

Children's Health Insurance Program Reauthorization Act: One Year Later

Connecting Kids to Coverage



In a decent society, there are certain obligations that are not subject to tradeoffs or negotiations - health care for our children is one of those obligations.

- President Barack Obama

A Message from Health and Human Services Secretary Kathleen Sebelius

February 4, 2010

Dear Friend,

On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act (CHIPRA) into law. Less than two weeks later, he signed the American Recovery and Reinvestment Act, which provided critical assistance to state Medicaid programs that allowed them to keep providing essential health services during the economic downturn. With these two actions less than a month into his term, President Obama demonstrated his Administration's strong commitment to ensuring America's children have the quality, affordable health care they need and deserve.

As this report shows, those steps have already created huge benefits for families around the country. In 2009 alone, 2.6 million previously uninsured children were served by Medicaid or the Children's Health Insurance Program (CHIP). This is a tremendous accomplishment, but it's only the beginning.

On the one year anniversary of CHIPRA becoming law, I am asking leaders from government and the private sector to step up their efforts to cover more children. We know there are about five million uninsured children in the U.S. who are currently eligible for Medicaid or CHIP coverage, but who are not enrolled.

The Secretary's Challenge: Connecting Kids to Coverage is a five-year campaign that will challenge federal officials, states, governors, mayors, community organizations, faith leaders, and concerned individuals to build on our success and take the next step by finding and enrolling those five million children in Medicaid and CHIP.

This report is a guide for how we can achieve that goal. It provides an important look back at what we've accomplished since CHIPRA was enacted. And it talks about some of the tools that are in place to help us do even more for children and families in the years ahead.

We all have a stake in America's children, and together, we will assure that millions more get the care they need.

