DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

JAN 23 1998

Dear State Health Official:

This letter highlights new and existing opportunities for outreach to uninsured children. We share a mutual interest in and commitment to enrolling uninsured children in both Medicaid and the new State Children's Health Insurance Program (CHIP). An estimated 3 million children are eligible for Medicaid, but remain uninsured. Millions more will be eligible for CHIP because of historic, bipartisan legislation passed by the Administration and Congress. Successfully enrolling these eligible but uninsured children is critical to both the success of these programs and the health of these children; as such, outreach is a high priority for the President, First Lady, and Department of Health and Human Services.

In this letter, we describe examples of and options for successful outreach and enrollment and Federal funding available for these activities. Most of these provisions are currently options within Medicaid or reflect preliminary guidance for CHIP. Two of these provisions -- expanding the entities that can determine presumptive eligibility and expanding access to a special fund for outreach -- are proposals in the President's fiscal year 1999 Budget that would provide nearly $200 million a year in additional Federal dollars to States that choose to take advantage of these initiatives. If passed, they would be effective on October 1, 1998.

I. Funding for Outreach

States have several options for receiving Federal matching funds to find and enroll uninsured children in Medicaid and/or CHIP. Medicaid will match States' expenditures associated with outreach to Medicaid-eligible children. Similarly, CHIP funds may be used to pay for outreach to CHIP-eligible children (up to the 10 percent limit, described below). Because of the importance of outreach, the President's fiscal year 1999 Budget contains proposed legislation that, if enacted, would provide a higher matching rate for outreach activities for all children, regardless of their eligibility. This section describes these options.

- **Federal Matching of Outreach under Medicaid**

  There have been questions about what types of outreach activities Medicaid will fund. The Federal government matches State Medicaid expenditures for outreach activities that bring potential eligibles into the Medicaid system to determine if they qualify for Medicaid benefits. These activities include: informing families about Medicaid through brochures or other promotional material; assisting families in completing Medicaid applications; and providing the necessary forms and packaging for Medicaid eligibility determinations. These activities are considered allowable Medicaid administrative activities for the purpose of Federal matching. Since the Medicaid program is an open-ended entitlement program, there is no limit on the amount of allowable Medicaid outreach expenditures States may claim for Federal matching.

♦ **Federal Matching of Outreach under CHIP**

Title XXI places a strong emphasis on outreach. State child health plans cannot be approved without a description of how States will educate families, assist them in enrolling children in the appropriate program, and coordinate health insurance programs across the State. There are several ways that CHIP outreach expenditures may be matched.

Non-Medicaid CHIP Option. Outreach activities related to a non-Medicaid CHIP program only would be matched from the State's CHIP allotment. States may spend up to 10 percent of their total CHIP expenditures (Federal and State) on non-benefit activities, including: outreach conducted to identify and enroll eligible children in CHIP; administration costs; health services initiatives; and other child health assistance. These expenditures are matched at the enhanced CHIP matching rate and count against both the 10 percent limit and the allotment.

Medicaid CHIP Option. Outreach activities related strictly to a Medicaid expansion under CHIP can be matched either from the State's CHIP allotment or under regular Medicaid, at the State's option. If a State elects to claim Federal matching for its outreach expenditures from the CHIP allotment, such Federal payments will count against the State's 10 percent limit and allotment and will be matched at the enhanced CHIP matching rate. Once the State reaches its 10 percent limit and/or its CHIP allotment, it may then claim Federal matching for any additional Medicaid outreach expenditures under the Medicaid program. States may claim Federal matching for outreach expenditures under the Medicaid program only if such expenditures are for CHIP-related Medicaid expansion groups. Alternatively, a State may elect to claim Federal matching for outreach expenditures for CHIP-related Medicaid expansion groups under the Medicaid program at the regular Medicaid administrative matching rate. If claimed in this way, Federal payments for these expenditures would not count against the 10 percent limit or the CHIP allotment.

Joint Medicaid-CHIP Option. Joint outreach efforts for Medicaid and CHIP may similarly be matched by either Medicaid or CHIP. Detailed guidance on these options was provided in a December 8, 1997 letter to State Health Officials on financial issues.

♦ **Enhanced Matching for Children's Outreach Efforts [Proposed Legislation]**

In the welfare reform bill that created the Temporary Assistance for Needy Families (TANF) program, a $500 million Medicaid fund was established to help States ensure that children and parents losing welfare know about their continued eligibility for Medicaid. These funds, which are allotted to States, provide an enhanced Federal matching rate for outreach and administrative costs related to this narrow group of Medicaid-eligible people. Certain outreach activities are eligible to receive a 90 percent matching rate from the fund. (See the May 14, 1997 *Federal Register* notice for details.) Few States, however, have

taken advantage of this fund so far, in part, due to the difficulty of targeting outreach only to a subset of Medicaid-eligible children.

The President's fiscal year 1999 Budget includes a legislative proposal that, if enacted, would expand the use of this fund. States would be able to receive a 90 percent matching rate for outreach activities for all uninsured children, not just those who would have been eligible for welfare. The Federal funds to cover the extra matching (above Medicaid's regular matching amount) would come from this fund. In addition, the proposal would remove the sunset on the fund in 2000 and add another $25 million to assist States with increased outreach activities.

II. Expanding Sites for Enrolling Children

In the wake of welfare reform, families often misunderstand their children's continued eligibility for Medicaid. They also may be unsure about differences between Medicaid and CHIP. Thus, it has become more important than ever that States have and pursue options to conduct educational activities and enrollment of children in a wider array of community settings.

- **Allowing Immediate Medicaid Coverage Through Schools, Head Start, and Child Care Centers [Proposed Legislation]**

  The Balanced Budget Act (BBA) of 1997 gave States a new option in Medicaid to grant "presumptive eligibility" to children. Certain children may receive immediate health care coverage without having to wait for a full Medicaid eligibility determination. Under this option, a "qualified entity"and/or its employees may presume that a child is temporarily eligible for Medicaid if, using preliminary information, family income does not exceed the State's applicable income eligibility level. The child's parent or guardian has until the end of the following month to submit a full Medicaid application for the child. Until a final eligibility determination on that application is made by the State, the child is covered for Medicaid services. Although the CHIP statute does not expressly provide for presumptive eligibility, States also could use this option in their eligibility for a CHIP separate State program.

  The BBA defines "qualified entities" as providers of health care items and services under the Medicaid State plan (including IHS, Tribal and urban Indian health care providers that participate in a Medicaid State plan) and entities that determine eligibility for Head Start, WIC and child care subsidies under the Child Care and Development Block Grant. It also requires that certain costs associated with presumptive eligibility be subtracted from the State's child health allotment (see the December 8, 1997 letter on financial issues).

The President's fiscal year 1999 Budget proposes to make this presumptive eligibility option more flexible and attractive to States. First, it would broaden the definition of "qualified entities" to include sites such as schools, child care resource and referral centers, child support enforcement agencies and CHIP eligibility workers. Second, it would eliminate the requirement that States subtract the costs of presumptive eligibility from their CHIP allotments. Instead, these costs would be matched as a regular Medicaid State plan option. Both of these changes would give States greater incentives and flexibility for using this important authority.

- **"Outstationing" Eligibility Workers in Communities**

Outstationing eligibility workers is a promising outreach strategy for enrolling Medicaid and CHIP-eligible children. "Outstationing" means locating eligibility workers in places other than welfare offices to assist with the initial processing of applications. (The final Medicaid eligibility determination must be made by the appropriate State agency.) Current Medicaid law requires States to outstation eligibility workers in Federally qualified health centers and disproportionate share hospitals. States also can receive Federal matching for outstationing eligibility workers in other locations.

We encourage States to consider outstationing eligibility workers at sites that are frequented by families with children such as schools, child care centers, churches, Head Start centers, WIC offices, community centers, Job Corps sites, GED programs, local Tribal organizations and Social Security offices.

- **Using Mail-In Applications**

One option that allows States to ease the enrollment process is the use of mail-in applications. Mail-in applications, especially for Medicaid, can significantly reduce the barriers to enrollment that may occur with requiring in-person applications. Transportation costs are eliminated, the stigma of going to a social services office is removed, parents will not have to miss work, and community groups like PTAs and church organizations can assist in distributing applications and information regarding Medicaid and CHIP. Many, but not all, States use this option in Medicaid today. We encourage all States to adopt this option.

III. Simplifying Enrollment

A key to successfully enrolling children at a wide range of sites is a simple application and enrollment process.

- **Simplifying the Medicaid Application and Eligibility Process**

  One barrier to enrollment in Medicaid is the complexity of the application. Some States have applications over 20 pages long, posing an often insurmountable challenge for families. We encourage States to develop strategies to simplify these processes by: preparing a simplified Medicaid application for the eligibility groups that include most children; using a "less restrictive" eligibility methodology that drops the Medicaid assets test for children; shortening the Medicaid application form generally; and allowing mail-in applications. Also, there are few verification requirements under Federal law that are mandatory. While it is important to maintain program integrity by verifying income, excessive requirements can deter families from completing the application process.

  Medicaid administrative funds can be used to redesign the Medicaid application form. Attached are some examples of shortened and simplified Medicaid applications used in some States (see attachment A).

- **Using a Single Application for Medicaid and CHIP**

  We encourage States to use one application for both Medicaid and CHIP. The advantages of a single application form include a reduction in paperwork for the State and a simplified process for families potentially eligible for Medicaid or CHIP. Attachment B includes a model joint application form and its instructions. We also encourage States to use single applications for health and non-health programs like TANF.

- **Eligibility Screening and Enrollment for Medicaid and CHIP**

  CHIP requires States to ensure that only targeted low-income children are furnished child health assistance and that children found eligible for Medicaid through screening are enrolled in Medicaid. At a minimum, State screening processes should assure that all children who are potentially eligible for Medicaid under the poverty-level-related groups are identified. The State may initially use a gross income test that compares total family income to the applicable Medicaid standard. The initial gross income test would immediately identify children whose family income is low enough that Medicaid eligibility would be almost certain. A second test would be needed, however, to detect those children whose gross family income exceeds the Medicaid standard but who are Medicaid-eligible when income disregards are applied. Without this second test, the State would not be meeting its responsibility to ensure that children eligible for Medicaid are identified and enrolled in Medicaid. (Some States have used this technique with simplified Medicaid applications.) Screening is not required for States that elect to expand Medicaid under CHIP, because the child's eligibility for regular Medicaid will be determined as part of the State's eligibility determination process.

The statute clearly says that States must include in their State child health plans a description of procedures to ensure that children found to be eligible for Medicaid must be enrolled in Medicaid; a simple referral procedure to Medicaid will not meet this requirement. The Department of Health and Human Services (DHHS) will be providing guidance on options to meet this requirement in the near future. Some examples include:

- **Single State agency for eligibility determination**: States can use the Medicaid State agency to make eligibility determinations for non-Medicaid CHIP expansions as well as Medicaid CHIP expansions.

- **Joint application for both CHIP and Medicaid**: States can use a joint CHIP and Medicaid application. As noted earlier, DHHS has developed a model application form for CHIP and Medicaid (see attachment B). States could use interagency agreements to send applications to the appropriate place for processing.

- **Presumptive eligibility**: If the President's fiscal year 1999 Budget proposal is enacted, States will have the option of allowing their CHIP eligibility workers to make presumptive Medicaid eligibility determinations as well as CHIP eligibility determinations. (The final Medicaid eligibility determination must be made by the appropriate State agency.)

♦ **Granting 12-Month Continuous Eligibility**

Another way to increase the number of children with health insurance is to grant children eligibility for Medicaid for a longer period of time. Many families fall in and out of income eligibility due to job changes or fluctuations in paychecks. The BBA provides States the option to provide individuals under age 19 with up to 12 months of continuous eligibility after they are determined eligible for Medicaid, even if there is a change in the family's income, assets, or size. Under this option, Medicaid eligibility is granted for a period of up to one year regardless of changes in circumstances. States that use their CHIP funds for separate State programs can also provide continuous eligibility, since they have the flexibility to determine how frequently follow-up screening (redetermination) will be conducted.

IV. Other Outreach Strategies

In addition to expanding sites for enrollment and simplifying the process, States have used a number of valuable approaches to help them locate children and facilitate their enrollment in Medicaid and other health programs. This has been especially true for children who are members of special populations, such as children with special health care needs, homeless children and migrant children. State strategies to reduce barriers to enrollment range from advertising on billboards to linking health with other types of public programs like Head Start. Promising examples of State outreach activities are described in attachment C.

Summary

Every successful outreach model requires cooperation among diverse entities. Potential partners for outreach programs include school districts, community-based organizations, local health and human service providers, Head Start programs and child care centers. In addition, collaboration between the Federal and State governments, private businesses, foundations and advocacy groups could also produce creative and effective outreach initiatives.

We believe that the new children's health insurance program provides a unique opportunity to ensure that the millions of eligible children are enrolled in public or private health insurance plans and receive essential health care services. We hope you will join us in meeting this challenge.

Sincerely,

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Claude Earl Fox, M.D., M.P.H.
Acting Administrator
Health Resources and Service Administration

Enclosures

cc: HHS Regional Directors
HCFA Regional Offices
PHS Regional Offices
TANF State Agencies
Title IV-D Agencies
Child Care Directors
Child Welfare Directors
Ms. Lee Partridge, American Public Welfare Association
Ms. Jennifer Baxendell, National Governors' Association
Ms. Joy Wilson, National Conference of State Legislatures
Ms. Cheryl Beversdorf, Association of State and Territorial Health Officials
Ms. Mary Beth Senkewicz, National Association of Insurance Commissioners

(Attachment A)

EXAMPLES OF SIMPLE MEDICAID APPLICATION FORMS

- List of States that have Simplified the Medicaid Application Process
- Delaware's Application
- Georgia's Application
- South Carolina's Application

States That Have Simplified the Medicaid Application Process

The following States have taken steps to simplify their Medicaid application processes, by allowing mail-in applications, shortening the Medicaid application form, or eliminating the assets test for children or by using a combination of these techniques.

Mail-In Applications (24)
Alabama
Alaska *
Connecticut
Delaware
District of Columbia
Hawaii *
Illinois *
Maine *
Massachusetts
Michigan (local decision)
Minnesota
Mississippi
Missouri
New Mexico *
North Dakota *
Ohio
Oklahoma
Oregon
Pennsylvania
Utah *
Vermont
Virginia
Washington
Wyoming *

Short Application (29) **
Alabama
Alaska
Arkansas
Colorado
Georgia
Hawaii
Illinois
Indiana
Iowa
Kentucky
Michigan
Mississippi
Missouri
New Hampshire
New Mexico
New York
Ohio
Oklahoma
Oregon
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wyoming

No Assets Test (36) ***
Alabama
Alaska
Arizona
Connecticut
Delaware
District of Columbia
Florida
Georgia
Illinois
Indiana
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Mississippi
Missouri
Nebraska
New Hampshire
New Jersey
New Mexico
New York
North Carolina
Ohio
Oklahoma
Pennsylvania
South Carolina
South Dakota
Tennessee
Vermont
Virginia
Washington
West Virginia
Wisconsin

* After the mail-in application is received, the Medicaid agency will conduct a telephone interview.
** Applications are the same length or shorter than the HCFA model application
*** AR, CA, HI & UT count assets in determining Medicaid eligibility for some children.
Source: Center on Budget and Policy Priorities, August 1997

FAMILY AND COMMUNITY MEDICAL ASSISTANCE APPLICATION

This form must be completed before we can see if you are eligible for medical assistance. If you need help completing the form, ask your worker. Return this application within 30 days of the date you asked for Medicaid. If you do not, this may change the date your Medicaid will start.

We must take action on your application for Medicaid within 45 days from the date we receive your application in our office (90 days for disabled children or others who apply on the basis of disability).

We need you to give us proof of the following items for you and your family:

- Birth (birth certificate, driver's license, marriage license)
- Social Security number (copy of card or proof you have applied for one)
- Lawful alien status (registration card, immigration papers)
- Current income (pay stubs, letter from employer, award letter or check)
- Child care costs (receipts or letter from provider)
- Delaware residency and address (enclosed household form, utility bill, lease)
- Medical insurance, such as Medicare (copy of card, benefit letter)
- Pregnancy and due date (statement by medical professional)
- Disability for Disabled Child Program (enclosed medical forms)
- Emergency medical condition for illegal aliens (enclosed medical forms)
- Resources for QMB, SLMB, Disabled Child and SSI related programs (bank statements, life insurance policies, burial fund, savings bonds, trust fund)

You may need to give us more information. If you have already given this information to a Department of Health and Social Services office, let us know. You may not have to give it again. Failure to provide the above information may result in delayed or denied benefits.

HEAD OF HOUSEHOLD:

LAST NAME	FIRST NAME	M.I.
STREET ADDRESS		
DEVELOPMENT OR APARTMENT NAME		APT.NO
CITY	STATE	ZIP CODE
DAYTIME TELEPHONE NUMBER		
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)		
PLEASE LIST ANY OTHER NAMES THAT YOU HAVE USED		

HOUSEHOLD MEMBERS

Please list everyone in your household (including yourself) and complete each space by their name.

ARE YOU APPLYING FOR THIS PERSON?	LAST NAME	FIRST NAME	M.I.	OFFICE USE ONLY (MCI #)
YES NO				
YES NO				
YES NO				
YES NO				
YES NO				
YES NO				
YES NO				

1. Have you ever been eligible for and received both a Social Security check and a Supplemental Security Income (SSI) check in the same month?
   Circle one: Yes No

   If yes, list the last month and year you were eligible for and received both benefits:_____

2. Does anyone in your family have unpaid medical bills from the last three months?
   Circle one: Yes No

   Was your income the same as it is now during those months?
   Circle one: Yes No

3. If you pay child care costs, please give names of the children and the monthly amount you pay for each child. Please also include any fees for summer camp or nursery school.

