-
7 cent" and inserting "50 percent"; and

8 (C) in subclause (II), by striking "25 per-
9 cent" and inserting "50 percent"; and
10 (3) in clause (iii)—

11 (A) in subclause (I), by striking "50 per-
12 cent" and inserting "25 percent"; and

13 (B) in subclause (II), by striking "50 per-
14 cent" and inserting "75 percent".

15 (b) FLOORS AND CAPS ON STATE ALLOTMENT
16 GROWTH.—Paragraph (4) of section 2104(b) of the Social
17 Security Act (42 U.S.C. 1397dd(b)) is amended to read
18 as follows:

19 "(4) FLOORS AND CAPS FOR STATES —

20 "(A) DOLLAR FLOOR.—In no case shall
21 the amount of the allotment under this sub-
22 section for one of the 50 States or the District
23 of Columbia for a year be less than \$2,000,000.

24 [note: combined (B) and (C) from prior
25 draft]"(B) FLOORS AND CAPS ON ALLOTMENT

O:\ERN\ERN009.278

DISCUSSION DRAFT

S.L.C.

7

1 GROWTH.—Subject to subparagraph (A), in no
2 case shall the proportion of the allotment under
3 this subsection for one of the 50 States or the
4 District of Columbia for fiscal year 2000 and
5 each fiscal year thereafter—

6 “(i) decrease or increase by more than
7 35 percent of the proportion for such State
8 for fiscal year 1999, and

9 “(ii) decrease by more than 10 per-
10 cent or increase by more than 22 percent
11 from the preceding fiscal year.

12 “(C) RECONCILIATION.—To the extent
13 that the application of any of the preceding
14 subparagraphs results in a decrease or an in-
15 crease in the allotment to a State as compared
16 to the amount otherwise provided (determined
17 without regard to this paragraph), the allot-
18 ments for the other States and the District of
19 Columbia under this subsection shall be in-
20 creased or reduced in a pro rata manner (but
21 not so as to contravene any of the preceding
22 subparagraphs) so that the total of such allot-
23 ments in a fiscal year does not exceed the
24 amount otherwise provided for allotment under
25 paragraph (1) for that fiscal year.”

rewrite to
set ceiling
to amount
for the effect
of 10% floor
(to add to 100%
of allotment)

O:\ERN\ERN99.278

DISCUSSION DRAFT

S.L.C.

8

(c) MODIFICATION OF DATA SET USED TO DETER-
MINE NUMBER OF CHILDREN.—Section 2104(b)(2)(B) of
the Social Security Act (42 U.S.C. 1397dd(b)(2)(B)) is
amended by striking “the fiscal year” and inserting “the
calendar year in which such fiscal year begins”.

6 *[review - correct for subsection (c)?]* (d) EFFECTIVE
7 DATE.—The amendments made by this section apply to
8 allotments determined under title XXI of the Social Secur-
9 rity Act (42 U.S.C. 1397a et seq.) for fiscal year 2000
10 and each fiscal year thereafter.

11 SEC. ____ PARITY IN REIMBURSEMENT FOR CERTAIN UTI-
12 LIZATION AND QUALITY CONTROL SERVICES.

13 (a) IN GENERAL.—Section 1903(a)(3)(C)(i) of the
14 Social Security Act (42 U.S.C. 1396b(a)(3)(C)(i)) is
15 amended—

16 (1) by striking "or by" and inserting ", by";
17 and

18 (2) by inserting “, or by a private accreditation
19 entity or other entity that provides services that are
20 the type of services provided by a utilization and
21 quality control peer review organization” before the
22 semicolon.

23 [review] (b) EFFECTIVE DATE.—The amendments
24 made by subsection (a) apply to expenditures made on and
25 after [October 1, 1999.]

1 SEC. ____ ADDITIONAL TECHNICAL CORRECTIONS.

2 (a) Section 1902(a)(64) of the Social Security Act
3 (42 U.S.C. 1396a(a)(64)) is amended by adding "and"
4 at the end.

5 (b) Section 1902(j) of such Act (42 U.S.C. 1396a(j))
6 is amended by striking "of of" and inserting "of".