Sincerely,

Kathleen Sebelius

Connecting Kids to Coverage

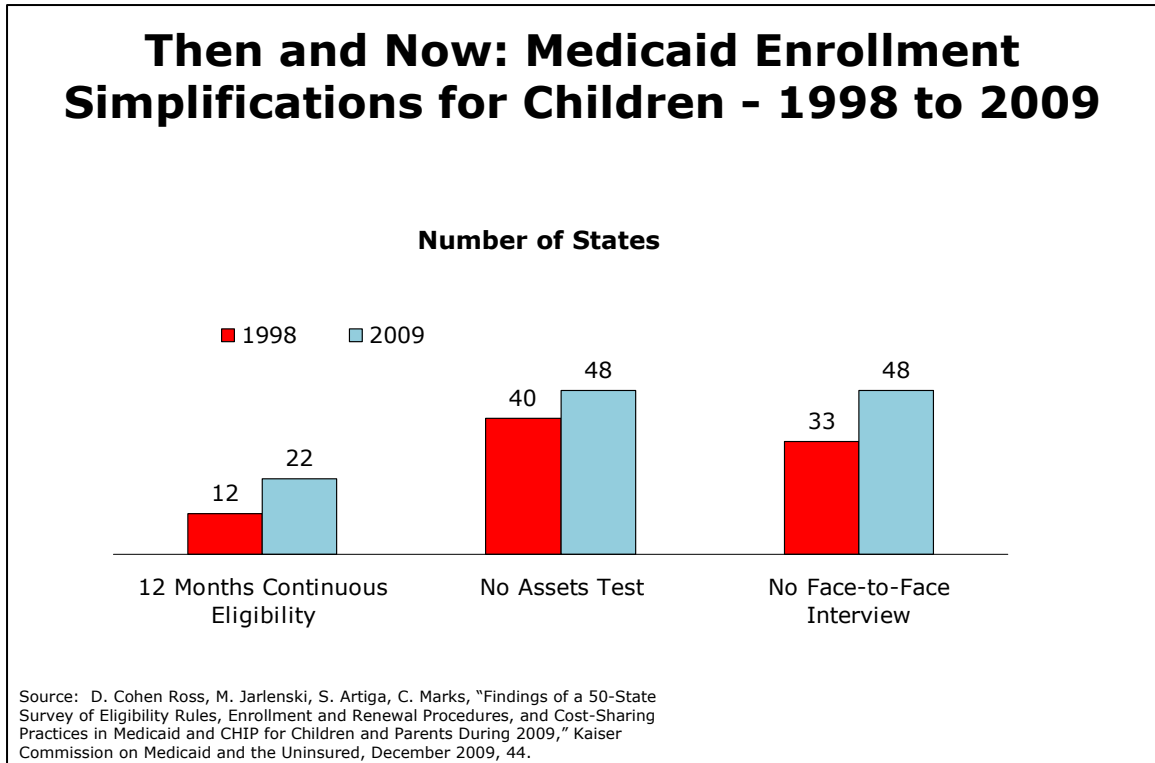
EXECUTIVE SUMMARY

One year ago, the Children's Health Insurance Program Reauthorization Act (CHIPRA) was enacted into law, offering states new financial resources and programmatic options to provide health coverage for children in Medicaid and the Children's Health Insurance Programs (CHIP). In addition, the financial support provided to state Medicaid programs through the American Recovery and Reinvestment Act (ARRA) has allowed states to cover more eligible children in Medicaid during difficult economic times. Together, CHIPRA and ARRA, coupled with a strong commitment to children's coverage at all levels of government, have led to significant coverage gains among children as well as new public and private efforts to enroll all eligible children and assure that children receive high quality health care.

This report reviews the progress achieved over the past year and the steps being taken to bring the nation closer to the widely shared goal of ensuring that all children in America have quality, affordable health coverage.

- **An additional 2.6 million children gained Medicaid or CHIP coverage during federal fiscal year 2009 (October 1, 2008 – September 30, 2009). In total, Medicaid and CHIP served nearly 40 million children last year.** This jump in enrollment is evidence of the important role that Medicaid and CHIP play for children, especially during economic downturns, as well as an early indication that CHIPRA and ARRA are helping to move children's coverage forward. Because so many decisions regarding Medicaid and CHIP are made at the state level, these coverage gains are also a testament to governors' and state policymakers' commitment to improving children's health coverage even in challenging economic times.
- **Enrollment gains were greatest among the lower income children eligible for Medicaid.** Of the 2.6 million children gaining coverage, 2.2 million were children enrolled in "regular" Medicaid (as distinguished from CHIP-funded Medicaid expansions or separate CHIP programs). The increased support to states in the form of enhanced federal matching payments for Medicaid has helped make these coverage gains possible, particularly given states' difficult financial circumstances. Enrollment of the lowest-income uninsured children was also a key goal of CHIPRA. CHIPRA made it easier for states to simplify enrollment for families and established new performance bonuses. The bonuses encourage states to adopt simplification measures in Medicaid and CHIP and provide

additional federal financial support to states that successfully boost enrollment above target levels among previously eligible but uninsured children in Medicaid. In December 2009, Secretary Sebelius awarded nine states performance bonuses totaling nearly \$73 million.¹



- **More than half of states have adopted children’s coverage improvements since CHIPRA was enacted.** These improvements include new efforts to simplify Medicaid and CHIP enrollment and renewal processes as well as expansions in coverage. Seventeen states submitted plans to the Centers for Medicare and Medicaid Services (CMS) to simplify their application or renewal processes to promote enrollment of eligible uninsured children, and others adopted measures (such as on-line applications) that did not require state plan changes. These program changes build on improvements that have occurred since 1997 when CHIP was adopted.
 - 22 states now take advantage of the “continuous” eligibility option to reduce coverage losses among eligible children in both Medicaid and

¹ States that received performance bonus payments for FY 2009 included Alaska, Alabama, Illinois, Louisiana, Michigan, New Jersey, New Mexico, Oregon, and Washington. The size of the bonus payments varied based on a formula set out in CHIPRA.

CHIP; and all states but one no longer require an in-person interview at renewal for Medicaid coverage.²

- Currently, 25 states have on-line applications for Medicaid and/or CHIP, and three states have approved plans to enroll children through the new “Express Lane Eligibility” (ELE) option created by CHIPRA. ELE allows states to rely on findings from other programs or sources to determine or renew Medicaid and CHIP eligibility, rather than requiring families to resubmit information that the government already has on hand. This recent activity focuses on ways to cut through red tape by increasing reliance on technology to enroll and renew coverage for children.