NAME OF CHILD	MONTHLY AMOUNT	NAME OF CHILD	MONTHLY AMOUNT

HOUSEHOLD MEMBERS

SOCIAL SECURITY NUMBER	SEX	RACE/ ETHNIC GROUP	IS THIS PERSON A U.S. CITIZEN OR A LEGAL ALIEN?	ALIEN REGISTRATION NUMBER
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	

YOUR RIGHTS AND RESPONSIBILITIES

I have read or have had read to me all statements on this form. I understand the questions on this form and the information is true and complete to the best of my knowledge. I understand that the State of Delaware has a law that prohibits giving false information or withholding information to get any type of assistance, including Medicaid, or to get more assistance than I am entitled to get. I understand that if I give any false information or withhold any information, I may be prosecuted to the full extent of the law.

I agree to help establish my eligibility by giving as much information as I can about my circumstances and by giving proof of statements on my application.

I certify, under penalty of perjury, that I am a U.S. Citizen or alien in lawful immigration status. I must provide proof of lawful immigration status. Lawful alien status requires submission of certain information to the Immigration and Naturalization Service for verification. Nonlawful aliens may be eligible for emergency services only.

All information and documentation gathered for determining my Medicaid eligibility is confidential. Medicaid has safeguards and limits disclosure of information about me. Disclosure of information concerning my Medicaid eligibility to anyone not authorized to receive the information is a violation of State and Federal laws and may result in legal sanctions. While Medicaid will keep my eligibility information confidential, these provisions do not affect my right to give specific written consent to release information to other persons or sources.

YOUR RIGHTS AND RESPONSIBILITIES

I understand that I am required by law to assign to the State all rights to medical support and other third party payments (hospital and medical benefits) and to cooperate with the State in establishing paternity and securing medical support. This assignment is a condition of Medicaid eligibility. Medicaid cannot be denied to eligible children because of their parent's refusal to establish paternity or secure support from absent parents. I understand that pregnant women are not required to cooperate in establishing paternity and securing medical support.

I agree to allow the Department of Health and Social Services, or its representatives, to have access to all medical records that are related to payment and medical services by Medicaid. I agree to allow the Department of Health and Social Services, or its representatives, to act as my agent in recovering money spent by the Medicaid Program when other money from insurance, estates, etc., becomes available to pay my medical bills.

I understand that I may appeal to the Division of Social Services or the U.S. Department of Health and Human Services if I am not satisfied with any decision on my application or if I feel that I have been discriminated against because of race, color, national origin, religion, sex or handicap.

I understand that I may be represented by an attorney at a fair hearing, or any other person I choose. If I am not satisfied with the decision on my fair hearing, I understand that I may request a judicial review in Superior Court in the County where I live. I also understand that I must file for a judicial review within 30 days of the date of my fair hearing decision.

I certify that I have had the services of the Division of Child Support Enforcement explained to me and have been offered an opportunity to participate in their program.

I agree to enroll in a Managed Care Organization if I am required to by the Medicaid Program.

I understand that pregnant or nursing women and children age five and under may apply for WIC benefits by contacting the Division of Public Health at 1-800-222-2189.

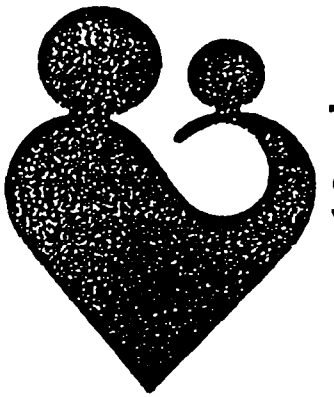
I agree to report within ten days changes in my household situation that could affect my eligibility, such as a change in how many people live with me, a change in income, or if I move.

This application must be signed by an adult household member (age 18 or over) or by an emancipated minor (under age 18).

Sign, date and return the application as soon as possible. Include copies of all the items listed on page one that apply to your family. If you have questions, call your local Medicaid office.

IMPORTANT REMINDER

Signature of Applicant or Representative	Date
Signature of DSS Worker	Date



Right from th Start

FREE

A HEALTHY START IN LIFE FOR YOU AND YOUR BABY.

- GET FREE PRENATAL CARE RIGHT NOW.
- YOU CAN QUALIFY IF YOU'RE MARRIED OR SINGLE.
- YOU DONT HAVE TO BE PREGNA TO RECEIVE FREE MEDICAL CARI FOR YOUR CHILD.
- YOUR LOCAL HEALTH DEPART-MENT CAN GIVE YOU A MEDICAII CARD THE SAME DAY YOU VISIT.

Medicaid Program: Patient Rights and Responsibilities

I agree to give correct information to see if I can receive Medicaid.

I agree to provide the county information to prove any statements given in this application and hereby give permission to the county to get such proof.

I understand that for Medicaid I must report any changes in my circumstance within ten (10) days of becoming aware of the change.

I understand that if I DO NOT like the decision made on my case, I have the right to a fair hearing. I can request a hearing by writing or calling the county where I applied.

If you want AFDC for any family member, you will have to sign a different application form. However, we will use the date on this form to determine your eligibility.

FACTS : RIGHT FROM THE START

- SEE THE SAME DOCTOR FROM FIRST EXAMINATION TO DELIVERY.
- APPLYING IS SIMPLE AND EASY.
- FREE MEDICAL CARE IS AVAILABLE FOR ELIGIBLE CHILDREN BORN AFTER SEPTEMBER 30, 1983.

For more information, contact your county health department or county Department of Family and Children Services.

Georgia Department of Medical Assistance
Recipient Inquiry Unit
Post Office Box 38420
Atlanta, Georgia 30334

To:

County Department of Family and Children Services

Address

City State Zip Code

Place Stamp Here

MEDICAID NOW HELPS ALMOST 50,000 GEORGIA WOMEN LIKE YOU.

Married or single. Insured or uninsured. You and your children can receive FREE medical help immediately. Apply today. Medicaid forms are now simple to read. The approval process is now faster. And more doctors than ever before will care for you and your children. Ask at your local health clinic how you can join the Right from the Start program. Get the right care. Get the right start. It's simple. It's easy. And it's smart.

Right from the Start has the right stuff.

When you become pregnant you create life. It's a miracle. Suddenly, a little person lives within you. To help the baby grow inside, you must care for him or her from the outside. See a doctor early and regularly. Get prenatal care. Only you can keep the baby inside happy. Eat right. Quit smoking or cut back. Don't drink alcohol, including beer or wine. Give your baby the right stuff Right from the start.

So, if you think you're pregnant but can't afford a doctor-- we can help you. If you are pregnant but can't pay your medical bills -- we can help you. And if you have young children who have not seen a doctor regularly -- we can help you.

GET HELP NOW -- Right from the Start.

Apply for medical care inside and out.

If you are pregnant or have a child under a year old, you will qualify for Right from the Start Medicaid if your yearly income is about $14,000 or less. If you already have two children, you can earn almost $21,000 a year and still qualify.

Your baby can stay in the Medicaid program until its first birthday. After that, the income requirements become a little stiffer, but most children will still be covered until age 5.

Getting medical care for you and your children is easier than ever before. If you think you might qualify, just fill out this application and send it in or contact your county health department or county Department of Family and Children Services.

Application Date: _____

NAME _____
First Initial Last Maiden Name Telephone #

ADDRESS _____
Street Apt. City County State Zip Code

1. Is anyone in your house pregnant? ☐ Yes ☐ No If yes who? _____
   Is she on Medicaid? ☐ Yes ☐ No
2. Whom do you want to receive Medicaid?

List all people in your home (write your name first):

First	M.I.	Last	Social Security No.	Date of Birth	Race	Sex	Relationship	U.S. Citizen yes/no
MYSELF							Self	

3. INCOME: Do you or does anyone in your home get money from:

		Amount Before Any Deductions	How Often Received	Name of Person(s) Receiving
Current Job Employer's Name:	Yes ☐ No ☐			
Social Security Income/SSI	Yes ☐ No ☐			
AFDC	Yes ☐ No ☐			
Pensions or Retirement Benefits	Yes ☐ No ☐			
Child Support or Contributions	Yes ☐ No ☐			
Unemployment Benefits	Yes ☐ No ☐			
Student Loan/Grant	Yes ☐ No ☐			
Other Income	Yes ☐ No ☐			

4. Do you have health insurance on anyone for whom you are qualifying? ☐ Yes ☐ No
   (Provider: Complete Form 285) Health insurance company _____
   Policy number _____
5. Do you have any unpaid medical bills from the past three months? Yes ☐ No ☐

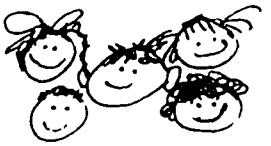
Medicaid Program • I agree to give correct information to see if I can receive Medicaid. • I agree to provide the county information to prove any statements given in this application and hereby give permission to the county to get such proof. • I understand that I am breaking the law if I give wrong information. • I understand that for Medicaid, I must report any changes in my circumstance within ten (10) days of becoming aware of the change • I understand that if I DO NOT like the decision made on my case, I have the right to a fair hearing. I can request a hearing by writing or calling the county where I applied.

I certify that the information I have provided is correct.
I have read (or had read to me) and understand the information on this form.
I agree to apply for a social security number if I do not have one.

_____ _____
Applicant's Signature Date

_____ _____
Representative's Signature Date

_____
Title



South Carolina
Partners for Healthy Children

Dear Parent,

Welcome to **Partners for Healthy Children**, our new program of health coverage for children. **Partners for Healthy Children** provides free health care to children in families with low income. Health care can be expensive. I am pleased that South Carolina can offer this help to your family as you struggle to meet your child's needs.

So I want to join in a partnership with you. We will provide **Partners for Healthy Children** and, if your family qualifies, your child's health care will be free. But you need to join us as a partner, too. You are in charge of the health care your child receives. You need to fill out and mail an application for **Partners for Healthy Children**. After you get your **Partners for Healthy Children** card in the mail, you will need to make appointments with a doctor and make sure your child gets the health care he needs.

Look at the chart on the back of this letter. If your family income is no more than the amount shown for your family size, your children should qualify for **Partners for Healthy Children.** To apply, simply fill out the attached application form and mail it in.

If your income is greater than the amount on the chart, *your children may still qualify*. In that case, go to one of the locations listed on the back of this letter and ask for assistance in applying for **Partners for Healthy Children**.

I hope this will be a great year for your family and I hope **Partners for Healthy Children** will help you provide the health care for your children that you decide they need.

Sincerely,

David M. Beasley

David M. Beasley

Office of the Governor
Post Office Box 11369
Columbia, South Carolina 29211

Do Your Children Qualify for Free Health Care from Partners for Healthy Children?

Number of people in family (Count parent(s) and children)	Income levels to qualify for Partners for Healthy Children (Income slightly above may still qualify. See NOTE below.)			
	Hourly wage	Weekly income	Monthly income	Annual income
2	$7.65	$306	$1,327	$15,915
3	$9.63	$385	$1,667	$19,995
4	$11.58	$463	$2,007	$24,075
5	$13.53	$541	$2,347	$28,155
6	$15.50	$620	$2,687	$32,235
7	$17.45	$698	$3,027	$36,315
8	$19.43	$777	$3,367	$40,395

The number of people in the family includes the parents and the children. Add together all the income received by all family members and see if your income is not more than the amounts above. If so, your children should qualify. If more than 8 people live in your family, please call 1-888-549-0820 for assistance.

NOTE: If your family income is slightly more than the amounts on the chart above, you may still qualify but you will need to apply in person, at one of the following offices. Call the phone number in your county to find out where and when to go to apply. Many county DSS offices have Medicaid eligibility workers located at hospitals, health departments, or federally qualified health centers where applications can be filed also.

Abbeville County DSS
459-5481

Aiken County DSS
642-3650

Allendale County DSS
584-7063

Anderson County DSS
260-4100

Bamberg County DSS
245-4363

Barnwell County DSS
541-1210

Beaufort County DSS
525-7861

Berkeley County DSS
761-8044

Calhoun County DSS
874-3384

Charleston County DSS
792-0444

Cherokee County DSS
487-2704

Chester County DSS
377-8131

Chesterfield County DSS
623-2150

Clarendon County DSS
435-4305

Colleton County DSS
549-6090

Darlington County DSS
398-4420

Dillon County DSS
774-8284

Dorchester County DSS
563-4337

Edgefield County DSS
637-4040

Fairfield County DSS
635-5502

Florence County DSS
669-3354

Georgetown County DSS
546-5134

Greenville County DSS
467-7700

Greenwood County DSS
229-5258

Hampton County DSS
943-3641

Horry County DSS
365-5565

Jasper County DSS
726-7747

Kershaw County DSS
432-7676

Lancaster County DSS
286-6914

Laurens County DSS
833-0100

Lee County DSS
484-5376

Lexington County DSS
957-7333

McCormick County DSS
465-2627

Marion County DSS
423-4623

Marlboro County DSS
479-4520

Newberry County DSS
321-2155

Oconee County DSS
638-4400

Orangeburg County DSS
531-3101

Pickens County DSS
898-5810

Richland County DSS
735-7048

Saluda County DSS
445-2139

Spartanburg County DSS
596-3099

Sumter County DSS
773-5531

Union County DSS
429-1660

Williamsburg County DSS
354-5411

York County DSS
684-8108

South Carolina
Partners for Healthy Children

If you have Medicaid, you do not need to fill out this form.

1. Tell us who you are and where you live.

Last name (Parent's)	First Name (Parent's)	Middle Initial	Phone	
Street Address	City	State	Zip Code	County
Mailing Address, if different	City	State	Zip Code	

2. Tell us who in your family lives with you. List the parent shown in item 1, on the first line below.

Last name *List parent(s) and children*	**First Name** *List parent(s) and children*	**Middle Initial**	**Sex**	**Race**	**Date of Birth**	**Social Security Number**	**How is this person related to you?**

3. Tell us how much income your family has.

Fill in the amount of money you make. If you are married and your spouse works, fill in the amount of money your spouse makes, too. Check one box to show if the amount is hourly, weekly, monthly or yearly. **Enter GROSS pay, not take home pay.** Enter zero ("0") if you or your spouse have no earned income.

Your Income	**Spouse's Income**
Amount you earn: $_____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly Hours worked each week _____	Amount your spouse earns: $_____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly Hours worked each week _____
Employer Name and Phone Number	Employer Name and Phone Number

4. Tell us if you have any other income.

List any additional income you or family members living with you may have from the sources listed below and tell us how often you get this income (for example, once each week, every three months, once a year, etc.)

Source	**Amount**	**How Often?**	**Who Gets this Money?**
Interest from bank account	$		
Child support	$		
Alimony	$		
Social Security payment	$		
Other (Please explain)	$		

5. Attach proof of income.

We need proof of your income. For earnings, provide copies of pay stubs for the last four weeks. If you do not have pay stubs, you may provide a letter from your employer or a copy of your most recent state or federal income tax form. Other documents can be used to provide proof of income. If you are not sure what to send, call our toll-free number 1-888-549-0820 and we will help you.

6. Tell us about any health insurance you already have.

Tell us the name of your insurance company, the policy number and the insured persons name on the policy. Even if you already have health insurance, you can still qualify for **Partners for Healthy Children.**

Insurance Company or Employer	Phone Number of Insurance Company or Employer	Policy Number or Group Plan Number	Insured (Name on policy)

7. Tell us whether any child received medical services in the last three months.

Did any of your children living with you receive medical services in the past 3 months:

☐ Yes ☐ No

8. Please sign this statement.

I certify that the information I have provided above is true to the best of my knowledge and I give permission for the State of South Carolina to make any necessary contacts to check my statements. I have read the list of my rights and responsibilities that is printed below. I know that I could be penalized if I knowingly give false information. I certify that the children listed on this application are U.S. citizens or lawful immigrants.

Signature of applicant:_____Date:_____

9. Mail this completed, signed form, together with proof of income, to:

South Carolina Partners for Healthy Children
Post Office Box 100101
Columbia, South Carolina 29202-3101

If you need more information, please call this toll-free number: 1-888-549-0820.

Rights and Responsibilities

Partners for Healthy Children is a program funded through a partnership with regional hospitals, state government and the federal government.

1. I know that my children under age 19 who are eligible for Partners for Healthy Children can have free health checkups under a special Partners for Healthy Children prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT) programs.

2. I know that the information I have given is confidential. I agree that medical information about my children can be released only if needed to administer this program.

3. I know that any information I have given may be reviewed and verified by State of South Carolina staff. Also I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission is needed to get verification or other information.

4. I know that this application will be considered without regard to race, color, sex, age, handicap, religion, national origin or political belief.

5. I know that I may ask for a hearing if I am not satisfied with any action taken by the State of South Carolina in connection with the Partners for Healthy Children program. I may also ask for a hearing if I feel that I have been discriminated against.

6. I know that the State of South Carolina will request and use information from a computer system called the State Income and Eligibility Verification System (IEVS). This computer system compares the Partners for Healthy Children information about me and other members of my family with information from other agencies. Other agencies may include the Internal Revenue Service, Social Security Administration and Employment Security Commission.

7. I know that Partners for Healthy Children does not pay medical expenses that a third party, such as a private health insurance company, is supposed to pay. If my children get Partners for Healthy Children, I give my rights to any third party payments to the Department of Health and Human Services. These payments may include payments from hospital and health insurance policies. I know that if I refuse to give my rights to third party payments to the Department of Health and Human Services, my children will not be eligible to receive a Partners for Healthy Children card.

(Attachment B)

MODEL JOINT APPLICATION FOR CHIP/MEDICAID FOR CHILDREN

Purpose: The attached model joint application can be used for both the Children's Health Insurance Program (CHIP) and children's Medicaid eligibility (under the children's poverty level related groups). States could allow individuals to use this form to apply for both programs and the information on this form would be sufficient for determining which program a child is eligible for. It includes only that information which is required in all circumstances and is provided as a base form which a State can adapt to meet its own needs. As presented, the form is suitable for completion by an intake worker. Modifications would be required to make the form suitable for direct completion by the applicant.