7 (c) Section 1902(l) of such Act (42 U.S.C. 1396a(l))
8 is amended—

9 (1) in paragraph (1)(C), by striking "children
10 children" and inserting " children";

11 (2) in paragraph (3), in the matter preceding
12 subparagraph (A), by striking the first comma after
13 "(a)(10)(A)(i)(VII)"; and

14 (3) in paragraph (4)(B), by inserting a comma
15 after "(a)(10)(A)(i)(IV)".

16 (d) Section 1902(v) of such Act (42 U.S.C. 1396a(v))
17 is amended by striking "(1)".

18 (e) Section 1903(b)(4) of such Act (42 U.S.C.
19 1396b(b)(4)) is amended, in the matter preceding sub-
20 paragraph (A), by inserting "of" after "for the use".

21 (f) Clauses (i) and (ii) of section 1903(d)(3)(B) of
22 such Act (42 U.S.C. 1396b(d)(3)(B)) are each realigned
23 so as to align with the margin of section 1903(d)(3)(A).

24 (g) Section 1903(f)(2) of such Act (42 U.S.C.
25 1396b(f)(2)) is amended by striking the extra period at
26 the end.

O:\ERN\ERN98.878

DISCUSSION DRAFT

S.L.C.

10

1 (h) Section 1903(m)(2)(A) of such Act (42 U.S.C.
2 1396b(m)(2)(A)) is amended—

3 (1) in clause (vi), by striking the semicolon the
4 first place it appears; and

5 (2) by redesignating the clause (xi) added by
6 section 4701(e)(3) of the Balanced Budget Act of
7 1997 (Public Law 105-83; 111 Stat. 493) as clause
8 (xii).

9 (i) Section 1903(o) of such Act (42 U.S.C. 1396b(o))
10 is amended by striking "1974))" and inserting "1974)".

11 (j) Section 1903(w) of such Act (42 U.S.C.
12 1396b(w)) is amended—

13 (1) in paragraph (1)(B), by striking "puroses"
14 and inserting "purposes";

15 (2) in paragraph (3)(B), by inserting a comma
16 after "(D)"; and

17 (3) by realigning clause (viii) in paragraph
18 (7)(A) so as to align with clause (vii) of that para-
19 graph.

20 (k) Section 1905(b)(1) of such Act (42 U.S.C.
21 1396d(b)(1)) is amended by striking "per centum,," and
22 inserting "per centum,".

23 (l) Section 1905(l)(2)(B) of such Act (42 U.S.C.
24 1936d(l)(2)(B)) is amended by striking "a entity" and in-
25 serting "an entity".

O:\ERN\ERN99.278

DISCUSSION DRAFT

S.L.O.

11

1 (m) The heading for section 1910 of such Act (42
2 U.S.C. 1396i) is amended by striking "OF" the first place
3 it appears.

4 ~~【review with HCFA -does this conform to their inter-~~
5 ~~pretation and practice?】~~ (n) The last sentence of section
6 1915(d)(5)(B)(iii) of such Act (42 U.S.C. 7
7 1396n(d)(5)(B)(iii)) is amended by striking "75" and in-
8 serting "65".

9 (o) Section 1915(h) of such Act (42 U.S.C.
10 1396n(h)) is amended by striking "90 day" and inserting
11 "90 days".

12 (p) Section 1919 of such Act (42 U.S.C.1396r) is
13 amended---

14 (1) in subsection (b)(3)(C)(i)(I), by striking
15 "not later than" the first place it appears; and

16 (2) in subsection (d)(4)(A), by striking "1124"
17 and inserting "1124)".

18 (q) Section 1920(b)(2)(D)(i)(I) of such Act (42 7
19 U.S.C. 1396r-1(b)(2)(D)(i)(I)) is amended by striking
20 "329, 330, or 340" and inserting "330 or 330A".

21 (r) Section 1920A(d)(1)(B) of such Act (42 U.S.C.
22 1396r-1a(d)(1)(B)) is amended by striking "a entity" and
23 inserting "an entity".

12

1 (s) Section 1923(c)(3)(B) of such Act (42 U.S.C.
2 1396r-4(c)(3)(B)) is amended by striking "patients." and
3 inserting "patients,".