In addition to adopting new simplification measures, in light of the growing health insurance affordability gap for families, 15 states increased income eligibility for children in 2009. Today, all but two states offer CHIP coverage to children with family incomes up to at least 200 percent of the FPL (\$36,620 for a family of three in 2009); families at these income levels contribute to the cost of coverage (through premiums, cost sharing or both) on a sliding scale basis.

- **With funding from CHIPRA, the Department of Health and Human Services (HHS) has awarded outreach grants to establish new public-private partnerships throughout the country to enroll more children.** On September 30, 2009, Secretary Sebelius awarded \$40 million in federal funds to a diverse array of states, community-based organizations, health centers, and faith-based organizations through outreach and enrollment grants designed to promote children’s enrollment in health coverage. In November 2009, the 69 grantees joined a group of over 500 participants at a Children’s Summit convened by HHS to share strategies for successfully enrolling uninsured children who are eligible for Medicaid or CHIP.
- **Quality measures promise further improvements in children’s access to care.** Building on the collaborative work undertaken by a National Advisory Committee, the Agency for Healthcare Research and Quality and CMS, HHS proposed a core set of new quality standards for children covered through Medicaid and CHIP to help ensure that children receive high-quality care. In

² Donna Cohen Ross, Marian Jarlenski, Samantha Artiga, and Caryn Marks, “Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents during 2009,” Kaiser Commission on Medicaid and the Uninsured, Washington, DC, December 2009, 44. Available at <http://www.kff.org/medicaid/upload/8028.pdf>.

addition, later this month, CMS will award 10 demonstration grants to states aggressively pursuing the use of health information technology and an electronic health record format for children as a means of promoting quality. These efforts, combined with the ARRA health information technology investments, hold great promise for measuring and improving the quality of care that all children receive.

Much has been accomplished. And yet, with over 7 million children in the U.S. still uninsured – most of whom are now eligible for Medicaid and CHIP – the work has just begun. Building on the strong base of activity and achievement in 2009, Secretary Sebelius is issuing a *Connecting Kids to Coverage* challenge to schools, community and faith-based organizations, health care providers, businesses, families, and all levels of government to enroll the uninsured children who are eligible for Medicaid or CHIP but not enrolled. With this call to action, we expect that activity – and coverage gains – on behalf of children will accelerate over the next few years.

INTRODUCTION

On February 4, 2009, President Obama signed the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The second bill signed into law by the President, this legislation marked a new era in children’s coverage by providing states with significant new funding, new programmatic options, and a range of new incentives for covering children. One of the clear goals of the legislation is to support states in developing efficient and effective strategies to identify, enroll, and retain health coverage for uninsured children who are eligible for Medicaid or CHIP but are not enrolled. CHIPRA also provided flexibility to states to expand health care coverage to children who need it, and tasked the Secretary of Health and Human Services (HHS) with developing standards by which states can measure the quality of the care that children are receiving.

The passage of the American Recovery and Reinvestment Act (ARRA) followed soon after the signing of CHIPRA in early 2009. ARRA also made a significant contribution to children’s coverage by increasing federal payments for Medicaid coverage during the economic downturn – over half of all Medicaid beneficiaries are children.³ ARRA has also played a significant role in strengthening health coverage more broadly.

U.S. Census Bureau data show that, in 2008, the uninsurance rate among children was at the lowest level since 1987, yet 7.3 million children did not have health insurance

³ CMS Medicaid Statistical Information System Data Mart, available at <http://msis.cms.hhs.gov/>

coverage.⁴ Many more children suffer gaps in coverage throughout the year. Most of these uninsured children are eligible for Medicaid and CHIP but are not enrolled. Although a great deal of progress has been made in recent years, administrative barriers can still make it difficult for families to enroll their children in health coverage programs and to keep their children covered for as long as they are eligible. In addition, many families either do not know about Medicaid or CHIP or mistakenly believe that their children are not eligible. Surveys show families are eager to sign their children up once they learn that they may be eligible, and families that are losing jobs and experiencing financial stress during the economic downturn describe CHIP and Medicaid as an essential financial support mechanism.⁵ Stable funding along with effective outreach, enrollment, and retention measures are critical to making further progress in ensuring that children across the nation have health coverage.

During 2009, HHS worked closely with states, other federal departments, and a broad array of private and public leaders and organizations interested in children's coverage, to implement CHIPRA. These efforts are focused on promoting CHIPRA's goals by continuing down the successful paths that have already been forged as well as identifying new and innovative approaches to making the promise of health coverage a reality for all children.