Screening: This application will meet the statutory requirement in Title XXI that States identify children who are eligible for Medicaid.

NOTE: In situations where the State has contracted out the CHIP program eligibility (i.e., determinations will be made by non-State employees), this form can be modified to be used as a pure screening form (or a combination of an application for CHIP and screening form) by removing all references to Medicaid. The statement about the use of the Social Security number [33] would be required. Inclusion of the rights and responsibilities section (without reference to Medicaid), however, would be at State option. Non-State employees cannot make a determination of Medicaid eligibility. If the form is so modified, in order to permit the information on the form to be submitted for use in making a Medicaid determination, the non-State employees could have a separate page for those whom the screen indicates are Medicaid-eligible. On that page, the individual should consent to submission of the information as part of a Medicaid application, and accept the rights and responsibilities outlined on this draft (including a statement under penalty of perjury that the information provided on the "attached screening form" or "attached CHIP application" is correct). After this page is completed, the form could be forwarded to the State for a Medicaid eligibility determination.

Mandatory Information About Medicaid: If a State uses a joint CHIP/Medicaid application and denies the Medicaid application, then the State must thoroughly inform the individual about the availability of Medicaid and his or her right to apply for Medicaid on a basis other than as a poverty-level child. This includes an explanation of the Medicaid program and the various eligibility groups, the advantages of Medicaid over CHIP and information about how and where to apply for Medicaid.

Federal Verification Requirements: Under Federal law, there are no verification requirements pertaining to eligibility for the children's poverty-level-related groups under Medicaid other than those related to alien status of non-citizens, and the posteligibility requirements of §1137 pertaining to use of the individual's social security number and an income and eligibility verification system. Eligibility of a citizen child may be established on the basis of a declaration under penalty of perjury. States are permitted to require further verification as a condition of eligibility.

Additional Simplification of Medicaid Eligibility Determination: If the total gross income of the family is at or below the applicable Medicaid income standard, the questions in the shaded areas need not be answered. The individual is obviously income eligible for Medicaid without further information.

Explanation of Certain Fields: There are some questions on the application that may not elicit all the information needed to make a determination. Under certain circumstances, additional information will be required. For example:

- If the answer to the question about citizenship [18] is no, actual status will need to be determined, official documents submitted, etc.

- If the child has insurance [22] and is Medicaid-eligible, information about the insurance company and policy number will be needed; and

- If the child had medical bills in the last 3 months [32] and is Medicaid-eligible, eligibility information for the last three months will be needed to establish retroactive eligibility, in addition to information about the bills.

In addition, the question concerning employment by a public agency in the State [25] is only needed for CHIP eligibility and is not needed for Medicaid. This field does not ask directly about the availability and nature of health insurance on the assumption that the eligibility worker would have access to a list of public agencies which offer State health insurance of the type which precludes CHIP eligibility. If this is not the case in your State, this field would need to be expanded.

Examples of State Modifications:

- A State may wish to include voter registration; or

- A State may want to use this as an application for Medicaid for the adults which would require additional information about the adults and stock affidavits concerning assignment of rights and pursuit of support.

- A State will need to add a question concerning each individual's resources (assets) if:

  - the State applies a resource test for the poverty level children; or

  - the State has not chosen to cover children born before 10/1/83 under the poverty level group AND the State applies a resource test for the optional group of categorically needy children ("Ribicoff children").

CHILDREN'S HEALTH INSURANCE PROGRAM / MEDICAID
JOINT APPLICATION FORM

I. Person Applying for the Child or Children					
Name [1] FIRST MIDDLE LAST			Home Phone [2]		Work Phone [3]
Home Address [4] Street	Apt. # [5]	City [6]	State [7]	Zip [8]	County [9]
Mailing Address (if different from above) [10] Street	Apt. # [11]	City [12]	State [13]	Zip [14]	County [15]

II. Family Members Living in the Home (Attach extra sheet if needed)						
Children (under 19) living in the home NAMES [16]	Date of Birth [17]	Citizen (Yes or No) [18]	Social Security Number [19]	Mother's Name [20]	Father's Name [21]	Covered by Health Insurance other than Medicaid [22]
Adults living in the home NAMES [23]	Social Security Number [24]		If employed by a public agency in the State, what agency? [25]			

III. Income and Child Care Payments

List all the Income Received by Family Members Listed Above (Attach Extra Sheet if Needed)

Name of person(s) working or receiving money* [26]	**Who provides the money?** [27] Employer, program or person	**How Often?** [28] Weekly, twice a month, monthly	**What amount?** [29] Before taxes or any deductions
1.			
2.			
3.			

*Be sure to include all sources of gross income (before taxes) such as wages, dividends & interest, TANF, SSI annuities, pension, disability, child support, alimony, cash gifts, & other unearned income.

List the payments made for child care (or care for an adult who cannot care for himself) so that someone in your household can work. [30]

Name of person(s) who works	**Name of Person Care For**	**Under Age 2?**	**How Often?**	**What amount?**
		Yes ☐ No ☐		

IV. Medicaid Questions

Is any child: [31] Pregnant Yes ☐ No ☐ In an Institution Yes ☐ No ☐

Do any of the children have unpaid medical bills from the last 3 months? [32] Yes ☐ No ☐

Social Security Number (SSN) [33]

You must give us your SSN in order to receive Medicaid. This is required by section 1137(a)(1) of the Social Security Act and the Medicaid regulations of 42 CFR 435.910. The Medicaid agency will use the SSN to verify you Income, eligibility, and the amount of medical assistance payments we will make on your behalf It is possible that we will also use the SSN to determine another person's right to Medicaid or to comply with Federal law requiring that we release information from Medicaid records. The information may be matched with the records in other agencies, such as the Social Security Administration or the Internal Revenue Service. These matches may be done by computer or on an individual basis

Rights and Responsibilities [34]

I agree to the release of personal and financial information from this application form and supporting documents to the agencies that run these programs so that they can evaluate it and verify eligibility. I understand that the agencies that run the programs will determine confidentiality of this information according to the federal laws, 42CFR 431.300-431 307.1, and any applicable federal and state laws and regulations.

Officials from the programs that I, or members of my household, have applied for may verify all information on this form.

I understand that I must immediately tell the Medicaid agency about any changes in information on this form.

I understand that I may be asked to provide additional information.

I understand my eligibility will not be affected by my race, color, national origin, age, disability, or sex, except where this is restricted by law

I understand that this application is an application for one kind of children's health benefits under Medicaid and is not a full Medicaid application. I understand that if I am not found eligible for this kind of children's health benefits under Medicaid, I may be eligible for Medicaid benefits on some other basis and have a right to complete a full Medicaid application.

I have the right to appeal any decisions made by a local Medicaid program. Information on the appeals process can be obtained from the local Medicaid agency.

I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth is committing a crime which can be punished under federal law, state law, or both. I understand that I may also be liable for repaying in cash the value of the benefits received and my be subject to civil penalties.

I certify under penalty of perjury that everything on this application form is the truth as best I know.

Signature [35] _____ **Date** _____

Date Received by Agency [36] _____

(Attachment C)

DISCUSSION OF PROMISING OUTREACH STRATEGIES

Significant barriers exist to providing health care coverage for uninsured children and enrolling them in Medicaid. States and local communities are implementing a variety of approaches to reducing these barriers. Many States are simplifying the complicated application forms and enrollment processes, as well as allocating more resources to developing innovative outreach activities. The Department of Health and Human Services (DHHS) is prepared to assist States and local communities by facilitating the exchange of information regarding successful outreach endeavors and information related to enrollment simplification. The following are examples of promising outreach strategies currently practiced or being considered in various places.

- Implement an 800 hotline number for enrollment information in each State, to provide information (in appropriate languages) on child health insurance programs, referrals, and telephone assistance in completing application forms. To the extent possible, publicize a single number; several 800 numbers may lead to confusion. Most States already have an effective toll-free hotline through their Title V Maternal and Child Health offices that could be serve as a base for disseminating information relating to Medicaid and CHIP.

- Streamline the eligibility process, have simplified application forms in appropriate languages, and allow application by mail. Ask only for necessary information. Allow for enrollment on certain evenings and Saturdays at convenient sites. Allow appropriate entities, especially in remote areas, to determine eligibility presumptively.

- Use billboards in bus and subway stations and radio stations to publicize the programs, including information that uninsured children of low-income working parents may also qualify for Medicaid or CHIP. Place posters (that have been field-tested in that community) at locations frequented by target families -- e.g., thrift shops, discount stores, fast-food restaurants, laundromats, and ethnic festivals.

- Encourage prenatal care and child health through unified State-wide public service outreach campaigns which are advertised with an identifiable logo and reader-friendly materials that appeal to lower-income families.

- Distribute information about child health insurance programs through child care centers, Head Start programs, schools, child support enforcement agencies, community action programs, refugee resettlement programs, TANF offices, family preservation and support programs, Special Education and Social Security offices -- with materials in simple, appropriate languages. Also, verbally ask the children in the above settings (as they take the literature home) to tell their families that they may be eligible for health care.

- Provide enrollment opportunities at local sites where children receive health care; school-based health centers are a particularly good vehicle for identifying and enrolling children in insurance programs.

- Station eligibility workers in hospitals to assure prompt enrollment of newborns, in health centers, and at locations where immunizations are provided.

- Coordinate with other programs, such as TANF, child support enforcement agencies, family support councils, local Tribes, WIC, food stamps, Title V, free or reduced-price lunch programs, Head Start, Special Education and Social Security offices.

- Establish a State-wide computer program, wherein applications for any one public assistance program will (with the client's permission) be automatically "cross-referred".

- Develop outreach strategies with local community-based organizations, and have them assist in outreach efforts, including at events such as community fairs. Word-of-mouth can be the best outreach tool in communities where there is mistrust of the system. Provide speakers and program information to community, school and religious programs.

- Use trained, trusted persons within the local community to do eligibility outreach and to provide assistance to their neighbors in completing application forms.

- De-stigmatize Medicaid to the extent possible. Some States have addressed this issue by renaming the program with names such as "Dr. Dynasaur", or "KIDMED" or "Child Health Plus." Encourage eligibility workers to treat clients with courtesy and respect. Ensure that the card issued to the family is free of any perceived "welfare stigma." Have posters reflect a positive image of Medicaid and those who use Medicaid.

- Enlist the support of businesses and foundations to provide incentives (e.g., gift certificates, coupons for free meals or merchandise, movie passes) for families who apply for and/or use services.

DRAFT REMARKS BY HILLARY RODHAM CLINTON
CHILDREN'S HEALTH OUTREACH ANNOUNCEMENT
CHILDREN'S HOSPITAL
FEBRUARY 18, 1998

Thank you. I am so honored to join you today as we take another important step forward in putting quality health care within the reach of every child in America. None of this would have been possible without the people in this room...and I want to especially thank the President, Secretary Shalala, [other acknowledgments]

One of my favorite children's folktales is the one about Stone Soup -- where travelers arrive in a village with nothing to eat, but with a clever plan. In the center of town, they boil a pot of water with a stone in it. And soon, the curious villagers come by and are encouraged one by one, to add a carrot here, a cabbage there -- ultimately transforming a stone into a wonderful "stone soup" created by all and benefiting all.

what is CHIP

Like this fable, the success story that we celebrate today is really the timeless story of what works in meeting our biggest challenges. Last August, when the President signed into law the largest expansion of health care in 30 years, he made not only a major federal commitment, but an historic promise to millions of uninsured children and their parents: As a nation, we said: Whether your children need check-ups or immunizations, broken bones healed or deadly diseases treated, you shouldn't have to choose between caring for your kids and bankrupting your family.

$24 billion

We knew that keeping that promise would be the hard part...and that the hard work would come in the years ahead. We knew we needed a ~~massive~~ national outreach effort to give parents the information and other tools they need to sign ~~campaign~~ up their children for Medicaid and the new Children's Health Insurance Program. And, like the ~~villagers~~ making stone soup, we knew that our magic stone will always be collaboration, everyone bringing something unique to the pot to make the whole ~~richer than~~ any single ingredient.

effort is too

As the President will announce today, that's exactly what's happening. The Federal government is stepping up to the plate with new resources. States are devising local solutions to fit their local needs. Businesses are working to reach parents with information about insuring their children. Foundations are supporting innovative outreach initiatives. Doctors and teachers are learning how to be front-line soldiers in the battle to enroll kids. And today, the NGA is sending the states a best practices report on CHIP to shine a spotlight on what's working around the country.

As I've traveled the nation, talking to parents and meeting children in

need, I've often been struck by the fact that there isn't a problem in America that isn't being solved by someone somewhere. Our challenge to do what we're doing today – to find out what works for our children and then come together as a nation to replicate it in every state and every community, in every school and every child ~~care center~~. As we approach the next century, there is no greater gift we can give to our children, to our parents, to our future. Now it is my great honor to introduce...

use it as a model -- can be slightly different

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) IMPLEMENTATION UPDATE

February 10, 1998

FEDERAL UPDATE

Public Information. The following is a list of the releases of information to date:

- **Program announcement** (State Medicaid Directors' letter, August 27):Informed the states of the organization of the program at HHS its basic parameters, and a summary of the statute.

- **State allotments** (Federal Register notice, September 10): Announces the states' preliminary allotments from the over $4 billion appropriation for fiscal year 1998.

- **Qs and As #1** (September 10): Responses to some of the most frequently asked questions.

- **State plan template** (September 15): Guide on the minimum requirements for a state children's health insurance plan

- **Qs and As #2** (October 3): Responses to some of the most frequently asked questions.

- **Medicaid issues** (State Medicaid Directors' letter, October 10): Describes the Medicaid provisions in the children's health program and includes model state plan amendments for these options as well as a set of q.s. and as on Medicaid issues.

- **Qs and As #3** (November 26): Responses to some of the most frequently asked questions.

- **State plan approval** (State Medicaid Directors' letter, December 2): Describes the process for filing from the states and review and approval by HHS.

- **State financial reporting** (December 8): Details the financial rules and reporting requirements for CHIP.

- **Legal Immigrants** (January 14): Describes rules regarding financing health care for legal immigrant children.

- **Outreach** (January 23): Describes options for receiving Federal funding for outreach as well as options that are effective.

All documents can be found on the internet; www.hcfa.gov.

STATES UPDATE

STATE	ACTIVITIES UPDATE
STATES WITH APPROVED CHILD HEALTH PLANS	
Alabama	**PLAN**: Medicaid expansion for poor children up to age 19 **STATUS**: Plan submitted: 11/3/97; plan approved: 1/30/98. Implementation: 2/1/98 **BACKGROUND**: After a contentious special legislative session, $5 million was budgeted for health with a contingent $10 million if revenues are sufficient. The Governor signed the state plan on November 1. Although the plan only includes Medicaid benefits for children at or below 100 percent of the poverty line, a State commission voted to create a non-Medicaid program for children between 100 and 200 percent of poverty. However, since they also proposed to fund this expansion through a tobacco tax, the Governor is objecting
STATES WITH SUBMITTED CHILD HEALTH PLANS (in chronological order)	
Missouri	**PLAN**: Medicaid expansion for children up to 200 percent of poverty **STATUS**: Plan submitted: 9/26/97 (including Medicaid 1115 waiver request); request for additional information: 11/12/97; additional information submitted: 2/6/98. Expected implementation: 7/98. **BACKGROUND**: The State has been seeking a Medicaid 1115 waiver that combines children with adults. The proposal would expand Medicaid to 200 percent of poverty through CHIP and from 200 to 300 percent of poverty through a Medicaid 1115 waiver. The State wants to waive Medicaid requirement to cover non-emergency medical transportation and to use illegal provider taxes as their source of State share.
Colorado	**PLAN**: Non-Medicaid expansion for children up to 185 percent of poverty **STATUS**: Plan submitted: 10/14/97; request for information: 11/97; additional information submitted: 1/21/98. Expected implementation: 3/1/98. **BACKGROUND**: The State had funded a State program expansion through "Child Health Plan Plus" prior to the passage of the Balanced Budget Act. It intends to build upon this expansion in a second phase, to be applied for next year. Colorado's benefits are actuarially equivalent to the State employee health plan. The State is planning a second phase of the expansion to subsidize children in employer health plans.
Pennsylvania	**PLAN**: Non-Medicaid expansion for children up to 185 percent of poverty **STATUS**: Plan submitted: 11/3/97; request for additional information: 12/97; additional information received: 2/4/98. **BACKGROUND**: Governor announced on October 1 that he will expand the state's existing Children's Health Insurance Program (CHIP); its benefits are grandfathered in the statute. It would fully subsidize premiums up to 185 percent of poverty, and allow for enrollment of children on current waiting list.
New York	**PLAN**: Non-Medicaid expansion for children up to 222 percent of poverty **STATUS**: Plan submitted: 11/5/97; request for information: 1/6/98; additional information received: 1/31/98. Implementation: 10/1/97. **BACKGROUND**: Governor plans to expand Child Health Plus; its benefits are grandfathered in the statute. Democratic Assembly proposed an alternative plan on 2/9/98 to cover children up to 300 percent of poverty with more generous benefits.