4 (t) Section 1925 of such Act (42 U.S.C. 1396r-6)
5 is amended—

6 (1) in subsection (a)(3)(C) by striking "(i)(VI)
7 (i)(VII),," and inserting "(i)(VI), (i)(VII),"; and

8 (2) in subsection (b)(3)(C)(i), by striking
9 "(i)(IV) (i)(VI) (i)(VII),," and inserting "(i)(IV),
10 (i)(VI), (i)(VII),".

11 (u) Section 1927 of such Act (42 U.S.C. 1396r-8)
12 is amended—

13 (1) in subsection (g)(2)(A)(ii)(II)(cc), by strik-
14 ing "individuals" and inserting "individual's";

15 (2) in subsection (i)(1), by striking "the the"
16 and inserting "the"; and

17 (3) in subsection (k)(7)—

18 (A) in subparagraph (A)(iv), by striking
19 "distributers" and inserting "distributors"; and

20 (B) in subparagraph (C)(i), by striking
21 "pharmaceutically" and inserting "pharma-
22 ceutically".

23 (v) Section 1929 of such Act (42 U.S.C. 1396t) is
24 amended—

18

- 1 (1) in subsection (c)(2), by realigning clauses
2 (i) and (ii) of subparagraph (E) so as to align with
3 the margin of clauses (i) and (ii) of subparagraph
4 (F) of that subsection;
- 5 (2) in subsection (k)(1)(A)(i), by striking "set-
6 tings," and inserting "settings,"; and
- 7 (3) in subsection (l), by striking "State wide-
8 ness" and inserting "Statewideness".
- 9 (w) Section 1932 of such Act (42 U.S.C. 1396u-2)
10 is amended—
- 11 (1) in subsection (c)(2)(C), by inserting "part"
12 before "C of title XVIII"; and
- 13 (2) in subsection (d)—
- 14 [review](A) in paragraph (1)(C)(ii), by
15 striking "Act" and inserting "Regulation"; and
- 16 (B) in paragraph (2)(B), by striking
17 "1903(t)(3)" and inserting "1905(t)(3)".
- 18 (x) Section 1933(b)(4) of such Act (42 U.S.C.
19 1396u-3(b)(4)) is amended by inserting "a" after "for a
20 month in".
- 21 (y) Section 2104(b)(3)(B) of such Act (42 U.S.C.
22 1397dd(b)(3)(B)) is amended by striking "States." and
23 inserting "States,".

O:\ERN\ERN99.278

DISCUSSION DRAFT

S.L.C.

14

1 (z) Section 2105(d)(2)(B)(iii) of such Act (42 U.S.C.
2 1397ee(d)(2)(B)(iii)) is amended by inserting "in" after
3 "described".

4 (aa) Section 2109(a) of such Act (42
5 U.S.C.1397ii(n)) is amended—

6 (1) in paragraph (1), by striking "title II" and
7 inserting "title I"; and

8 (2) in paragraph (2), by inserting ")" before
9 the period.

10 (bb)(1) The section 1908 of such Act (42 U.S.C.
11 1396g-1) that relates to required laws relating to medical
12 child support is redesignated as section 1908A.

13 (2) Section 1902(a)(60) of such Act (42 U.S.C.
14 1396b(a)(60)) is amended by striking "1908" and insert-
15 ing "1908A".

Kevin Kullman
DPC

INSURE KIDS NOW CAMPAIGN
DRAFT: NEW COMMITMENTS
February 23, 1999

• post this
on the
webs
• BN

Today, the President and the First Lady, along with Governors Carper and Leavitt and Secretary Shalala, launched the nationwide Insure Kids Now campaign that aims to enroll every eligible but uninsured child in Medicaid and the new Children's Health Insurance Program (CHIP). About half of the 10 million uninsured children qualify for these programs but remain unenrolled. To ensure that families know that their children may be eligible, the President has engaged a broad-based, bipartisan, public-private coalition to use whatever means possible to educate and assist families in insuring their children.

Public-Private Partnership. The Insure Kids Now campaign has three components: (1) a new television, radio, and print media campaign; (2) new efforts by private corporations and non-profit organizations; and (3) new proposals and actions from the President, all designed to educate families about the health insurance options available through Medicaid and CHIP. Parents will hear the message from teachers, volunteers, health care providers, and on the radio, and see the new toll free number on television, tray liners, grocery bags, and on diaper boxes.