CHIPRA: Children Come First

Some of the features in CHIPRA that will help states and communities boost participation rates among eligible children include:

- A new **Express Lane Eligibility** option that allows states to enroll children into Medicaid or CHIP based on information available through other programs and data bases.
- **Outreach and enrollment grant** funding dedicated to promoting effective enrollment and renewal strategies.
- A first-of-its-kind payment incentive for states – the **Performance Bonus** – that offset some of the costs associated with states' success in covering more children in Medicaid.
- An option for states to verify U.S. citizenship through **data matches** with the Social Security Administration to reduce coverage losses and delays due to paperwork requirements that were difficult for both families and states to manage.
- **Automatic eligibility for newborns** whose mothers are covered through Medicaid and CHIP.

⁴ DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-236, "Income, Poverty, and Health Insurance Coverage in the United States: 2008," U.S. Government Printing Office, Washington, DC, 2009. Available at <http://www.census.gov/hhes/www/hlthins/hlthin08.html>

⁵ Paradise J., C. Marks, K. Schwartz, and B. Lyons. "Next Steps in Covering Uninsured Children: Findings from the Kaiser Survey of Children's Health Coverage." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2009. Available at <http://www.kff.org/uninsured/7844.cfm>

BACKGROUND: THEN AND NOW

CHIP and Medicaid have become a trusted resource for families over the 12 years since the CHIP program was created. Governors and state legislative leaders strongly embraced the new opportunities that CHIP presented in 1997, and have steadily increased eligibility for children as the escalating cost of private insurance made coverage unaffordable and unavailable for more and more families with modest means. States have also made great strides in making their programs more straightforward, accessible, and user-friendly for families.

In 1998, in half the states, Medicaid coverage for children was limited to the federal statutory minimum level, which at the time was 133 percent of the Federal Poverty Level (FPL) for children under age 6 and 100 percent of the FPL for some older children (a statutory requirement was in place to phase in coverage for children living in poverty over time).⁶ Options to extend coverage above the federal minimums were available, but, in 1998, children in families with incomes up to 200 percent of the FPL were eligible in only eight states. Today, 48 states are providing coverage to children with incomes up to at least 200 percent of the FPL (\$36,620 for a family of three in 2009) and 18 states cover children in families with incomes at 300 percent of the FPL (\$54,930 for a family of three in 2009).⁷ Five of the states that reached 300 percent did so during 2009.⁸ States that have expanded coverage to these income levels also require families to pay a share of the cost of coverage.

States' progress toward streamlining enrollment processes can be as significant as eligibility expansions themselves in terms of making coverage gains. Over the years, states have improved their Medicaid and CHIP participation rates by simplifying the enrollment and renewal processes – achieving more than 84% participation for FY 2008.⁹ For example,

- In 1998, 10 states provided 12 months of continuous eligibility for children in Medicaid; in 2009, 22 states have taken up this option in Medicaid and 30 states provide it in their separate CHIP programs (39 states were operating separate CHIP programs in 2009).
- In 1998, 17 states had eliminated the asset test for their separate CHIP programs; by 2009, 38 out of the 39 separate CHIP programs were no longer counting assets. 48 states have eliminated assets tests in their Medicaid programs for children.

⁶ L. Ku, F. Ullman, R. Almeida, "What Counts? Determining Medicaid and CHIP Eligibility for Children," The Urban Institute, June 1, 1999; available at <http://www.urban.org/url.cfm?ID=409076>