California	**PLAN**: Medicaid expansion for children up to 100 percent of poverty; non-Medicaid expansion for children up to 200 percent of poverty **STATUS**: Plan submitted: 11/20/97; additional information requested: 1/ /98; some additional information received: 2/10/98. Expected implementation: 7/1/98. **BACKGROUND**: The "Healthy Families" plan passed the State legislature n 10/2/97. It expands Medicaid to 100 percent of poverty for all children id creates a new program for children 100 to 200 percent of poverty equiv ent to benefits offered to State employees through the State group purchas g coop or employers.
Florida	**PLAN**: Medicaid expansion for poor children; non-Medicaid expansion fc children between 100 and 185 percent of poverty **STATUS**: Plan submitted: 12/4. Implementation: 1/1/98. **BACKGROUND**: Expanding the Healthy Kids program whose benefits ar grandfathered in the statute. Uses school-based enrollment to facilitate access to health services. Tobacco settlement money may be used as the stat contribution.
South Carolina	**PLAN**: Medicaid expansion for children up to 150 percent of poverty **STATUS**: Plan submitted: 12/9; additional information requested: 1/98 additional information received 1/28/97. Implementation: 10/1/97. **BACKGROUND**: "Partners for Healthy Children". State passed Medicai expansion over the summer, will cover children up to 19 to 150 percer of poverty through Medicaid on October 1. Uses simple mail-in applicati is distributed through schools, doctors' offices, neighborhood pharmacie and hospitals. May add a second, non-Medicaid expansion for children w/ i income between 150 to 200 percent of poverty.
Ohio	**PLAN**: Medicaid expansion for children up to 150 percent of poverty **STATUS**: Plan submitted: 12/24/97; request for additional informatio 1/26/98. Implementation: 1/98 **BACKGROUND**: The State had already planned this Medicaid expansi n and the Governor has appointed support for expanding Medicaid to childr n up to 200 percent of poverty and appointed a task force to make recommi dations by 7/1/98
Michigan	**PLAN**: Non-Medicaid expansion to children up to 200 percent of pc erty **STATUS**: Plan submitted: 12/30/97. Expected implementation: 4/9 **BACKGROUND**: Michigan's Department of Community Health has c veloped a non-Medicaid program called "MIChild".
Tennessee	**PLAN**: Medicaid expansion for children up to 200 percent of poverty **STATUS**: Plan submitted 1/3/98 (expanding Medicaid 1115 waiver); equest for additional information: 1/26/98. Implementation: 4/1/97 **BACKGROUND**: Re-opened enrollment in TennCare to uninsured ch dren in April 1997 and again on 1/1/98 for a limited period (through 3/30, : nce the State may use enrollment caps). State has removed $250 deductil e and lowered copayments to 2 percent (still may be out of compliance w h CHIP guidelines).
Illinois	**PLAN**: Medicaid expansion for infants up to 200 percent of poverty for children 1 to 18 up to 133 percent of poverty. **STATUS**: Plan submitted: 1/6/98. Implementation: 1/5/98. **BACKGROUND**: Governor announced plan in early 12/97, and also ppointed an 8-member, bipartisan legislative task force to look at additional ptions. The Governor also announced an outreach effort that includes sig ng up children for Medicaid at schools, clinics, neighborhood centers and other settings.

Rhode Island	**PLAN:** Medicaid expansion for children up to 250 percent of poverty **STATUS:** Plan submitted 1/6/98. Implementation: 5/1/97. **BACKGROUND:** The State expanded its Medicaid RiteCare program in Mu and wants to receive enhanced Federal match for this group.
Oklahoma	**PLAN:** Medicaid expansion for children up to 185 percent of poverty **STATUS:** Plan submitted: 1/12/98. Implementation: 12/1/97. **BACKGROUND:** Implementing SoonerCare program under an 1115 waiv . Part of the expansion planned under SoonerCare would be covered throu h CHIP.
Connecticut	**PLAN:** Medicaid expansion for children up to 185 percent of poverty; non-Medicaid expansion for children between 185 and 300 percent of p verty **STATUS:** Plan submitted: 1/15/98. Expected implementation: 4/1/98. **BACKGROUND:** Governor Rowland signed a law creating " HUSKY: Healthcare for Uninsured Kids and Youth" on 10/30/97. Builds on a Mi icaid outreach effort funded earlier in 1997. The non-Medicaid program's be efits would be modeled on the State employee health plan. The State inten to use a single application for both programs, the presumptive eligibility o ion to facilitate enrollment; and schools and child care sites for enrollment.
Massachusetts	**PLAN:** Medicaid expansion for infants up to 200 percent of poverty, ch dren ages 1 to 18 up to 150 percent of poverty; non-Medicaid expansion fo children between 150 and 200 percent of poverty. **STATUS:** Plan submitted: 1/16/98 (including Medicaid 1115 waiver re iest). Expected implementation: 3/98. **BACKGROUND:** State wants to expand its Medicaid 1115 waiver prop sal "MassHealth" and its non-Medicaid program, the Children's Medical S curity Plan. State funds are appropriated and supported by a tobacco tax.
Wisconsin	**PLAN:** Medicaid expansion for children (and parents) up to 185 perce t of poverty **STATUS:** Plan submitted: 1/21/98 (including Medicaid 1115 waiver r quest). Expected implementation: 7/1/98 **BACKGROUND:** Requesting a Medicaid 1115 for "BadgerCare" which would cover all children in uninsured families up to 185 percent of poverty as their parents. Premiums will be charged to children in newly eligible famil s.
ACTIVITIES IN OTHER STATES	
Alaska	**PLAN:** Medicaid expansion and non-Medicaid expansion for chil ren p to 200 percent of poverty (Governor's proposal) **STATUS:** Proposal submitted to State legislature in session beginn g 1/98. Plan to submit plan 7/98. Expected implementation: 10/98. **BACKGROUND:** Informal working group has been meeting; expecte to meet with the Governor on October 3 to discuss their proposal. Governo appears to want to expand to 200 percent of poverty by the end of 1998.
Arizona	**PLAN:** None yet **STATUS:** **BACKGROUND:** Governor has stated that getting a children's heal program going soon is a priority and included State funds in her projected b get. She will work with State legislature to fund the State contribution and plans for the use of those funds.

Arkansas	**PLAN:** None yet **STATUS:** Debating whether to seek CHIP funding for its Medicaid 1115 waiver expansion that began in October 1997. **BACKGROUND:** Within weeks of the passage of CHIP, Arkansas received a Medicaid 1115 waiver to expand coverage to children up to 200 percent of poverty. Benefits in this waiver are below the standards outlined in CHIP. The State is considering whether it should submit its Medicaid expansion through a Medicaid 1115 waiver or convert its Medicaid to a non-Medicaid program for the purposes of CHIP.
Delaware	**PLAN:** None yet **STATUS:** **BACKGROUND:** State Health Care Commission will submit a proposal to the legislature during this session.
DC	**PLAN:** Medicaid expansion for children up to 200 percent of poverty (tentative) **STATUS:** Plan to submit a plan 3/98. **BACKGROUND:** In review process with Mayor, City Council and pending final approval by the Financial Authority.
Georgia	**PLAN:** Medicaid expansion for children under age 6 up to 200 percent of poverty; non-Medicaid expansion for children ages 6 to 18 up to 200 percent of poverty (Governor) **STATUS:** Plan to submit plan by 7/1/98. **BACKGROUND:** Health Policy Center at Georgia State University, the official task force, recommended Medicaid expansion for children between 133 and 200 percent of poverty. Legislature meets in January.
Hawaii	**PLAN:** None yet **STATUS:** **BACKGROUND:** Considering expanding its 1115 Medicaid waiver which covers children up to 300 percent of poverty.
Idaho	**PLAN:** Medicaid ~~expansion for children~~ up to 160 percent of poverty **STATUS:** Working on a state plan. Implementation: Medicaid: 10/1/97 **BACKGROUND:** Expanded Medicaid to children up to 160 percent of poverty in 10/97. Committee to discuss other long-term options beginning 1/98.
Indiana	**PLAN:** None yet **STATUS:** Plan to submit a plan 3/7/98. **BACKGROUND:** Governor created a children's health task force.
Iowa	**PLAN:** None yet **STATUS:** Working on a plan to submit by 7/98 **BACKGROUND:** Nine public forums occurred in 10/97. The State Public Policy Group, a task force, recommended in 11/97 a Medicaid expansion for children up to 133 percent of poverty, and a non-Medicaid program for children between 133 and 200 percent of poverty. A legislative task force will also present options.
Kansas	**PLAN:** Medicaid expansion for children up to 150 percent of poverty, and a non-Medicaid program for children between 150 to 200 percent of poverty (tentative). **STATUS:** Plan to submit plan in the Spring of 1998. **BACKGROUND:** Two planning groups (Insurance Department and Department of Social and Rehabilitation Services) to report to Governor and state legislature in 1/98. Preliminary recommendation described above.

Kentucky	**PLAN:** Medicaid expansion for poor children; non-Medicaid program for children between 100 and 200 percent of poverty (Governor announced 1/7/98) **STATUS:** Governor announced plan on 1/7/98, plan to submit a plan on 4/1/98. Expected implementation: 7/1/98. **BACKGROUND:** Set up work group; considering a range of options, including implementing and expanding their 1115 Medicaid waiver. Health Services Secretary proposes to expand Medicaid to cover children ages 14 to 18 whose family incomes are at 100 percent of poverty and a non-Medicaid expansion for children between 100 and 200 percent of poverty.
Louisiana	**PLAN:** None yet **STATUS:** **BACKGROUND:** Governor-appointed and legislative task forces held public meetings; developing costs of options.
Maine	**PLAN:** Medicaid expansion for children up to 150 percent of poverty; non-Medicaid program for children between 150 to 185 percent of poverty (Commission) **STATUS:** Plan submitted to State legislature; plan to submit Spring 1998 **BACKGROUND:** Governor & State legislature-appointed Maine Commission on Children's Health Care, which made its recommendations on 12/2?/97. The State already has sufficient State share funding reserved.
Maryland	**PLAN:** Medicaid expansion for children up to 200 percent of poverty (Governor); **STATUS:** Debate in the early part of the year **BACKGROUND:** Maryland's Children's Health Program would have no cost sharing for families up to 200 percent of poverty. The Legislature has proposed a Medicaid expansion for children up to 185 percent of poverty and non-Medicaid expansion for children between 185 and 250 percent of poverty. There is some question about how the State's current Medicaid 1115 program will be integrated or cordoned off from the new program.
Minnesota	**PLAN:** None yet **STATUS:** **BACKGROUND:** State already covers children up to 275 percent of poverty. May seek a waiver to cover children at current levels (e.g., outreach) or create a new program.
Mississippi	**PLAN:** None yet **STATUS:** **BACKGROUND:** Interagency task force is developing proposal.
Montana	**PLAN:** **STATUS:** **BACKGROUND:** Health officials plan to submit a funding plan during 1999 Legislature session. Public hearing were held in November and December.
Nebraska	**PLAN:** Non-Medicaid program up to 185 percent of poverty (Governor announced on 1/12/98) **STATUS:** Proposal still being developed. Plan to submit plan 3/30/98. Expected implementation: 9/98 **BACKGROUND:** "Kids Connection". State working group will give recommendations to Governor. Members agree that expanding Medicaid would be the simplest approach, but are concerned that there would be a welfare stigma.

Nevada	**PLAN**: Non-Medicaid expansion for children up to 200 percent of poverty (Governor announced on 1/7/98) **STATUS**: Plan in development. Expected implementation: 6/98. **BACKGROUND**: "Nevada Check-Up". Governor working with state health agency to plan non-Medicaid program based on the most common HMO in the state; he has announced plans to use Family Resource Centers, school based clinics and Early Children programs to deliver services.
New Hampshire	**PLAN**: None yet **STATUS**: **BACKGROUND**: Governor announced intention to develop plan on 1/7/98. State legislature may appoint a special panel to develop options.
New Jersey	**PLAN**: Medicaid expansion for children up to 133 percent of poverty and non-Medicaid expansion for children between 133 and 200 percent of poverty. **STATUS**: Governor signed legislation on 12/19/97; developing state plan. Expected implementation: 2/1/98 for Medicaid, 3/1/98 for non-Medicaid. **BACKGROUND**: "New Jersey KidCare". Governor has committed State share and has appointed a commission to come up with recommendations for permanently funding the program. Benefits based on the most common HMO in the State. Plan includes outreach through schools, Scout groups, Head Start programs, child-care agencies, and other community organizations.
New Mexico	**PLAN**: Medicaid expansion for children up to 235 percent of poverty **STATUS**: Legislature working on the proposal. Expected implementation: 3/1/98 **BACKGROUND**: May expand through a Medicaid 1115 waiver funded by a 16-cent tobacco tax.
North Carolina	**PLAN**: Non-Medicaid expansion for children up to 200 percent of poverty **STATUS**: Legislature working on a plan. Expected implementation: Summer 1998. **BACKGROUND**: Task force recommended non-Medicaid expansion on 11/17/97. On 12/15/97, the Governor proposed this recommendation. North Caroline is putting emphasis on providing coverage to children with special needs. Also likely to be included in the new package are dental and hearing coverage.
North Dakota	**PLAN**: None yet **STATUS**: **BACKGROUND**: No planning process in place
Oregon	**PLAN**: Non-Medicaid expansion for children up to 170 percent of poverty (pending) **STATUS**: State still in the planning process **BACKGROUND**: Likely to build on existing 1115 Medicaid program and a recently passed State subsidy program for low-income families. Its Medicaid expansion will begin in 1/98; its state program requires a waiver since they want to use children's health subsidies to purchase family policies. The State held a public hearing 10/21/97.
South Dakota	**PLAN**: None yet **STATUS**: **BACKGROUND**: Health advisory committee reviewing State options.
Texas	**PLAN**: None yet **STATUS**: State plans to submit a plan by 3/1/98 **BACKGROUND**: Working group of state agency and legislative staff to brief lawmakers on present options in mid-October. Public hearing held 1/7/98. Considering 1115 Medicaid waiver and / or new program. The legislature doesn't meet until January 1999.

Utah	**PLAN**: Non-Medicaid expansion for children up to 200 percent of poverty **STATUS:** Close to submitting a plan. Implementation: 4/1/98 **BACKGROUND**: Governor's Health Policy Commission planning on building on State insurance program. Benefits actuarially equivalent to Public Employees Health Plan for state workers. On 12/6/97, the Governor proposed a budget that included $16 million for State matching funds and on 12/23/97 announced that the State health department would administer the program.
Vermont	**PLAN**: Medicaid expansion for children up to 300 percent of poverty (tentative) **STATUS**: Plans to submit a plan in 2/98 **BACKGROUND**: State officials will probably request an expansion it's Medicaid 1115 waiver ("Dr. Dynasaur") to 300 percent of poverty.
Virginia	**PLAN**: Non-Medicaid expansion to 175 percent of poverty (Governor's proposal 2/9/98) **STATUS**: **BACKGROUND**: The former Governor recommended on 12/15/97 that the State expand coverage through a non-Medicaid program called "KidsCare" for children up to 175 percent of poverty. Legislative committee recommended on 1/6/98 that the State expand through Medicaid to 200 percent of poverty.
Washington	**PLAN**: Non-Medicaid expansion to children up to 250 percent of poverty (Governor announced on 12/15/97) **STATUS**: Disagreement in the State legislature **BACKGROUND**: State already covers children up to 200 percent of poverty. The State wants to be able to access its allotment for newly covered children below 200 percent of poverty because the state legislature does not want to expand higher. The Washington Congressional delegation may introduce legislation to support this approach.
West Virginia	**PLAN**: None yet **STATUS**: **BACKGROUND**: Governor appoint task force and legislative leaders are looking at options for both expansion and the State share of the program.
Wyoming	**PLAN**: None yet **STATUS**: **BACKGROUND**: Work group to plan for legislative session in February. Looking at new program with implementation in the summer of 1998

CHILDREN'S HEALTH IMPLEMENTATION
Non-Government Activities

ACTIVITY	IDEAS
COORDINATION	
Administration work group	***WH:*** Like NEC meetings, have a monthly principals meeting on kids implementation. Include key Secretaries, White House staff, etc. The goal would be to both oversee HHS activities as well as consider big ideas, interdepartmental collaboration, and external activities.
External steering group	***Foundation-funded:*** Encourage development of a nonprofit organization to oversee the implementation and operation of the kids program (kind of like Kaiser Commission on the Future of Medicaid). Include very public figures with connections to businesses, providers, entertainment & sports, etc. Possibly include President and / or First Lady. Goal would be to be a shadow group to ensure that the goals of the program are fulfilled.
Nationwide town meeting	***Administration:*** Set a particular day to be national kids' town meeting day (probably some time in November or December). Goal is discuss local problems and solutions to kids' coverage. Note: state plans require public process. Work with Congressmen, governors, mayors and town managers to organize in local areas. Have a national message from the President at prescribed time. We could produce fact sheets for each state on the problems and process in that state. We could also connect this effort with a town-by-town census of uninsured children conducted through schools.
Monthly Newsletter	***Foundation-funded:*** Develop a monthly newsletter which contains: (1) latest information from HCFA on implementation issues; (2) state updates on who is doing what; (3) research / analysis / facts of interest; (4) announcements of upcoming meetings, events, etc. Have NGA and NCSL endorse the newsletter as well as some advocacy groups like CDF and Families.
DESIGN	
Targeting	***Researchers:*** Fact sheets on groups of uninsured children; paper on kids of workers between jobs (Foundations, researchers). Policy brief on combined program: Medicaid to 133%, kids grant program above it.
Simple application process	***VP:*** In the spirit of ReGo, have the VP lead working group to coordinate simple, single application form for public benefits (Medicaid, kids health insurance and, if possible, school lunch programs, Food stamps, WIC). Could also work on internet information dissemination for applications and eligibility. RWJ has funded a $13 million demonstrating some of these ideas.
Benefits	***Children's groups:*** Assist in advocating for strongest package possible (e.g., identifying option in the state that covers the most benefits and promoting it) ***Researchers/actuaries:*** Conference on actuarial value in October / November. ***Pediatricians***: Encourage to develop recommendations and "seal of approval" for plans that meet minimum criteria. ***Managed care plans:*** Develop coalition with providers like Pediatricians to encourage particular benefits packages.
Delivery systems	***Researchers / Foundations***: Get some up-front, externally validated set of guidelines for waiver for purchasing group coverage.