Launching 1-877 KIDS NOW, a new, national toll-free number for children's health outreach. Today, the President and First Lady launched 1-877 KIDS NOW, a new toll free number developed by the National Governors Association in partnership with Bell Atlantic and the Administration that provides information on Medicaid and CHIP to families nationwide. This number will provide families in all 50 States with State specific information about Medicaid and CHIP. Families calling the line will speak with an eligibility counselor who can provide information about eligibility criteria, benefits, and how to apply for coverage. Beginning in October, HHS plans to assume responsibility for this line.

THE NATIONAL MEDIA MAKES AN UNPRECEDENTED COMMITMENT TO CHILDREN'S HEALTH INSURANCE OUTREACH. Today, the President unveiled new efforts by national media organizations to provide families across the country with information about the importance of health insurance and how to apply for Medicaid and CHIP, including:

TELEVISION - *NBC / Sentinels and Lewis*

- am* • **NBC** will air PSAs on children's health insurance. Beginning on February 24, "The More You Know" campaign will air a public service announcement to educate parents and families about free or low cost health insurance options. This PSA, using NBC stars S. Epatha Merkerson and Benjamin Bratt, provides information about the importance of health insurance for children and includes the Insure Kids Now number.
- am* • **ABC** will air a PSA featuring the new Insure Kids Now number during their morning programming and evening programming for at least a year beginning on February 25 and will distribute it to their affiliates to air during local programming.

Am • **Viacom/Paramount** will air a PSA featuring the new Insure Kids Now number beginning March 1st. This PSA will air on 19 of their stations throughout the country.

Am • **Turner Broadcasting** will air a PSA featuring the First Lady and the Insure Kids Now number later this year.

Victor Rivas, HHS • **Univision** will air Spanish language PSA developed by the Department of Health and Human Services beginning on February 23. The PSA will air once a day (during the day or in prime time) over the next year. Univision is watched by 90 percent of Hispanic households -- over 18 million people. Over 25 percent of Hispanic children are uninsured.

OW • **Martha Stewart Inc.** will produce a PSA featuring Martha Stewart and the Insure Kids Now number later this year.

Am • **National Association of Broadcasters (NAB)** will distribute a PSA featuring the new Insure Kids Now number. The NAB, the national trade association representing broadcast stations, will make the PSA available to all their member stations on Monday, February 22nd.

RADIO

Am • **Airing radio ads in 45 States.** Beginning on February 23, the Department of Health and Human Services will fund radio ads to be aired in 45 States and the District of Columbia. In each State, the spots will run for 4 weeks (15 per week). The spots will run in groups of 10-11 States at a time, beginning with California, Utah, Colorado, Alabama, Illinois, Ohio, Kentucky, North Carolina, New Jersey, Connecticut, and Maine.

Am • **Radio Disney/ABC radio** will run ads specialized for children in their 25 markets, and will distribute the audio version of the PSA to all affiliate stations.

Sub • **Bonneville** will run six public service announcements narrated by General Powell that will be aired in Chicago, Salt Lake City, San Francisco, and Washington DC. The Ad Council will distribute these ads nationwide.

PRINT MEDIA

BL • **USA Today** will run an editorial on the importance of children's health insurance. USA Today has agreed to do a editorial in their weekend edition on the importance of health insurance for children and the new options available to families through Medicaid and CHIP. The editorial will feature the new Insure Kids Now hotline number.

PRIVATE ORGANIZATIONS JOIN THE ADMINISTRATION'S NATIONAL EFFORT.

Today, the First Lady and the President lauded the efforts of private sector companies to get the word out about the new free or low cost children's health insurance options available to families

across the nation. The following is a list of the new commitments:

CORPORATIONS - BLU

- BLU • **American Medical Response** will include the Insure Kids Now number on ambulances and other transport vehicles, such as school buses, which transport over 2,000,000 students daily. In addition, they will provide information on Medicaid and CHIP to communities in 36 States through their 20,000 employees.
- BLU • **K-Mart Corporation** will dedicate two columns on children's health insurance in the K-Mart circular distributed to more than 70 million homes and they will also put daily public service announcements on K-Mart in-store radio network and put the Insure Kids Now number on all K-Mart shopping bags during June and September of 1999. In addition, during the month of May, K-Mart will work with the March of Dimes to staff counter displays at 1,600 K-Mart pharmacies nationwide with brochures for the Insure Kids Now campaign. →
- BLU • **McDonalds** will distribute information about Insure Kids Now to its millions of customers.
- BLU • **General Motors** will work with La Raza to affix labels with the Insure Kids Now number to child safety seats being donated to families in low-income communities across the country.
- BLU • **Ralphs Grocery** will place bag stuffers in shopping bags and to air PSA announcements in their in-store radio network to promote the Insure Kids Now toll free number.
- BLU • **Kids Korner Gift Shops**, owner of the 1-800-KIDS NOW and 888- KIDS NOW numbers, has already fielded over 900 phone calls on behalf of the Insure Kids Now campaign and will continue to refer callers to the 1-877 KIDS NOW number. Kids Korner Gift Shops will also include Insure Kids Now materials in packets sent to thousands of schools nationwide.
- BLU • **Romano & Associates Inc.** will work with CHIP corporate partners to produce a television PSA featuring the President, First Lady, or celebrity athlete to distribute on behalf of the campaign, to millions of people across the country.

HEALTH INDUSTRY - BLU

- BLU • **Blue Cross & Blue Shield Association** will begin to educate local physicians, hospitals and state government partners about the new health insurance options for low income children next month by distributing posters, brochures, and other materials featuring the Insure Kids Now number. In addition, Blue Cross / Blue Shield's national association will produce and distribute a radio public service announcement nationwide as well as print advertorials on the Insure Kids Now campaign in the April issues of Readers Digest and Time Magazine.
- BLU • **Pfizer, Inc** has agreed to incorporate the Insure Kids Now onto their patient/parent resource publication, mailings to their pediatricians, and in their Pharmacy Assistance Program. In

addition, Pfizer will distribute an outreach kit to 400 community health centers in the Spring.

- **Wyeth Lederle Vaccines** will distribute handbooks this March that include the Insure Kids Now toll free number and information on how to educate families about health insurance options for their children to 1500 local community based organizations and providers.

- **Schering-Plough** will provide information on the Insure Kids Now effort to the nation's 33,000 school nurses information through their health education website later this year.

PROFESSIONAL ASSOCIATIONS

- **American Dental Hygienists' Association**, will include the Insure Kids Now toll free number on toothbrushes and on a tear out flyer in its Access magazine, which reaches 80,000 dental hygienists in each of the 50 states nationwide.

- **American Nurses Association** has committed to distribute posters featuring the Insure Kids Now number and other materials to their 180,000 member nurses this spring. Information will also be posted on their new web site.

- **American College of Emergency Physicians** has agreed to send information to 20,000 members through their March newsletter, including how to download posters and access outreach materials through the internet.

- **American College of Physicians / American Society for Internal Medicine** will advertise the Insure Kids Now toll free number through its national website, in its monthly publication, the Observer, and in its bi-monthly legislative newsletter. These materials are distributed to 110,000 physicians.

- **Association of State and Territorial Health Officials** will distribute outreach resource packets to publicize the Insure Kids Now toll free number to state health departments leaders and staff in 57 states and territories.

- **American Maternal and Child Health Association** will devote the front page of their newsletter Updates, which is mailed to over 500 national, State, and local public health organizations and officials, to Insure Kids Now. They will also add an ad banner to their website that will link to the Insure Kids Now website.

- **American Dental Association** will put the Insure Kids Now number on their website.

- **American Psychiatric Association** will develop a Medicaid/CHIP Tool Kit to educate doctors and patients about Medicaid and CHIP programs for use by its 42,000 members nationwide.

- **American Medical Association** will promote the Insure Kids Now toll free number to the nation's 600,000 physicians in its weekly newspaper, the American Medical News, and by posting information on AMA's website.

GRASSROOTS ORGANIZATIONS JOIN TOGETHER WITH PRIVATE SECTOR PARTNERS IN THIS BROAD BASED EFFORT.

In addition, numerous groups representing health care providers, volunteers, children's advocates, educators, child care providers, and religious organizations come in contact with low-income and working families on a regular basis and can help educate them about Medicaid and CHIP.