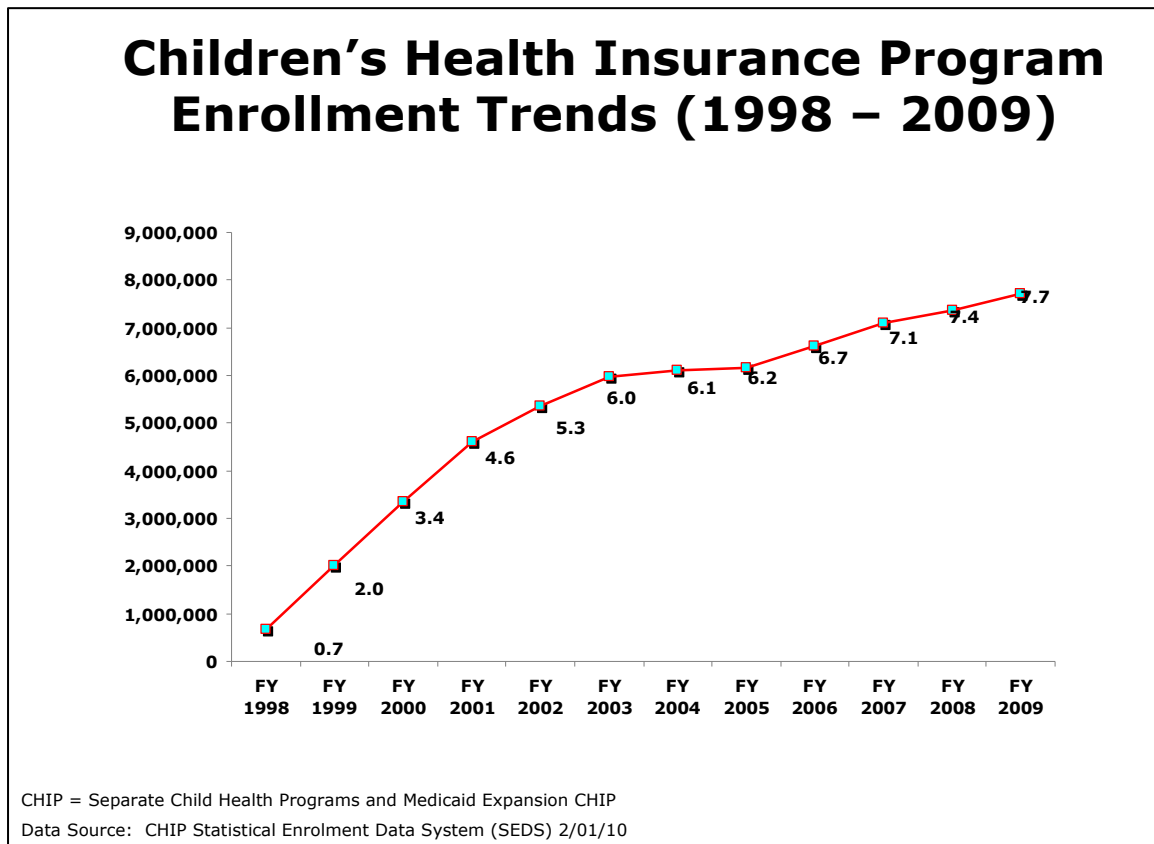
⁷ D. Cohen Ross, et. al., Kaiser Commission on Medicaid and the Uninsured, "Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009, December 2009, available at <http://www.kff.org/medicaid/upload/8028.pdf>

⁸ One state, New York, had covered children in this income range with state funds but gained the ability to rely on federal CHIP matching funds due to change in the law adopted under CHIPRA.

⁹ Based on Urban Institute analysis of CPS and CMS SEDS data for FYs 2008 and 2009

- And while 18 states required families to complete an in-person interview at the point of application for Medicaid in 1998, only three states still have this requirement today.¹⁰

The cumulative value of these multi-year advances is confirmed by Census Bureau data released in September 2009, indicating the number of uninsured children in the United States is at the lowest level since 1987. In 2008, there were 7.3 million uninsured children, a decline of 800,000 from 8.1 million in 2007. With employer-based coverage becoming less available and affordable for children and adults alike, Medicaid and CHIP are chiefly responsible for the insurance gains among children, more than offsetting losses in private coverage.¹¹ The data also show that while significant disparities continue to exist, the coverage progress achieved in recent years has helped to reduce the disproportionately high uninsurance rate experienced by Hispanic children and other racial and ethnic minority children and to narrow the difference in coverage rates across groups of children.¹²



¹⁰ Cohen Ross et. al., “Findings of a 50 State Survey...” 20-21

¹¹ DeNavas-Walt, et.al, “Income, Poverty, and Health Insurance Coverage...,” U.S. Census Bureau

¹² Urban Institute analysis of the 2001 and 2009 Annual Social and Economic Supplement to the CPS. See Kenney, Cook, Dubay, “Progress Enrolling Eligible Children...”