Quality	***NCQA***: Ask if they would conduct voluntary accreditation for children's plans ***Quality commission***: Ask to focus on strategy for developing recommendations for states.
State contribution	***NPR-like challenges / fundraisers:*** Get business groups to match local contributions toward state share of program. ***Children's groups & state researchers***: Monitor state contributions (Center on Budget). Act as watchdogs.
Preventing crowd out	***Researchers:*** Develop and disseminate fact sheet / guidance on what works (e.g., waiting period for uninsured). ***Businesses***: Encourage development of coalition to encourage employer-sponsored insurance. Could be done through some sort of public directory to employers offering basic coverage or some other public
OPERATION	
Education & enrollment	***National information hotline***: Work with AT & T (Charlotte Hayes is there) to develop a national phone bank that refers people to appropriate state numbers / agencies. Also will allow us to document the number / location of families calling so that we can track process. ***Schools/teachers:*** Work with NEA or other groups on education on options through schools, including collecting information on uninsured children; distributing information on available insurance options, etc. ***Business contributions***: Get McDonalds, Disneyland, Microsoft or Pizza Hut or other nationwide businesses to put information on coverage options on trays, boxes, Happy Meals, etc. ***Providers***: Chain drug stores may be interested in putting prompts on prescriptions. Applications could be distributed with vaccinations.
Oversight	***Reporter education***: Public scrutiny is the best way to hold states accountable. Perhaps engaging with reporters via a conference, fact sheet, etc would education them on what the program's intent is and how to monitor. ***Foundations***: Fund groups like the Center for the Study of States and consumer groups to oversee design, implementation, and operation of the programs. Encourage Concord Coalition or similar groups to be active.
MONITORING	
Baseline:	
State employee plans	***Unions, Advocates:*** Work with AFSCME to gather all information on state employee plans
State HMO	***AAHP*** may be interested in conducting a survey to determine most popular HMO.
State Medicaid	***HHS/ Foundations***: Carefully document states' eligibility in 1997.
State Spending	***HHS/ Foundations***: Review of state budgets.
Coverage	***School survey***: Empower groups like Teachers, Boy Scouts, Girl Scouts, Junior Chamber of Commerces, etc. to use a single form to assess children's health coverage in their towns / communities. ***Researchers***: Conference on how to modify existing data sets to evaluate coverage trends
Process	

Technical assistance	***Foundation-funded:*** Clearinghouse with easily accessible information on past and present activities. ***Conference***: Multi-faceted presentation of HHS interpretation, Congressional expectation, governors' plans, and researchers' understandings. October to November.
Outcomes	***Researchers***: Set up a public-private work group to develop the best strategy to gather data and evaluation programs.

Jennifer L. Klein
09/04/97 05:02:09 PM

Record Type: Record

To: Christopher C. Jennings/OPD/EOP, Sarah A. Bianchi/OPD/EOP

cc:
Subject: Misc

It seems as though you two are having a crazy day, so please page me when you have a chance if I'm not in the office. Three issues for you:

1. What should we do about 48 hour mastectomies? Should Chris and I write a memo to the First Lady about the problems with the issue? Can she call together women Members to discuss it?

2. What should HRC do for Child Health Day?

3. Where can she give a speech on quality? When?

Help.

JEN - WE'RE THINKING ABOUT A POSSIBLE OCT 1 Release - ON THIS?

Guidance on Targeting Uninsured Children through the State Children's Health Insurance Program

Jeanne

Effective October 1, 1997, Federal funds will be available for the State Children's Health Insurance Program (SCHIP). The President and Congress created this program to provide meaningful health coverage for millions of uninsured children. This draft report is intended to assist states in accomplishing this goal by addressing one specific topic: targeting. "Targeting" means efficiently finding and enrolling uninsured children without inadvertently replacing existing private or state coverage with the new Federal funds. Targeting is essential to the success of this program.

This draft report begins by describing why children lack insurance since states' first task is identifying which group of uninsured children to target. It then suggests policies that can be effective in three areas:

- **Preventing "crowd out"**, or use of new funds to cover children who would other have private coverage;
- **Coordination with Medicaid**, to ensure that children eligible for Medicaid are enrolled in that program; and
- **Outreach ideas for both programs**.

OUTLINE

1. **BACKGROUND** [extract from kids report]
- No access to employer-based coverage
- Access but unaffordable [possibly; depends on what we do with group waiver]
- Job changes
- Medicaid eligibles

2. **CROWD OUT**
- Summary of bill requirements
- Summary of literature
- Summary of state experience
- IDEAS

3. **COORDINATION WITH MEDICAID**
- Summary of bill requirements
- Examples of state programs (eg, Pennsylvania)
- IDEAS

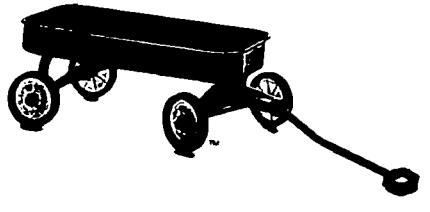
4. **OUTREACH**
- Summary of bill requirements
- Examples of successful Medicaid and state programs
- IDEAS

KIDCARE

FREE OR LOW-COST HEALTH INSURANCE IS NOW HERE FOR KIDS WHO NEED IT.

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 national initiative called KIDCARE. With KIDCARE, your children may be eligible for free or low-cost health insurance. Call our toll-free number. Don't let your kids go another day without health coverage.

1-877-KIDCARE



Affordable Health Insurance Is Now Here for Kids Who Need It

NEW! This year, a new nationwide health insurance program is beginning. Now, most families who work hard to make ends meet can get low-cost or free health insurance for their children.

Each State is developing its own Children's Health Insurance Program to make health care more affordable. In addition, Medicaid now provides free health coverage to most low-income children.

HEALTH INSURANCE MATTERS. Children with health insurance are more likely to:

- Be healthy as newborns,
- Receive needed immunizations as toddlers, and
- Get treatment for illnesses such as recurring ear infections and asthma.

Without treatment, these diseases can slow a child's learning and have lifelong consequences.

TOO MANY KIDS ARE UNINSURED. One out of every seven children in America is uninsured. This could be the child who plays with yours at school, the child next door, or your own child. Why?

- **Too expensive**: Private insurance can cost families thousands that they cannot afford.
- **Don't know about options**: Even though affordable health care is available to many working families, too few parents know about their options.

THESE CHILDREN NEED YOUR HELP. We encourage all concerned Americans to join this public-private campaign to insure American children. You can help. Please:

- ✓ **Learn about your State programs**. All States have Medicaid programs for children and most States have begun their new Children's Health Insurance Programs. Find out who is eligible for assistance and how families can apply.
- ✓ **Educate others**. Tell friends, relatives, parents you meet at work, and all other working families whose children or grandchildren may be uninsured about these options.
- ✓ **Community efforts**. There are many groups around the nation that are involved in children's health outreach. If you are interested, you may wish to contact one of these organizations for information and ideas on how you and your community can become more involved.

FOR MORE INFORMATION, SEE NUMBERS ON THE BACK OF THIS FLYER

The White House (July 1998)

WHERE YOU CAN GET MORE INFORMATION

FEDERAL CONTACTS AT THE NATIONAL LEVEL

Health Care Financing Administration (HCFA)
Lillian Gibbons - 410-786-8705
(www.hcfa.gov/init/children.htm)

Health Resources & Services Administration (HRSA)
Marcia Brand - 301-443-4619
(www.hrsa.dhhs.gov/childhealth)

OTHER SOURCES OF INFORMATION *

National Governors' Association
(www.nga.org)
National Conference of State Legislatures
(www.stateserv.hpts.org)
National Association of State Medicaid Directors
(medicaid.apwa.org)
Center on Budget and Policy Priorities
(www.cbpp.org)
Children's Defense Fund
(www.childrensdefense.org)
Families USA
(www.familiesusa.org)
National Academy of State Health Policy
(www.nashp.org)
Southern Institute on Children and Families
(www.kidsouth.org)

FEDERAL CONTACTS AT THE REGIONAL LEVEL

I. Boston Regional Office
(CT, ME, MA, NH, RI, VT)
HCFA - Maureen Farley - 617-565-1248
HRSA - Barbara Tausey - 617-565-1433

II. New York Regional Office
(NJ, NY)
HCFA - Jane Salchli - 212-264-3125
HRSA - Gilberto Cardona-Perez - 212-264-2566

III. Philadelphia Regional Office
(DE, DC, MD, PA, VA, WV)
HCFA - Rosemary Feild - 215-861-4278
HRSA - Frank Heron - 215-861-4407

IV. Atlanta Regional Office
(AL, NC, SC, FL, GA, KY, MS, TN)
HCFA - Andriette Johnson - 404-562-7410
HRSA - Dr. Ketty Gonzalez - 404-562-7980

V. Chicago Regional Office
(IL, IN, MI, MN, OH, WI)
HCFA - Barbara England - 312-353-8720
HRSA - Dorretta Parker - 312-353-4042

VI. Dallas Regional Office
(AR, LA, NM, OK, TX)
HCFA - Art Pagan - 214-767-6278
HRSA - Marianne Davenport - 214-767-3903

VII. Kansas City Regional Office
(IA, KS, MO, NE)
HCFA - Nan Foster Reilly - 816-426-3406 x3305
HRSA - Bradley Appelbaum - 816-426-5292

VIII. Denver Regional Office
(CO, MT, ND, SD, UT, WY)
HCFA - Dee Raisl - 303-844-2121 x454
HRSA - Joyce Borgmeyer - 303-844-5955

IX. San Francisco Regional Office
(AZ, CA, HI, NV)
HCFA - Karen Fuller - 415-744-3600
HRSA - Irma Honda - 415-437-8078

X. Seattle Regional Office
(AK, ID, OR, WA)
HCFA - Liz Trias - 206-615-2400
HRSA - Margaret West - 206-615-2518

Note: By August 1, the phone numbers for where you can get State-specific information will be available from both the Federal and Regional Contacts and at the Federal Contacts' websites.

* These are examples and do not represent all of sources of information. The White House does not endorse these organizations or their positions. Numbers are from HCFA and HRSA are subject to change.

*U.S. Government Printing Office: 1998 — 443-113/89128

Responsibility: Women's office.

- Foundations and their partners - Annie E. Casey Foundation.

Responsibility: Jeanne/Jen.

DRAFT AGENDA FOR DISCUSSION

Goal: To plan the radio campaign in the 10 target states in October

States:

Colorado
Delaware
Florida
Idaho
Indiana

Massachusetts
Oklahoma
Ohio
Pennsylvania
Utah

Questions:

- In this test of the media campaign, do we want to use taped ads, have local announcers read scripts, or both

- If we use taped ads, who do we want to read them:

  - First Lady
  - General Powell
  - State and local politicians
  - Local athletes
  - Celebrities
  - Ordinary people

  Can and how would we get these taped and produced

- What mix of free and paid advertising do we want

  - Radio Disney may be interested in running the spots at prime time
  - What are the Ad Council distribution options
  - What type of niche could the paid ads fill

- Do we want to try different strategies in different states to compare the outcomes

CHILDREN'S HEALTH OUTREACH PLAN

For the month of October, we would test the basics of a national media campaign in a subset of states. This test would involve using the toll-free number, tagline and a consistent message in:

- Pro bono radio spots, distributed through the Ad Council (checking today) and Radio Disney (they have tentatively committed to running spots at good times, but we need to finalize this; their stations are listed in parentheses below)

- Paid radio spots in communities with at-risk populations

- Corporate and community group promotional material and efforts: a number of corporations have said that they could target their efforts to particular states and would be interested in this test; community groups are willing to provide on-the-ground assistance to families in these states

NGA recommends the following states for testing based on two main criteria: willingness to participate and the efficient operation of their current telephone system (e.g., able to give both CHIP and Medicaid information and to send out applications to callers).

Colorado	(Radio Disney: Denver)
Delaware	
Florida	
Georgia	(Radio Disney: Atlanta, Savannah)
Idaho	
Indiana	
Massachusetts	(Radio Disney: Boston)
Oklahoma	
Ohio	(Radio Disney: Cleveland)
Utah	(Radio Disney: Salt Lake City)

Jeanne Lambrew
08/18/98 08:44:16 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: Summary of Kids' Outreach Meeting

Hello,

Ann, thank you very much for coming by -- as usual, your vision set the stage for a constructive conversation. Chris, thanks for guiding this meeting to a successful closure. Neera and Barbara, let me know if I missed some details or if there is something else to do. Jen, we are making progress!

Today, we agreed to:

1. Hook up the toll-free number in all states in September to test it technically.

2. Conduct a "Phase I" media campaign. This includes running the media campaign like we had originally planned in 8 to 10 states beginning in late September. We would use the toll-free number (but not tell people that it is national) and get as many corporations, groups, etc as possible to focus on those states. Some type of monitoring and evaluating will be built in.

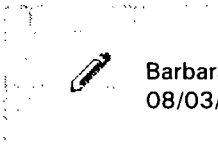
3. Conduct a "Phase II" in mid-November to add another 15 or so states to the campaign.

4. Go nationwide in early January. Everyone agreed that this is enough time to work on infrastructure, to work out the kinks in the toll-free number, and prepare for a nationwide push.

We will pick the 8 to 10 states for the Phase I by Thursday. We will also know by then what America's Promise can do. Specifically, we want to know whether America's Promise will produce the First Lady's radio spot and one with General Powell for testing in these states; whether the Ad Council is willing to help distribute these spots; and which corporations can target these states. We also want to get the camera-ready taglines in the next few days.

Once we have this information, we will (a) send a letter to kids' groups, the faith communities, corporate friends etc. to inform them of this plan and see if they are interested in helping in these states; (b) work with Megan on what Radio Disney can do; (c) work with Jon Jennings to get sports teams in the targeted states helping out; (d) build HHS's funds and paid ads around what America's Promise, Ad Council and Radio Disney are doing; and (e) consider what type of event (if any) we want to launch this Phase I.

Again, please let me know if there are different or additional ideas of next steps, and thanks to all for your help.



Barbara D. Woolley
08/03/98 02:16:28 PM

Record Type: Record

To: Jennifer L. Klein/OPD/EOP, Neera Tanden/WHO/EOP, Jeanne Lambrew/OPD/EOP, Ann F. Lewis/WHO/EOP

cc: Ruby Shamir/WHO/EOP
Subject: Kids Health - Camera Ready - Final Question - ASAP

We need to make a decision on the 2 options ASAP. Americas Promise folks like Option 2 because they think Option 1 does not motivate folks (ie. bold is the part they would want removed). And, they are concerned that those folks calling for a new initiative will hang up when they get the Medicaid line.

Option 1: Original. "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 national initiative called INSURE KIDS NOW. With INSURE KIDS NOW, your children may be eligible for low-cost or free health insurance. Call our toll-free number.** Don't let your kids go another day without health coverage.

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

Option 2: "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. Don't let your kids go another day without health coverage.

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

Children's Health Outreach Initiative

- There is another important role for child care centers like the one we saw today. At least 10 million children are uninsured in America. Over 3 million of these children are already eligible for Medicaid. Millions more will become eligible for the historic, new Children's Health Insurance Program, enacted by the President and the bipartisan Congress last year.

- Clearly, one of the best places to sign up uninsured children is child care centers. To encourage this, the President's 1999 Budget will allow States to enlist child care referral centers, teachers, and others who work with children to help enroll children in health insurance. We will also give States the tools and the funding to simplify enrollment, link children's health programs, and conduct aggressive outreach campaigns.

- I am pleased that Connecticut's plan to cover uninsured children includes innovative ideas like outreach at child care centers and school-based clinics. We look forward to working with you so that, together, we can help children get the basic health care that they need to reach their full potential.

The President's Children's Health Outreach Initiative

Over 3 million children are uninsured but eligible for Medicaid. Millions more will become eligible for the Children's Health Insurance Program (CHIP) created by historic, bipartisan legislation passed last year. It is critical to the success of these programs and the health of uninsured children to find and enroll children in health insurance. To this end, the President's 1999 Budget invests nearly $200 million per year in children's health outreach.

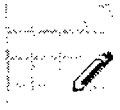
- **Fund for outreach**. In welfare reform, a special $500 million pool was set aside to fund activities to improve Medicaid enrollment of families affected by welfare reform. The President's 1999 Budget includes a proposal that would expand the use of this fund. States would be able to receive a 90 percent matching rate for outreach activities for all uninsured children, not just those who would have been eligible for welfare. The Federal funds to cover the extra matching (above Medicaid's regular matching amount) would come from this fund. In addition, the proposal would remove the sunset of the fund in 2000 and add another $25 million to assist States with increased outreach activities.

- **Allowing immediate Medicaid coverage through schools, Head Start, and child care referral centers.** The Balanced Budget Act (BBA) of 1997 gave States a new option in Medicaid to grant "presumptive eligibility" to children. Certain children may receive immediate health care coverage without having to wait for a full Medicaid eligibility determination. The President's 1999 Budget proposes to make this presumptive eligibility option more flexible and attractive to States. First, it would broaden the definition of who can determine eligibility to include sites such as schools, child care resource and referral centers, child support enforcement agencies and CHIP eligibility workers. Second, it would eliminate the requirement that States subtract the costs of presumptive eligibility from their CHIP allotments. Instead, these costs would be matched as a regular Medicaid State plan option. Both of these changes would give States greater incentives and flexibility for using this important authority.

In addition, the Department of Health and Human Services (HHS) has identified a number of ideas and options for States to simplify enrollment and integrate Medicaid and CHIP.

- **Model joint application form**. The use of one application form for all health programs would streamline enrollment and increase the number of children insured by Medicaid and CHIP. HHS has developed a simple, two-page model application that meets Federal requirements for both programs. It encourages States to develop similar applications.

- **Examples of successful outreach.** HHS has worked with states to identify approaches that are successful in identifying and enrolling uninsured children. The Administration will promote these ideas and work with States on an on-going basis to remove Federal barriers, encourage private sector involvement, and educate families about their options *(see letter to State Health Officials from HHS, dated January 23, 1998 for details).*



Jeanne Lambrew
12/11/97 12:49:31 PM

Record Type: Record

To: Jennifer L. Klein/OPD/EOP

cc:
Subject: kids' outreach

I don't know I told you but we missed our deadlines for the coverage and Medicare memos, so that the kids' ideas, listed below, are not final. But, since we have a little extra time, it would be great if you could take a look at it for us. Any additions? I may add Head Start sites as presumptive eligiblity sites as well.