COMMUNITY-BASED ORGANIZATIONS

- ms • **Volunteers of America** will make information on Medicaid and CHIP available to low-income families through the distribution of outreach material to homeless shelters, low income housing, and childcare centers.
- ms • **United Way of America**, together with the Department of Justice, will enroll 500,000 eligible children in CHIP and will mobilize select local United Ways (of which there are 1400 across the country) to partner with local organizations to coordinate training for outreach volunteers to pilot the program, then expanding to approximately 30-50 communities across the country.
- ms • **March of Dimes** will feature children's health insurance in a direct mail newsletter to be sent to 800,000 individual donors in September of 1999. In addition, they will promote the Insure Kids Now effort through the June issue of the local chapter and WalkAmerica newsletters which are sent to an additional 500,000 volunteers and 20,000 corporate supporters.
- ms • **Points of Light Foundation** will publicize the Insure Kids Now toll free number by providing it to over 20 million people through the "Connect America" initiative. Information will also be provided to 450 communities and 200 corporate members through the Volunteer Centers of the Points of Light Foundation. In addition, over 2,000 members will receive information on the Insure Kids Now toll free number.
- ms • **HOPE for Kids** has committed to make children's health insurance the primary focus of its national outreach event on April 17, 1999. Beginning this spring, it will also implement efforts to educate 400,000 people in 38 States about Medicaid and CHIP.
- ms • **Veterans of Foreign Wars (VFW)** has committed to distributing information about CHIP through its network of posts.
- LL • **YMCA** will fax information on the Insure Kids Now campaign to over 4,000 YMCA staff and volunteers. They will also incorporate information on Insure Kids Now into the materials distributed for Healthy Kids Day (April 10) a national YMCA day that highlights kids health issues, and will disseminate the information at the YMCA City Agenda Conferences over the next nine months.

EDUCATION AND CHILDREN'S ADVOCATES

- **National Child Care Association** has agreed to distribute advertisements and posters promoting the Insure Kids Now toll free number to 700,000 parents through the network beginning this spring.
- **National Collaboration for Youth** will distribute the toll free number to its 27 member organizations and 5 million volunteers, who collectively serve 40 million children aged 6 to 18. The collaboration includes Boys and Girls Clubs, Girls Inc., YMCA, YWCA, Big Brothers and Big Sisters, Campfire Boys and Girls, and the Salvation Army.
- **Public Education Network** will provide information on Insure Kids Now to the 2000 members participating in their listserve, and will display the Insure Kids Now toll free number on their website. They will also send information on Insure Kids Now to the participants of the Comprehensive School Health Initiative.

RELIGIOUS ORGANIZATIONS

- **Union of American Hebrew Congregations** will advertise CHIP and the Insure Kids Now toll free number to all 875 Reform Jewish Congregations across the nation through a mass mailing this spring.
- **Catholic Charities/USA** will host 10 training events to help facilitate enrollment in Medicaid and other state insurance programs during 1999.
- **Catholic Health Association** will put the Insure Kids Now toll free number on their website and in their newsletter, which reaches thousands of people. They are also hosting 10 training events together with the Catholic Charities.
- **National Council of Churches of Christ** will distribute the Insure Kids Now toll free number to their 33 member communions representing 52 million people.
- **International Union of Gospel Missions** will distribute the Insure Kids Now toll free number to their missions located in 260 cities where they serve over 7 million homeless and needy people.
- **United Synagogue of Conservative Judaism** will publicize the Insure Kids Now toll free number to their over 800 congregations across the country.
- **National Council of Catholic Women** will distribute the Insure Kids Now toll free number in their monthly newsletter to 350 diocesan leaders and their May/June magazine to 11,000 nationwide.
- **Council of Jewish Federations** will promote the Insure Kids Now toll free number in service settings across the country.

- mg • **NETWORK MAGAZINE** will advertise the Insure Kids Now toll free number in their magazine, which that reaches 10,000 people nationwide.
- mg • **The Evangelical Lutheran Church in America, Church Women United, Unitarian Universalist Service Committee, United Methodist Church-General board of Church and Society, and Women's Missionary Union** will distribute the toll-free number to their member churches.

NEW PRIVATE EFFORTS COMPLEMENT THE EXPANDING FEDERAL EFFORT.