Despite these gains, millions of children remain uninsured, even though most of these children are now eligible for Medicaid and CHIP. While participation rates are generally higher in Medicaid and CHIP than they are in other means-tested programs, they vary widely across the nation. For example, participation rates in the mountain states are at 74%, whereas the northern states in the Midwest have achieved an 88% Medicaid and CHIP participation rate.¹³

This report highlights federal and state activities over the course of the year since CHIPRA was enacted, and notes some of the plans for continued and enhanced activities in 2010.

CHIPRA: THE YEAR IN REVIEW

Eligibility and Enrollment Improvements

New Policies. 2009 was a busy year for both the federal government and states in terms of children's coverage. The Centers for Medicare & Medicaid Services (CMS) developed policy guidance in the form of letters and question-and-answer documents for state health officials (state Medicaid and CHIP directors as well as public health officials) to assist states in implementing the new provisions in CHIPRA. Many of these provisions relate to improving eligibility and enrollment practices, among other key policy issues. CMS released a dozen policy letters to states in 2009 on topics such as automatic Medicaid/CHIP eligibility for newborn babies, optional coverage of pregnant women in CHIP, application of the Medicaid managed care protections to CHIP plans, new requirements for dental services in CHIP, premium assistance options, and changes to and new options for meeting the citizenship documentation requirement in Medicaid and CHIP.¹⁴ CMS issued this guidance with the benefit of state input offered through a new CHIPRA Technical Advisory Group (TAG) made up of Medicaid and CHIP directors. The CHIPRA TAG provides advice and feedback to CMS as it undertakes the policymaking process. CMS expects to issue a comprehensive set of proposed regulations implementing CHIPRA in 2010.

More than half the states took advantage of new options in CHIPRA and/or made other improvements in their children's coverage programs since CHIPRA was enacted. Despite the economic downturn, most states have continued their progress toward the shared goal of assuring that children have access to health insurance coverage. Although some states put plans for coverage or other program improvements on hold in 2009 due to state fiscal constraints (and three states adopted enrollment freezes in their CHIP

¹³ These states include Ohio, Indiana, Illinois, Michigan, and Wisconsin. See Kenney, Cook, Dubay, "Progress Enrolling Eligible Children..."

¹⁴ All of the CMS CHIPRA guidance can be accessed at <http://www.insurekidsnow.gov/professionals/federal/index.html>

programs¹⁵), a recently released survey indicated that 26 states adopted new measures to improve health coverage for children and pregnant women last year.¹⁶ Since CHIPRA was enacted on February 4, 2009, states have been actively seeking CMS approval for program improvements, including the following:

- 15 states have expanded income eligibility levels in their CHIP and/or Medicaid programs since the enactment of CHIPRA.¹⁷
- 17 states have submitted state plan amendments to streamline their enrollment and renewal processes.¹⁸
- 3 states have received approval for the new Express Lane Eligibility option in Medicaid and/or CHIP.¹⁹
- 19 states have elected to lift the 5-year waiting period for eligible children and/or pregnant women who are lawfully residing in the US.²⁰
- All 50 states set up data agreements with SSA to verify citizenship for purposes of Medicaid and CHIP eligibility.

Oregon – Making Use of its Policy Tool Box

Oregon is using many of the tools available through CHIPRA to extend coverage to nearly every uninsured child in the state. In 2009, Oregon received approval to remove the asset test in CHIP and also to expand income eligibility for children up to 200% of the FPL. Beginning January 1 of this year, the state further expanded coverage opportunities for children by initiating “Healthy KidsConnect,” which offers a new low-cost (CHIP-financed) coverage plan to families with incomes up to 300% of the FPL and also makes available a buy-in option at full cost to the family for those with higher incomes. In addition, the state has adopted the CHIPRA option to provide Medicaid and CHIP coverage to eligible immigrant children who are lawfully residing in the U.S.