Thanks, Jeanne

CHILDREN'S HEALTH OUTREACH

The Children's Health Insurance Program (CHIP) provides funds for coverage of millions of working families' uninsured children, a population that previously had trouble affording coverage. It also builds upon the Medicaid program, which covers nearly 20 million children. But important work remains to be done. In particular, we need to work with states to enroll the millions of uninsured children in these programs.

Medicaid eligible children are especially at risk of remaining uninsured. Over three million uninsured children are eligible for Medicaid. Educating families about their options and enrolling them in Medicaid has always been a problem, but it has recently become even more challenging. The number of children covered by Medicaid leveled off in 1995 and, according to the Census, dropped by 6 percent in 1996. While some of this decline may be due to the lower number of children in poverty, another part may result from families' misunderstanding of their children's continued eligibility for Medicaid in the wake of welfare reform.

Options to Increase Outreach for Medicaid and the Children's Health Insurance Program

To address the need for children's health outreach, we propose a series of policy options. Together, these initiatives could cost $1 to 2 billion over five years (or more depending on policy choices about the enhanced match). Preliminary discussions with NGA and some children's advocates suggest they strongly support these efforts. In addition, the Administration is developing partnerships to encourage a complementary range of private outreach activities.

Enhanced match for outreach. One option for improving state outreach is to provide an enhanced match to enroll children who are eligible for but not previously enrolled in

Medicaid. At the end of each year, if a state can document that it has increased its enrollment over its baseline, it would receive an increased matching amount per newly covered child (possibly through administrative payments). This policy rewards states only if they succeed in outreach, rather than matching activities that may or may not work. Depending on the amount of the incentive and the administrative design, this option could cost to $0.5 to 1 billion over five years.

Moving outreach to schools and child care sites. We could build upon the " presumptive eligibility" provision in the Balanced Budget Act to make it easier to enroll children in Medicaid and CHIP. The BBA option allows limited sites (e.g., hospitals) to give low-income children temporary Medicaid coverage on the spot while they are formally enrolled in CHIP or Medicaid. This proposal would broaden these sites to include schools and appropriate child care sites, at the state's option. HCFA actuaries preliminarily estimate that this proposal would cost $400 million over 5 years. Also, under the BBA, states that use presumptive eligibility must pay for its costs out of the CHIP allotment, reducing the amount available for other coverage. States have advised us that this requirement discourages them from taking advantage of the presumptive eligibility provision. HCFA actuaries preliminarily estimate that dropping this requirement would cost $25 million over 5 years.

Accessing 90 percent matching funds for outreach. A third way to increase funding for children's health outreach is to increase states' flexibility in using a special Medicaid fund set aside in TANF for outreach for children losing welfare. This $500 million fund is currently allocated to states with a 90 percent matching rate for outreach activities to certain children. We could expand its use to all children, not just welfare children. HCFA actuaries preliminarily estimate that this policy would cost $100 million over 5 years. NGA supports this change.

Simplifying enrollment. A simple, accessible enrollment process could encourage more families to enroll their children in Medicaid or CHIP. To help create such a process, we propose several actions, all of which are inexpensive. First, we could streamline the application process by simplifying Medicaid eligibility and by encouraging the use of simple, mail-in applications. HCFA has already developed a model single application form for both Medicaid and CHIP. We could condition some of the financial incentives described above on using a single or simple application. Second, we are reviewing the feasibility and cost of a nationwide 1-800 number that will link families with their state or local offices. Such a number could be placed in public service announcements, on the bottom of school lunch program applications, and on children's goods like diaper packages.

Discussion

There is unanimous support across agencies for focusing on children's health outreach. HHS and Treasury believe that such outreach should be the Administration's first priority. NEC/DPC and OMB believe that aggressive outreach will be needed to meet or exceed the Administration's goal of covering 5 million uninsured children. Although OMB is supportive, it points out that because some children may be impossible to reach and some states may not use these options, we are unlikely to enroll all 3 million children. NEC, also supportive,

raises the concern that spending on an outreach initiative may be a communications challenge so soon after the enactment of the $24 billion base children's health program. However, policy experts, Governors, and children's advocates alike will endorse this initiative.

One great challenge is the difficulty of finding savings from Medicaid to offset the costs of this initiative. With this in mind, your advisors are considering the tobacco settlement as a financing source. Specifically, we are exploring the advisability of allowing states to retain the Federal share of the tobacco funds if they dedicate those funds to high-priority Administration initiatives like child care, education, and health care. Governor Chiles would support such an approach if we dedicate the funds to children's health care, not just outreach.

February 10, 1998

MEMORANDUM FOR JENNIFER KLEIN

FROM: ASHLEY RAINES
DIRECTOR OF OPD OPERATIONS

SUBJECT: Cellular Telephone Bill

Attached is the January telephone bills for the cellular telephone assigned to you. Please review the calls listed and certify these calls were made for official business purposes.

You are responsible for reimbursing the government for the cost of calls made for other than official business. Please review the list, highlight any calls that were not made for official business and return this memorandum to me by **Tuesday, February 17th** with a check payable to the *U.S. Treasury* for the cost of those calls.

Please note that this bill cannot be paid until your certification of official calls and reimbursement check (if applicable) has been returned to me.

Please call me at x62023 with any questions. Thank you for your attention to this matter.

Attachments

_____ All calls listed are for official government business.

_____ Attached is my check for non-official calls. The remaining calls were for official government business.

_____ _____
Signature Date

Bell Atlantic Mobile

Bell Atlantic

TELEPHONE DETAIL

Klein

CUSTOMER ACCOUNT NO: 000815136-00001
MOBILE TELEPHONE NO: 202-395-2131
PHONE USER NAME:

INVOICE NO: 0153384078
INVOICE DATE: JANUARY 16, 1998

SERVICE FEE		7.99
MONTHLY SERVICE FEE (FROM 01/17/98 TO 02/16/98)	7.99	
EQUIPMENT CHARGES		0.00
ENHANCED SERVICES AND BELL ATLANTIC® IQ® SERVICES		0.00
CALL DELIVERY	0.00	
ADDITIONAL CHARGES AND CREDITS		0.00
AIRTIME CHARGES		4.70
LANDLINE CHARGES		0.50
ROAMER AIRTIME CHARGES		0.00
ROAMER LANDLINE CHARGES		0.00
FEDERAL EXCISE TAX		0.00
STATE AND LOCAL TAXES		0.00
OTHER FEES AND SURCHARGES		0.95
DIST. OF COLUMBIA GROSS RECEIPTS SURCHARGE	0.95	
TOTAL CURRENT CHARGES FOR 202 395-2131		$14.14

CUSTOMER ACCOUNT NO: 000815136-00001
MOBILE TELEPHONE NO: 202-395-2131

INVOICE NO: 0153384078
INVOICE DATE: JANUARY 16, 1998

USAGE DETAILS FOR 202 395-2131 ON GOVT 100+PLAN 0873:
LONG DISTANCE SERVICE PROVIDED BY: BAM

DATE	TIME	ORIG BAND	ORIGINATING LOCATION	CALLS TO	TELEPHONE NUMBER	AIRTIME RATE	AIRTIME MIN	AIRTIME AMOUNT	LANDLINE RATE	LANDLINE TYPE	LANDLINE AMOUNT	TOTAL CHARGES
12/18	10:28 PM	1	WASHINGTON DC	WASHINGTON DC	202 965-4234	OFFPK	1	0.15		LCL	0.10	0.25
12/24	09:01 AM	1	WASHINGTON DC	WASHINGTON DC	202 965-4234	PEAK	1	0.35		LCL	0.10	0.45
01/13	02:28 PM	1	ROCKVILLE MD	WASHINGTON DC	202 662-3583	PEAK	6	2.10		LCL	0.10	2.20
01/13	02:35 PM	1	FERNWOOD MD	WASHINGTON DC	202 662-3583	PEAK	4	1.40		LCL	0.10	1.50
01/16	02:31 PM	1	WASHINGTON DC	WASHINGTON DC	202 872-9860	PEAK	2	0.70		LCL	0.10	0.80

TOTAL AIRTIME FOR 202 395-2131 ON GOVT 100+PLAN 0873:
LONG DISTANCE SERVICE PROVIDED BY: BAM

BAND 1 ALL W/B CELLS	CALLS	MINUTES USED	AIRTIME AMOUNT
PEAK	4	13	4.55
OFFPEAK	1	1	0.15
TOTAL	5	14	4.70

TOTAL ACTIVITY FOR ALL BANDS ON GOVT 100+PLAN 0873:

TOTAL INCOMING CALLS: 0
TOTAL OUTGOING CALLS: 5
TOTAL NUMBER OF CALLS: 5

DIRECTORY ASSIST/INFOASSIST CALLS: 0
TOTAL PRIOR MONTH CALLS: 0
PRIOR MONTH AIRTIME AMOUNT: $0.00

TOTAL LANDLINE FOR 202 395-2131:

RATE PERIOD	LOCAL CALLS	LOCAL AMOUNT	LEC CALLS	LEC AMOUNT	TOTAL CALLS	TOTAL AMOUNT
DAY	5	0.50	0	0.00	5	0.50
TOTALS	5	0.50	0	0.00	5	$0.50

Bell Atlantic Mobile provides billing services for AT&T Communications and Sprint Communications. Services provided by AT&T and Sprint are indicated as "AT&T" and "SPT" respectively, in the landline TYPE column. There is no connection between Bell Atlantic Mobile and these inter-exchange carriers.

A National Effort to Insure America's Children: Working Together for a Healthier Future

February 18, 1998

To meet the challenge of insuring millions of children, health care providers, foundations, corporations, teachers, child care providers, advocates, and public health officials are coming together to inform families about insurance options for their children. The following is a list of some major activities.

Enlisting Health Care Providers:

- The American Medical Association, the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, the American College of Obstetricians and Gynecologists, and the American Nurses Association are educating physicians and nurses throughout the country on how to enroll low-income uninsured children in CHIP and Medicaid.

Engaging Hospitals and Health Centers:

- The American Hospital Association has launched the *Campaign for Coverage... A Community Health Challenge* to expand health care coverage to 4 million more Americans through outreach and education efforts designed to bolster participation in CHIP, Medicaid, and other programs.

- The National Association of Children's Hospitals and the National Association of Public Hospitals are identifying and promoting innovative models of outreach and enrollment to uninsured children within hospital facilities and throughout the community.

- The Catholic Health Association has launched the *Children's Health Matters* campaign to provide support to local hospitals and social service agencies in 23 states in their efforts to enroll Medicaid eligible children.

- The National Association of Community Health Centers is working through its 700 centers to identify and enroll low-income uninsured children — including the 1.3 million such children they now serve — through Medicaid/CHIP enrollment services at Community Health Centers.

Making Children's Health Insurance a Public Health Priority:

- The National Association of County and City Health Officials, the American Public Health Association, and the Association of Maternal and Children Health Programs are working to inform all their members on ways to increase health insurance coverage for the children that they treat.

Investing in Innovative National, State and Local Outreach:

- The Robert Wood Johnson Foundation will spend $13 million over the next 3 years to fund innovative state-local coalitions to design and conduct outreach initiatives, simplify enrollment processes, and coordinate existing coverage programs.

- The Kaiser Family Foundation will spend up to $10 million over the next 5 years on studies to help understand why eligible children are uninsured, how best to provide insurance coverage for them, and which outreach initiatives work.

- America's Promise, with support from the Robert Wood Johnson Foundation and in collaboration with the American Academy of Pediatrics, will mobilize corporations and local communities nationwide in children's health outreach efforts. Already, two of the nation's major pharmaceutical

companies have joined this effort -- SmithKline Beecham and Schering Plough.

- The David and Lucile Packard Foundation will spend over a million dollars on children's health programs such as the Children's Health Collaborative Project, a joint project of the National Association for State Health Policy, the National Governors' Association, and the National Conference of State Legislatures.

Mobilizing Major Corporations:

- Bell Atlantic, in collaboration with the nation's Governors, will establish and support a single toll free phone number that directs families to their local eligibility offices.

- Pampers will distribute information on available health insurance options, including the toll-free number, in its childbirth education packages, which are given to 90 percent of first-time mothers.

- Safeway will display the toll-free number and information on children's health programs on their shopping bags.

- The National Association of Chain Drug Stores and the National Community Pharmacists Association will distribute the toll-free number to more than 150,000 pharmacists in over 60,000 pharmacies and will provide them with information so that they may refer parents to state health insurance programs.

Involving Teachers and Child Care Referral Centers:

- The National Education Association is launching an unprecedented campaign to educate teachers on how they can inform children and their families about health insurance, through national newsletters, conferences, and special training sessions.

- The National Association of Child Care Resource and Referral Agencies, which help over 1.5 million parents a year to find child care, will launch a campaign to inform parents of health insurance options for their children.

Strengthening Grassroots Efforts to Sign Up Uninsured Children:

- The Children's Defense Fund is disseminating information to over 10,000 individuals and organizations on state plans to enroll more children in coverage.

- The Center on Budget and Policy Priorities has increased its *Start Healthy, Stay Healthy* campaign, which works with community organizations, schools, child care programs, health clinics, and hospitals on ways to identify eligible children and get them enrolled in Medicaid and CHIP.

- Families USA is providing technical assistance to advocates nationwide to devise innovative strategies to enroll more children.

- The March of Dimes has committed funds to support demonstration projects to help states plan or implement creative outreach initiatives to reach and enroll children.

- The Children's Health Fund is organizing a major outreach campaign designed to enroll eligible children in Medicaid and CHIP, in order to reach an additional 50,000 uninsured children.

PRESIDENT CLINTON ANNOUNCES A SERIES OF NEW EFFORTS TO ENROLL UNINSURED CHILDREN IN HEALTH INSURANCE PROGRAMS
February 18, 1998

Today, the President is announcing the first major state coverage expansions under the recently enacted Children's Health Insurance Program (CHIP) and released information showing that many States will soon follow. He also unveiled an unprecedented set of public/private initiatives designed to enroll the millions of uninsured children who are eligible but not enrolled in Medicaid and other state-based children's health programs. These initiatives have been designed in partnership with Governors, health care providers, children's health advocates, foundations, businesses and many others who are committed to providing health care coverage for the nation's uninsured children.

Over 10 million children in America are uninsured. Nearly 90 percent of these children have parents who work, but do not have access to or cannot afford health insurance. Over 3 million of these uninsured children are already eligible for Medicaid. However, many families are not aware that their children are eligible for Medicaid, and others have difficulty filling out the application. Similar problems could undermine the new Children's Health Insurance Program's goal to enroll millions of uninsured children. With these challenges in mind, the President:

- ✔ **ANNOUNCED THAT COLORADO AND SOUTH CAROLINA HAVE JOINED ALABAMA AS THE FIRST COVERAGE EXPANSIONS UNDER THE NEW CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP).** Today, the President is announcing that Colorado and South Carolina join Alabama as the first states to come into the children's health program. In late January, Alabama received approval to expand its Medicaid program to children ages 14 to 18 up to 100 percent of poverty. South Carolina will expand its Medicaid program to provide coverage to all children up to 150 percent of poverty. And, Colorado builds upon its current non-Medicaid program to cover children up to 185 percent of poverty. The President is also announcing that many more States are well on their way to expanding coverage to more uninsured children. Currently, 14 additional states have submitted plans to HHS for approval, and another 18 States have active working groups or task forces to design plans to address the needs of uninsured children.

- ✔ **RELEASED A NEW PRESIDENTIAL DIRECTIVE TO LAUNCH A GOVERNMENT-WIDE EFFORT TO ENROLL UNINSURED CHILDREN.** In an executive memorandum to eight Federal agencies with jurisdiction over children's programs — the Departments of Agriculture, Interior, Education, HHS, HUD, Interior, Labor, and Treasury and the Social Security Administration -- the President is directing the establishment of a multi-agency effort to enroll uninsured children. These agencies run programs such as WIC, Food Stamps, Head Start, and public housing that cover many of the same children who are uninsured and eligible for Medicaid or other health insurance. The memorandum instructs these agencies: (1) to identify all their employees and grantees who might come into contact with these children and ensure that these individuals are aware of the health insurance programs available to children; (2) to develop an intensive children's outreach initiative, such as distributing information, coordinating toll-free numbers, and simplifying and coordinating application forms; and (3) to report back in 90 days on their plan to help enroll uninsured children.

✔ **HIGHLIGHTED BUDGET PROPOSALS THAT PROVIDE MEDICAID ENROLLMENT INCENTIVES TO STATES.** The President's FY 1999 budget invests $900 million over 5 years in children's health outreach policies, including the use of schools and child care centers to enroll children in Medicaid. The budget provides states with the option of automatically enrolling children in Medicaid even before having received all of the complicated eligibility and enrollment forms (a provision known as "presumptive eligibility"). It also expands the use of a Federally-financed administrative fund so that it can underwrite the costs for all uninsured children — not just the limited population allowed under current law.

✔ **ANNOUNCED A HISTORIC PRIVATE SECTOR COMMITMENT TO PROVIDE OUTREACH.** To complement the public outreach effort, the President is announcing unprecedented new contributions from the private sector to help ensure that all children who are eligible for health insurance receive it, including:

- **A new toll-free number that directs families around the nation to their state enrollment centers.** The President is announcing that Bell Atlantic will establish and operate a toll-free number to help states enroll uninsured children. The number, which will be put in place during the upcoming months, will be developed in cooperation with the nation's Governors. This will help millions of families around the nation by directing them automatically to their local state Medicaid enrollment agency.