Today, the President and First Lady unveiled the new steps Federal agencies are taking to identify and enroll uninsured children in free or low cost health insurance. These include:

- **HHS: Launching the "insurekidsnow.gov" website for outreach.** HHS has developed a website bringing together essential State-specific information for people who are potentially eligible to participate in the CHIP program, including contact information, benefits, and eligibility information in a user friendly format for families, educators, advocates and other non-health professionals. It will also provide information on the Administration's public-private outreach campaign, including posters, hand-outs, and descriptions of the effort.
- **HHS: Distributing 145,000 posters advertising the toll free number to over 20,000 Federal grantees and field offices beginning March 1.** HHS developed posters advertising the toll free number to be distributed to over 20,000 Federal grantees and field offices as part of their new and ongoing efforts to educate parents, health care providers, and other Federal employees about Medicaid and CHIP.
- **HHS: Development of a kit to teach other agencies about how to explain kids' health outreach to their employees and clients.** Today, HHS will distribute an outreach training kit has been prepared for to Federal workers from all Departments who will participate in the "Insure Kids Now" campaign. The kit contains a presentation outline, posters, and materials that can be used as handouts.
- **USDA: Sending 92,000 employees information about outreach.** On March 8, over 92,000 USDA employees will receive information on CHIP with the national toll-free hotline number on their Wage and Earnings Statements.
- **USDA: Reaching uninsured children through the Women, Infant and Children (WIC) program.** During February, over 115,000 Alabama WIC participants will receive a CHIP outreach message with the AI-Kids toll-free hotline number on their WIC food instruments. In the near future, over 90,000 Oklahoma WIC applicants and participants will receive assistance in completing CHIP applications during their WIC visit.
- **JUSTICE: Distributing information through Operation Weed and Feed.** The Department of Justice will work with Operation Weed and Feed, a crime prevention and community revitalization initiative that brings together the United States Attorney and 170

301 320

4255

community leaders nationwide to distribute a letter with information on CHIP and Medicaid and posters advertising the new toll free number beginning in March of 1999.

- **JUSTICE: Hands on involvement in communities nationwide.** Beginning in March of 1999, the Department of Justice, together with the United Way and HOPE for Kids (a non-profit charitable organization), will hold community forums, distribute enrollment information, and provide application assistance to residents in 6 to 10 cities to identify and enroll uninsured children in Medicaid and CHIP.
- **EPA: Distributing information on Medicaid and CHIP through the Child Health Champion Campaign.** The Environmental Protection Agency will distribute information on Medicaid, CHIP, and the new toll free number for children's health insurance outreach through the new Child Health Champion Campaign, which works with 200 communities nationwide to protect children from environmental hazards by providing information, technical assistance and other support.

THESE NEW ACTIVITIES BUILD ON THE COMMITMENTS MADE BY:

- **National Association of Chain Drug Stores (NACDS)** will include the Insure Kids Now number and include outreach campaign materials with each prescription filled. Additionally, NACDS will display outreach posters and have brochures available in 30,000 chain pharmacies visited by over 5 million people daily.
- **Safeway** will print the Insure Kids Now toll free number on grocery bags used at their stores nationwide beginning later this year.
- **National Community Pharmacists Association** will distribute information on Insure Kids Now to 50,000 pharmacists through their newsletter, journal, and satellite programs.
- **American Hospital Association** will include materials on the Insure Kids Now campaign in their "Campaign for Coverage" information, will reach over 6 million uninsured people.
- **Bell Atlantic** provided NGA with funding to implement the new Insure Kids Now number, the cornerstone of the President's new national effort.
- **Pampers** will include Insure Kids Now materials in their child birth education packages, which are given to 90 percent of first time mothers.
- **National Educational Association** will provide information on the Insure Kids Now toll free number to the presidents of their 14,000 local affiliates beginning this month. In addition, NEA will feature an article about CHIP in the October issue of the organization's magazine, distributed to 2.4 million educational employees.
- **American Medical Association** will distribute the Insure Kids Now number to 600,000

Carrie Baron
C&S 1074

contact
Barbara
re: fees

talk
to them
ahead
of time.

Contact

our
administrative
stuff

TANF / unfrast

pediatricians
page. Bridgett
need any
special
protections
bill or not -
we will know
special provision

~~POOR~~
immuniz.
giving gms

They go to
① fees

- ② Med rec the only
ones as primary care
provided providers
- ③ ability to write drugs
or formulate
based on clinical peers
case of child, fees.
- ④