Oregon is also providing 12 months of continuous eligibility for all children up to age 19 in Oregon's Medicaid and CHIP programs, meaning children are enrolled for a full year and are less likely to face unnecessary disruptions in medical care. In addition, the state has established procedures to make it easier to ensure that newborns are enrolled in coverage as quickly as possible. These program expansions and simplifications, coupled with aggressive outreach efforts and the use of an on-line application, have not only made Oregon's programs more efficient and family-friendly, they've resulted in the enrollment of an additional 30,700 children between July and December 2009. As a CHIPRA outreach grantee, Oregon is ramping up outreach activities in local communities, and paying special attention to helping children enroll through school-based health centers and athletic programs. Oregon has also awarded outreach grants to community-based organizations across the state and implemented an application assistance program.

¹⁵ Arizona, California, and Tennessee imposed enrollment freezes during 2009, however, the freeze in California was lifted shortly after it was imposed.

¹⁶ Cohen Ross et.al., “Finding of a 50 State Survey...” 2.

¹⁷ AL, AR, CO, IA, IN, KS, MT, ND, NE, NY, OK, OR, RI, WI, and WY

¹⁸ AK, AL, AZ, FL, IA, ID, LA, NJ, NM, OK, OR, PA, TX, UT, VA, WA, and WY

¹⁹ New Jersey (Medicaid), Alabama (Medicaid), and Louisiana (Medicaid).

²⁰ The majority of these states were previously providing coverage to this group of individuals with state-only funding, but the new option expands the scope of individuals who may be covered. These states have all submitted requests to receive federal matching funds for coverage of this new eligibility category.

Enrollment Gains. Children’s enrollment in Medicaid and CHIP increased by 2.6 million during federal Fiscal Year 2009. Together, these critical programs served nearly 40 million children over the course of the year. These enrollment gains were achieved through the fiscal year (October 1, 2008 – September 30, 2009), including a period before the effective date of CHIPRA and before some of the new state improvements were fully implemented. All but three months of this time frame coincided with the period during which enhanced federal Medicaid matching payments to states were made through ARRA. This enrollment increase reflects the greater need for affordable coverage options during this economic downturn as well as the strong programs that states have built over the past 12 years and the new efficiencies and improvements that states have incorporated into their programs to make them smarter and more accessible to families who need them.

Express Lane Eligibility

2010 promises many new developments among the states as they fully implement the new elements that CHIPRA has to offer. One of the key program options that were included in the CHIPRA statute is the new Express Lane Eligibility option, which enables states to use data and findings from other programs and databases (such as income tax records) to facilitate children’s enrollment in Medicaid and CHIP. For example, states are using SNAP (formerly Food Stamps) data, and income tax information to avoid duplicative requests for information and reduce the amount of information families must provide in order to enroll their children in coverage. To date, three states (New Jersey, Alabama, and Louisiana) have received approval to use Express Lane Eligibility in their Medicaid programs, and many more states have expressed interest in this option for both Medicaid and CHIP.

Performance Bonus Payments. CHIPRA established new incentive payments for states that adopt specific policies and procedures in Medicaid and CHIP and that were successful in enrolling already eligible children in Medicaid. CMS issued guidance on the bonus payment criteria on December 17, 2009.²¹ States need to meet two sets of criteria in order to qualify for a performance bonus payment. They need to have in place at least five eligibility and enrollment improvements known to promote coverage and retention, and demonstrate significant increases in Medicaid enrollment among children.²²

²¹ The State Health Official letter regarding performance bonuses is available at http://www.insurekidsnow.gov/professionals/CHIPRA/chipra_awards.html

²² The eight qualifying program features are 12-months continuous eligibility, liberalization of assets tests, eliminating the in-person interview requirement, using the same application and renewal forms for both Medicaid and CHIP, administrative or automatic renewals, presumptive eligibility, Express Lane Eligibility, and the new premium assistance option specified in CHIPRA.

Nine states received performance bonus payments for 2009 – Alaska, Alabama, Illinois, Louisiana, Michigan, New Jersey, New Mexico, Oregon and Washington – totaling nearly \$73 million. The amount of the awards was determined by a formula set forth in the CHIPRA statute that is based on the levels of increased Medicaid enrollment that were achieved. The 2009 bonus payments ranged in size from \$788,000 in Alaska to more than \$39 million in Alabama. This was a strong showing, particularly because states had less than a year to establish the qualifications for the bonus in 2009 and because the 2009 enrollment targets established in the law were aggressive. It is likely that even more states will qualify for bonus payments in 2010.