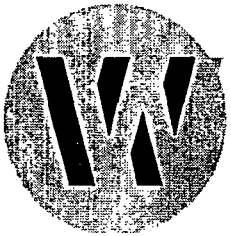
- **Over $23 million in commitments from private foundations across the country.** The Robert Wood Johnson Foundation will spend $13 million over the next 3 years to fund innovative state-local coalitions to design and conduct outreach initiatives, simplify enrollment processes, and coordinate existing coverage programs. The Kaiser Family Foundation will spend up to $10 million over the next 5 years on studies to help understand why eligible children do not enroll in existing programs and how best to provide insurance coverage for these children. America's Promise, with support from the Robert Wood Johnson Foundation and in collaboration with the American Academy of Pediatrics, will mobilize corporations such as SmithKline Beecham and Sheering Plough and local communities nationwide in children's health outreach efforts.

- **New initiatives from corporate and advocacy organizations to reach out to uninsured children.** Pampers has volunteered to include a letter in its child birth education packages, given to 90 percent of first-time mothers, providing families information about available health insurance options. Grocery stores and chain drug stores across the country will provide information about the new Bell Atlantic toll-free number to their customers. The National Education Association is launching an unprecedented effort to educate teachers on how they can inform children and their families about health insurance, through national newsletters, conferences, and special training sessions. The American Hospital Association's Campaign for Coverage will increase its nationwide initiative to engage hospitals in helping uninsured Americans, including children.

✔ **ISSUED A CHALLENGE ACROSS AMERICA TO FIND NEW WAYS TO REACH OUT TO UNINSURED CHILDREN.** The President is challenging every physician, nurse, health care provider, business, school, parent, grandparent, and community across the nation, to find new ways to ensure that uninsured children eligible for health insurance are enrolled in Medicaid or CHIP. This national commitment should not stop until every eligible child across the country is enrolled in one of the existing health care programs.

Health Care PulseLine:
Preliminary Results

prepared for
America's Promise



WIRTHLIN WORLDWIDE

21 May 1998

RESEARCH METHODOLOGY

- Two PulseLine Groups
  - Parents of 'at risk' children
  - Social Workers / Health Care Professionals that deal with parents of 'at risk' children

- Approximately 20 respondents per group

- First hour of each group consisted of extensive quantitative evaluation of potential promotional materials
  - 'Ballot Box' technology for instantaneous data display on multiple promotional iterations

- Second hour consisted of in-depth qualitative Focus Groups

RESEARCH METHODOLOGY

- Ten different 'story board' iterations

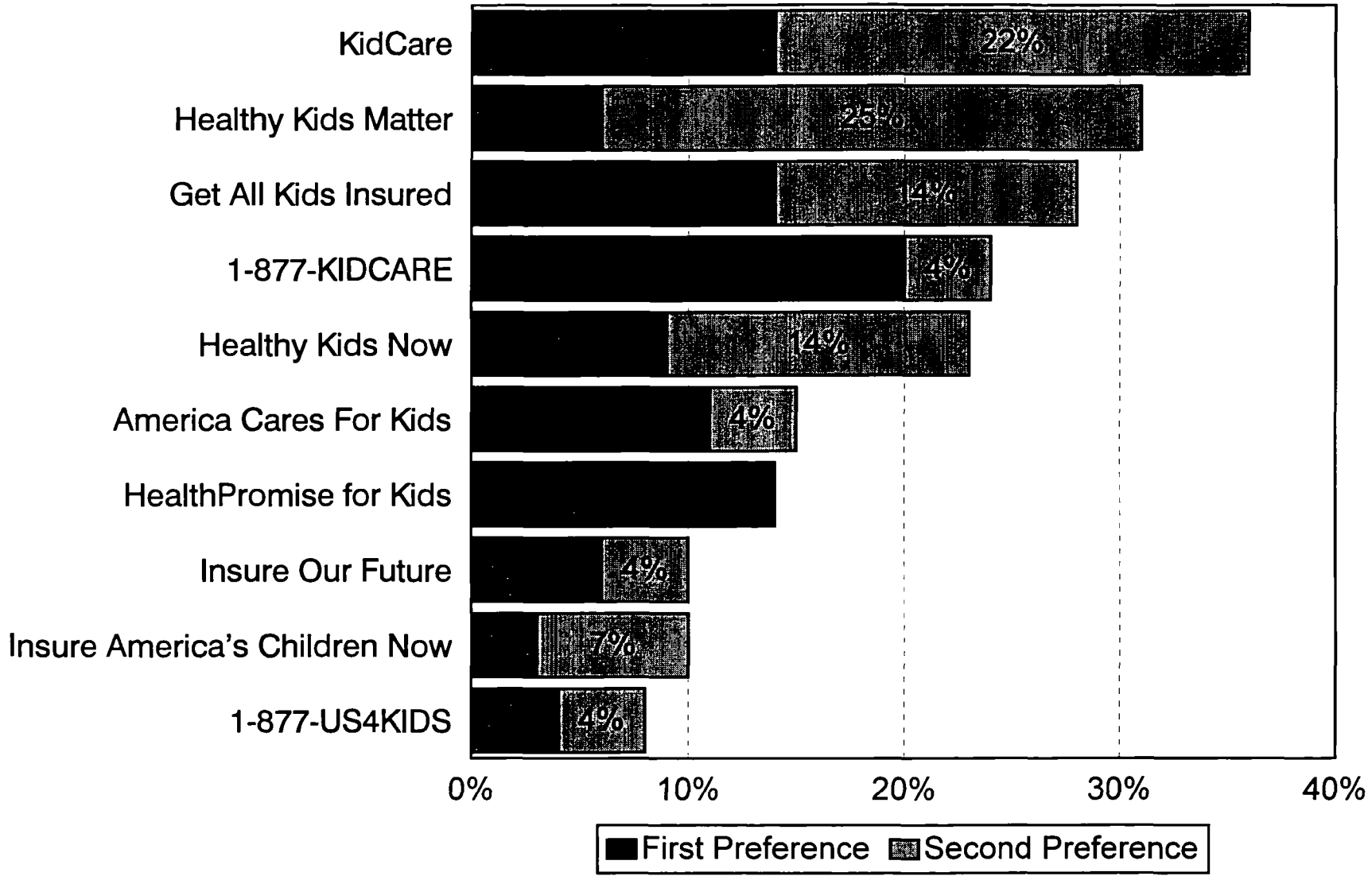
- Each story board included:
  - Potential initiative name
  - Tagline
  - Toll-free phone number
  - Program descriptive

- Respondents provided preferences for and against each component of each story board

- Given the instantaneous data display, the subsequent qualitative follow-up was fluid, allowing exploration of key issues unearthed in the quantitative portion

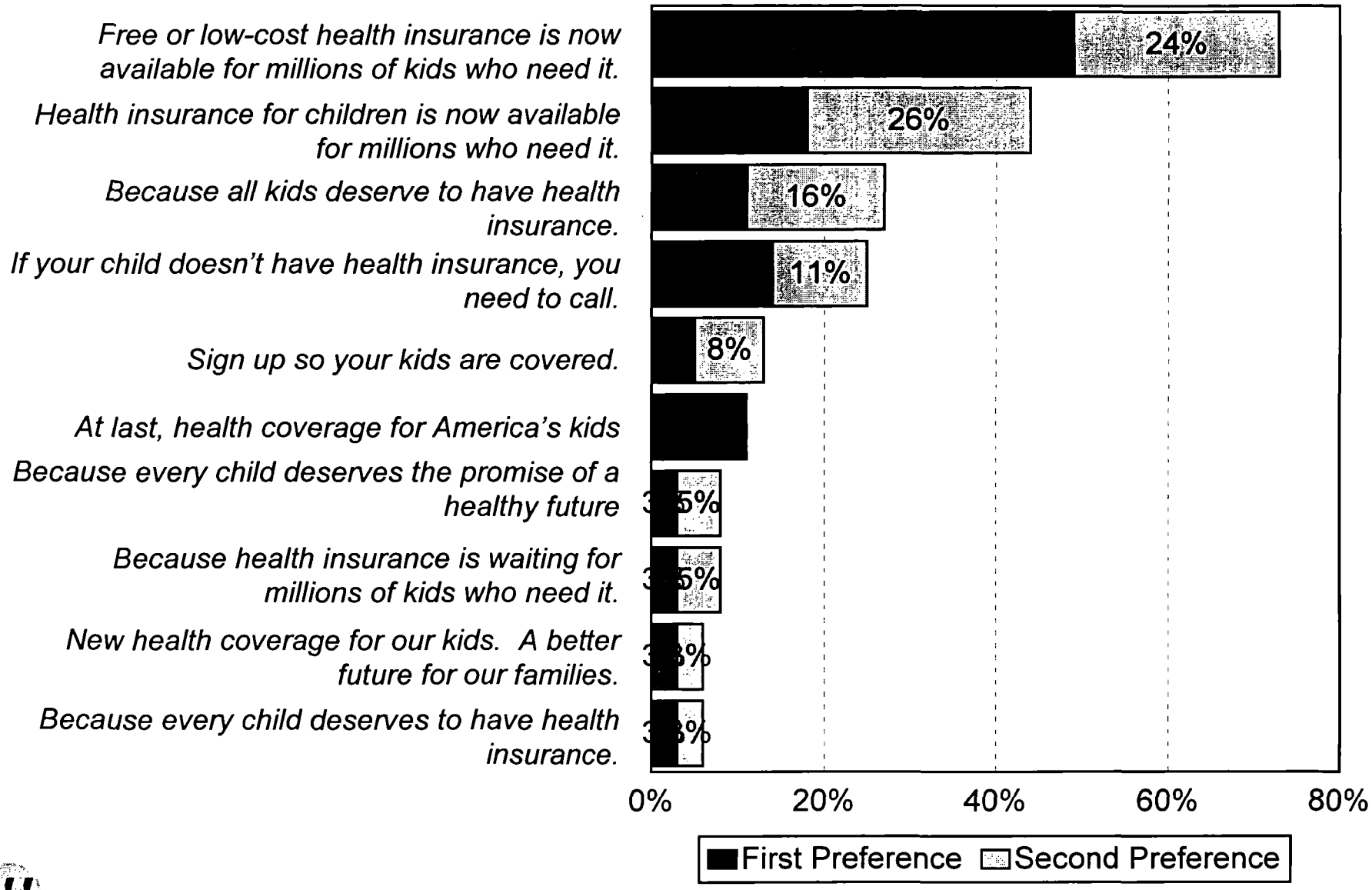
Preference for Name of Initiative

(Among both groups)



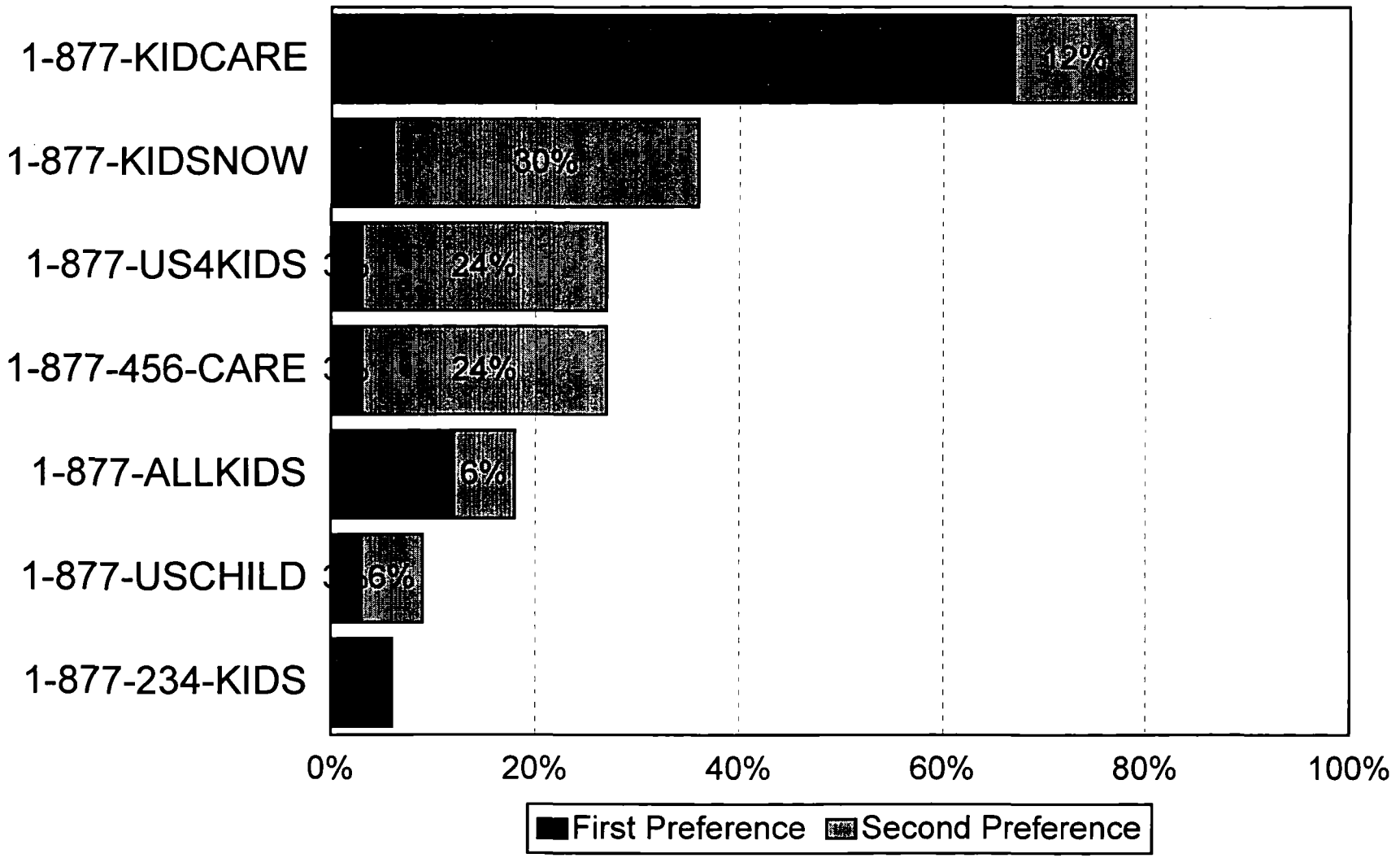
Preference for Tagline

(Among both groups)

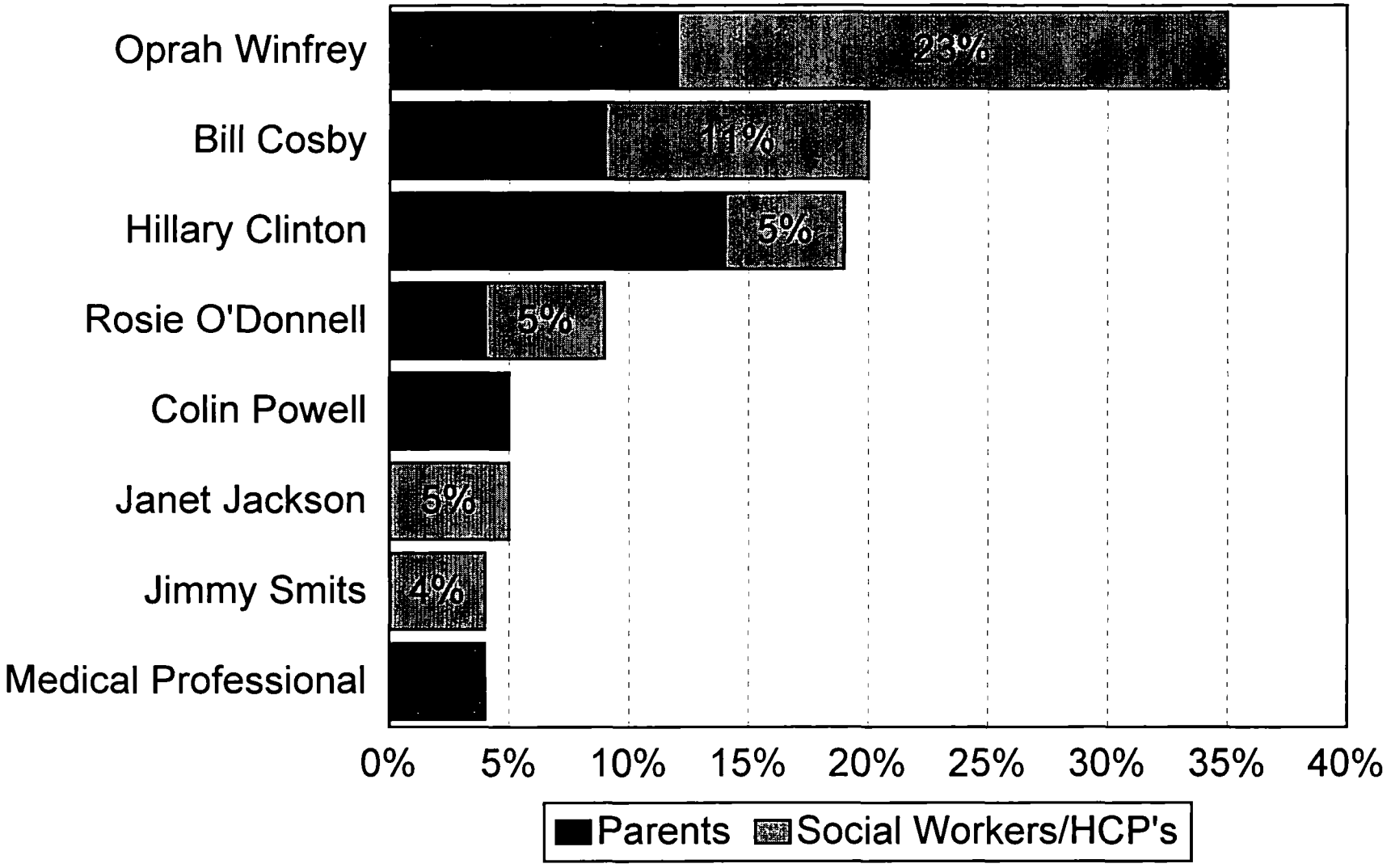


Preference for Toll Free Number

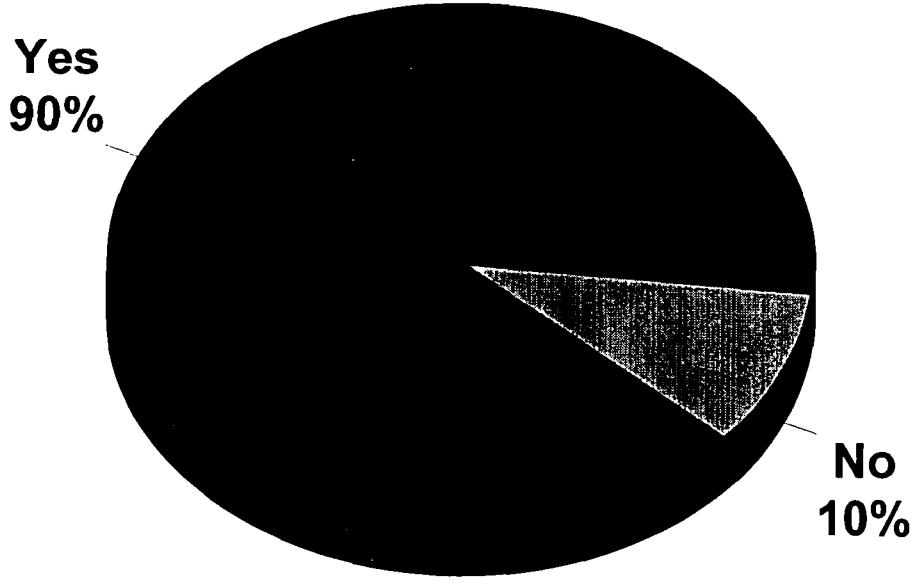
(Among both groups)



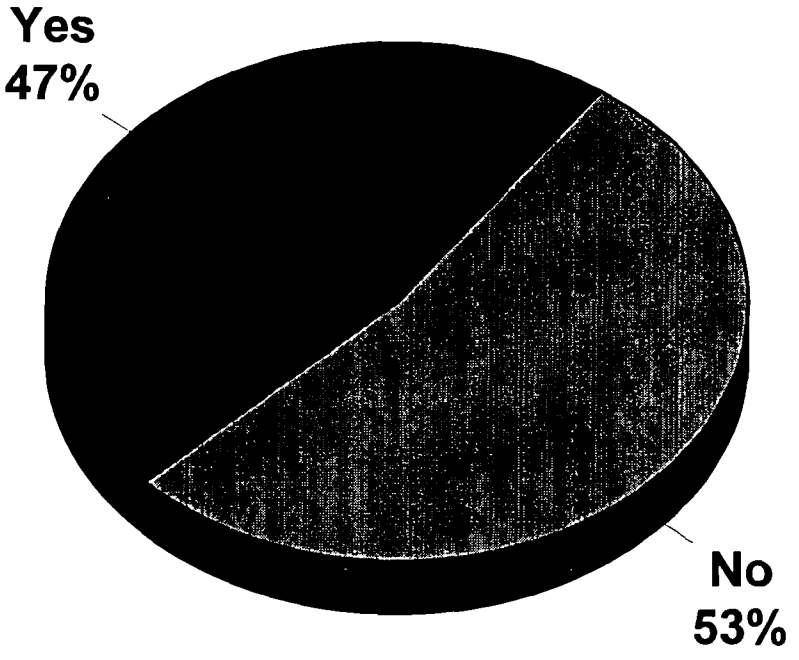
Preferences for Initiative Spokesperson



Do you (your clients/patients) feel that it is valuable to take children in for check-ups if they are not sick?

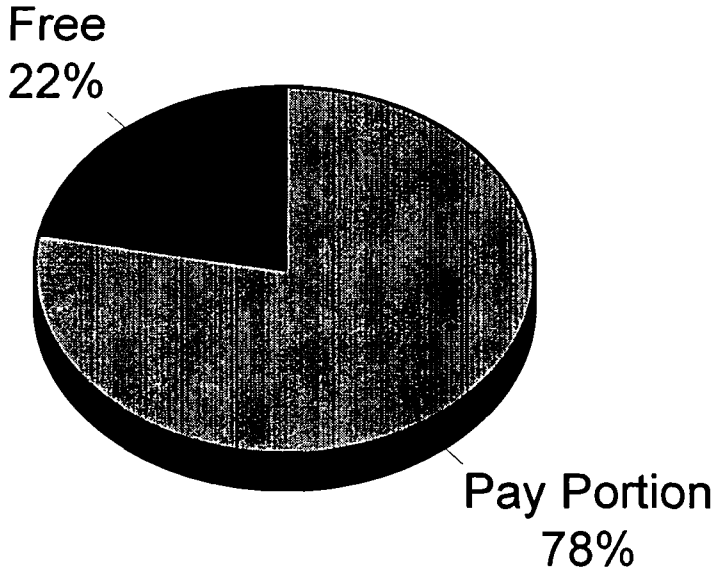


Parents / Caregivers

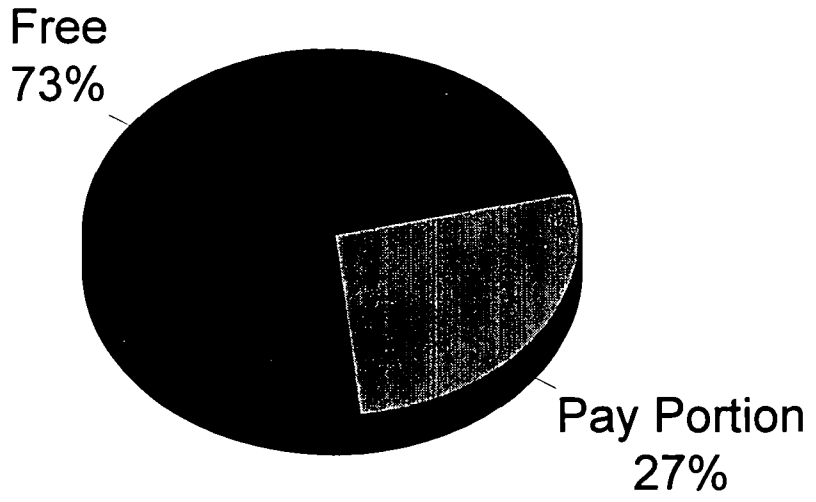


Social Workers / HCP's

Would you (your clients/patients) rather the government provide access to free health insurance for your (their) kids, or would you (they) prefer to pay a small portion, say $10 per month?



Parents / Caregivers



Social Workers / HCP's

COMMUNICATIONS IMPERATIVES

- Cost will be the number one concern among this audience. We absolutely must mention that this initiative is 'free' or 'low-cost'
- Emphasize that this initiative is something that is available NOW or available TODAY
- Acknowledge the efforts of these people despite their difficult situation
- Provide assurance that our target audience is eligible for this program

COMMUNICATIONS IMPERATIVES

- Emphasize that this program is 'new'. The fact that this is not something that they've seen or heard about before is appealing

- Somewhat less important, but still on the mental radar screen of these respondents, was the quality of this health care. We should emphasize that this is not a watered-down version of the insurance that middle-class America receives

- Our target audience lives from day to day - any references to *the future* make them distrustful (again, confirming the need to include the term 'today' or 'now' in our messages)

COMMUNICATIONS IMPERATIVES

- Avoid any terminology that connotes a 'Federal Program'. Pride will influence many of the individuals we are targeting into non-action. The term 'National Initiative' is a good alternative.

- Avoid limits such as *millions* and *ten million*. These people are eternal pessimists. The majority of the group voiced the opinion that 'if there are ten million slots, my child would be number ten million and one.'

- Avoid tone that 'we know what's best you.' Pride is very important and they prefer to make up their own mind about issues concerning their child. Phrases such as "you need to call" or "don't risk your child's health" can be a turn-off. They are, however, open to good advice.

cc: Melanne
Chris
Jean

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

SEP 28 1997

MEMORANDUM FOR THE FIRST LADY

FROM: Nancy-Ann Min DeParle NMD
Deputy Administrator

SUBJECT: Status of State Children's Health Insurance Program

I wanted to provide you with an update on the Department of Health and Human Services' (HHS) efforts to implement the State Children's Health Insurance Program. We started organizing even before the President signed the bill into law and already have provided States with a significant amount of information to assist them in developing the State Plans required by the law. In addition to several written communications, we have been talking with the States through face-to-face meetings in Washington, including the National Governors' Association (NGA) - sponsored summit on September 12th, and through informal contacts made by our regional offices.

Implementation of the new program involves a team effort throughout the HHS. The new program will be administered by the Center for Medicaid and State Operations (CMSO) within the Health Care Financing Administration (HCFA). We are working with the Health Resources and Services Administration (HRSA), which also administers programs such as the Maternal and Child Health Services Block Grant, to implement and monitor the new program as a part of our overall strategy to coordinate outreach to uninsured children. Among other things, HRSA's involvement help to underscore that we are not trying to push States into using Medicaid as the expansion model.

Guidance to States

We have provided States with a number of documents that will help them in developing their child health plans:

- On August 27th, we sent a letter to State officials providing an overview of the new program, describing our implementation plans, and enclosing a detailed summary of the law.

- On September 10th, we published a Federal Register notice that set forth the fiscal year 1998 State allotments available to States, Commonwealths, and Territories for expenditures on the new program. This notice also provided State-by-State information on the enhanced Federal matching available to States.

- In conjunction with the NGA meeting on September 11th, we provided States with the first set of responses to the highest priority, most frequently asked questions about the program. (We will release additional sets of questions and answers on a regular basis as we resolve key policy issues.)

- On September 12th, we provided States with a draft template and instructions to provide information on the requirements and options in the law to assist States in submitting their plans and relieve them from having to search through the law to ensure that they have made the proper assurances.

- We also created a WEB page to help States (and others) answer immediate questions about the new law and its implementation. (The address is http://www.hcfa.gov/init/children.htm).

For your information, I have appended these materials in a notebook that accompanies this memorandum.

In addition, we are developing materials to guide the review and approval of Title XXI plans. These will include instructions to States for the submission, approval and amendment of Title XXI plans, as well as instruction for HCFA Central Office, Regional Offices and DHHS partners on the process to follow for review of States' plans. We will also provide more payment information to States on the claims processing procedures and State matching requirements. We also are preparing instructions and guidance for States to access Title XXI funds through Medicaid expansions. Our goal is to provide these materials to the States in early October.

We also are working to assist States in developing strategies to find and enroll uninsured children without inadvertently replacing existing private or State coverage of children with the new Federal program. We plan to provide examples of strategies or best practices used by States in three areas:

- **Preventing "crowd out"** of current coverage to ensure that the new funds cover children who would otherwise have private coverage;

- **Coordination with Medicaid** to ensure that children eligible for Medicaid are enrolled in that program and to simplify the eligibility process; and

- **Outreach ideas for both programs.**

Finally, we are planning to invite States to a conference in early December to provide them with additional technical assistance. We think that early December is a good time for such a meeting because by then, States will have had time to more fully explore their options, and also because many States will need to be prepared to work with their State legislatures in developing their plans beginning in January 1998.

TO: Katie, Emily, Jennifer, Barbara

FROM: Jeanne

RE: **OUTLINE OF BIWEEKLY UPDATE**

DATE: September 17

Attached is a draft format for our biweekly update? Are there additional categories? Missing information?

Another thought that I had is that we get a 50-state table that shows whatever we know is going on in each state in a box.

We'll discuss at 12:30. Thanks!

Children's Health Insurance Program Update
DRAFT September 17, 1997

News / Releases

Last week, Administration officials and staff attended a National Governors' Association (NGA) meeting on children's health. The two-day meeting included panel discussions and round tables about the new program. At that time, we released two documents:

- The Federal Register containing the state allotments
- A first set of questions and answers about major issues

On Monday, September 15, DHHS sent to states and other interested parties a draft state plan "template" to help guide states as they develop their state plans.

The next planned release of information is possibly October 1, the first effective date of the program, including general guidance on targeting. Other works in progress include: a second set of q.s. and as; a letter outlining financial reporting forms; a letter describing the state plan approval process; and a description of how the Medicaid option would work.

State News

Wisconsin intends to submit a concept paper [when]

California held a special session of their state legislature in August to discuss its state plan.

Meetings / Speeches

A series of regular meetings have been set up. These include: [biweekly NGA, groups, etc].

Chris Jennings and Nancy Ann Min DeParle spoke at the NGA meeting.

NCSL?

Upcoming Events

Secretary Shalala, March of Dimes, September 26

First Lady, October 6

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1997 Children's Health *September* 1997

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	1	2	HHS Steering Committee 3	HCFA Center on Beneficiary Services, Baltimore, MD (Fenton) 4	5	6
7	HHS Steering Committee 8 CSG/Southern Gov's Annual Meeting, 9/7-9, Hot Springs, VA	WH /DPC/HHS Meeting 9	HHS Steering Committee 10	NGA Meeting 11 Advocacy Group Meeting at HHS	NGA Meeting 12	13
APWA-Information Systems Management Annual Conference, 9/14-19, St. Louis, MO 14	-HHS Steering Committee 15 -NCSL/Assembly of Federal Issues Chairs meeting, DC -Nat'l Advisory Committee on Rural Health, DC (Barnette) -AHCPR, User Liaison Program, 9/15-17, Charlottesville, VA -Nat'l Latino Child. (speech)	WH/DPC/HHS Meeting 16 Will/WAND mtg OEOB	HHS Steering Committee 17 CHIP IGA Meeting (biweekly) Nat'l Coalition on Health Care meeting	18	19	Nat'l Association of Insurance Commissioners Fall Meeting, , 9/20-24, DC 20
21	HHS Steering Committee 22	WH/DPC/HHS Meeting 23	HHS Steering Committee 24 ASTHO 1997 Annual Meeting, 9/23-26, Scottsdale, AZ	CSG/Midwestern Legis.ative Conference, 9/25-27, Lincoln, NE 25	Sec'ty speech-March of Dimes, NYC,NY 26	27
28	HHS Steering Committee 29	WH/DPC/HHS Meeting 30				

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1997 Children's Health October 1997

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
			HHS Steering Committee 1 CHIP IGA Meeting	2	3	4
5	HHS Steering Committee 6 APWA-Organizational and Professional Development Seminar, 10/6-7, Denver, CO (child care and other issues) CHILDREN'S HEALTH DAY	WH/DPC/HHS Meeting 7	HHS Steering Committee 8	Nat'l Commission on Partnerships for Children's Health meeting (Sec'ty's calendar) 9	10	11
12	HOLIDAY 13	WH/DPC/HHS Meeting 14	HHS Steering Committee 15 CHIP IGA Meeting	16	NCSL Health Seminar, 10/17-19, Naples, FL (HHS invited) 17	18
19	HHS Steering Committee 20	WH/DPC/HHS Meeting 21	HHS Steering Committee 22	23	24	25
APWA-Nat'l Association of State Medicaid Directors, Annual Conference, 10/26-29, Alexandria, VA 26	HHS Steering Committee 27	WH/DPC/HHS Meeting 28	HHS Steering Committee 29 CHIP IGA Meeting	30	31	

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1997 Children's Health November 1997

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
30						American Academy of Pediatrics Annual Meeting, 11/1-5, New Orleans, LA 1
2	HHS Steering Committee 3	WH/DPC/HHS Meeting 4 (Election Day)	HHS Steering Committee 5 NCSL, Assembly on Fed'l Issues, and Assembly on State Issues joint meeting, 11/5-7, DC	6	7	8
CSG/Southern Legislative Conference Fall Issues Conf.., 11/9-12, Oklahoma City, OK American Public Health Assoc. Annual Meeting, 11/9-13, Indianapolic, IN 9	HHS Steering Committee 10	HOLIDAY 11 Veterans' Day	HHS Steering Committee 12 CHIP IGA Meeting	NACO, Employment-Human Services Conference, 11/13-17, Tulsa, OK 13	14	15
16	HHS Steering Committee 17	WH/DPC/HHS Meeting 18	HHS Steering Committee 19 NCSL Sr. Legislative Drafting Seminar, 11/19-22, Sacramento, CA	20	NCSL Health Seminar, 11/21-23, Newport , RI (HHS invited) 21	22
23	HHS Steering Committee 24	WH/DPC/HHS Meeting 25	HHS Steering Committee 26 CHIP IGA Meeting	HOLIDAY 27 THANKSGIVING	28	29

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1997 Children's Health December 1997

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	HHS Steering Committee 1	WH/DPC/HHS Meeting 2	HHS Steering Committee 3 --CSG-WEST-50th Pacific Assoc. Meeting, 12/3-5, Kohala Coast, Island of Hawai --American Legislative Exchange Council, Freshman Legislator Orientation, 12/3-6, D C	National League of Cities annual meeting, 12/4-7, Philadelphia, PA 4	CSG 1997 Annual Meeting S State Leadership Forum, 12/5-9, Honolulu, Hawaii 5	APWA-Nat'l Council of State Human Svc Admin. & Nat'l Council of Local Public Welfare Admin. Winter meeting, 12/6-10, San Francisco, CA 6
7	HHS Steering Committee 8	WH/DPC/HHS Meeting 9	HHS Steering Committee 10 CHIP IGA Meeting	11	12	13
14	HHS Steering Committee 15	WH/DPC/HHS Meeting 16	HHS Steering Committee 17	18	19	20
21	HHS Steering Committee 22	WH/DPC /HHS Meeting 23	HHS Steering Committee 24 CHIP IGA Meeting	HOLIDAY 25 CHRISTMAS	26	27
28	HHS Steering Committee 29	WH/DPC/HHS Meeting 30	HHS Steering Committee 31	HOLIDAY NEW YEAR'S DAY		