Data Matches with the Social Security Administration. Working closely with states, the Social Security Administration (SSA) and CMS put the needed systems and administrative changes in place to implement the new option for SSA to confirm Medicaid and CHIP applicants' citizenship through a data matching process. This new system promises to assure program integrity while promoting enrollment among eligible children and reducing the administrative burden on families as well as states. The first data matches were conducted on January 4, 2010, and SSA reports an average 95-percent rate of confirmation.

Setting the Stage for Further Coverage Improvements

HHS has initiated a multi-pronged strategy designed to ensure further improvements and to reach those children who are eligible but unenrolled. The strategy involves use of the \$100 million in federal funding that CHIPRA dedicated to promoting outreach and enrollment strategies focused on children. The legislation specifically allocated \$10 million for a national outreach campaign, \$80 million for grants to community-based organizations, states, schools, faith-based organizations and health care providers to develop enrollment strategies, and \$10 million for grants to health care providers and Indian Tribes that serve the Native American community.²³

National Children's Summit and Enrollment Campaign. In November 2009, CMS launched the national CHIPRA outreach and enrollment campaign with a conference in Chicago. HHS Secretary Kathleen Sebelius, kicked-off the National Children's Health Insurance Summit with a call to action to the more than 500 people in attendance to find and enroll the uninsured children who are eligible for Medicaid or CHIP coverage but are not enrolled.²⁴ Participants representing states, community-based

²³ The Tribal outreach grant solicitation is available at http://www.cms.hhs.gov/CHIPRA/12_outreachenrollmentgrantsindianchildren.asp#TopOfPage

²⁴ Remarks by Secretary of Health and Human Services, Kathleen Sebelius, November 4, 2009, transcript available at http://av.conferencearchives.com/pdfs/091105/401.1_t.pdf

organizations, the policy and research communities, and health center and other health care providers came together for two days of learning and information exchange around strategies for identifying and enrolling children in Medicaid and CHIP and for keeping them enrolled for as long as they are eligible. The conference also highlighted new and enhanced collaboration between HHS agencies like CMS, the Health Resources and Services Administration, and the Administration for Children and Families, as well as cross-departmental relationships with, for example, the Departments of Agriculture and Education with the shared goal of ensuring that the children that come into contact with the programs administered by these agencies gain streamlined access to health coverage. The summit was the largest gathering focused on children's health coverage sponsored by the federal government in over a decade. The enthusiasm generated by the conference served as a launching pad for participants to go out into their communities to get these strategies underway.

At the summit, the Secretary also announced the launch of a newly refurbished "Insure Kids Now" Web site, www.insurekidsnow.gov, which has been updated and enhanced to include information for consumers interested in learning about the Medicaid and CHIP programs in their states. The Web site includes direct links to individual state CHIP and/or Medicaid sites where families can access the program application or even apply on-line. The Web site also includes information for professionals and states interested in federal activities around children's coverage broadly and CHIPRA implementation specifically. Insurekidsnow.gov will continue to be augmented, and will serve as a resource for research and policy analysis conducted by government and other organizations about the effectiveness of these programs.

Outreach Grants – Forging New Public and Private Partnerships. As noted above, CHIPRA made a total of \$90 million in outreach grant funds available between FY 2009 and FY 2013. The first \$40 million in grant awards was announced in September 2009. Out of a strong pool of over 400 applicants, CMS awarded 69 grants that distributed funds across 42 states and the District of Columbia. The grant awards were based on merit ranking, with additional considerations given to geographic distribution and level of innovation. Of the 69 grantees, 20 grants were awarded to coalitions, many of which include local community organizations along with the CHIP or Medicaid agency in that state. Twelve of the grantees are individual state Medicaid or CHIP agencies.²⁵ Many grantees or coalition partners represent county or local governments. All of the grantees expressed a commitment to reaching under-served populations that are more likely to be uninsured. Many will target Hispanic populations specifically -- a group of children that are disproportionately uninsured -- while others will work with Native American or immigrant communities. Nearly a quarter of the grantees will target children in rural areas.

²⁵ NC, OR, KS, MT, MD, ME, OK, WI, WY, LA, NM, & NJ

The \$10 million Tribal outreach grant solicitation was released in December 2009 and applications were due by January 15, 2010. These grants will be distributed among Tribal health care providers, Indian Health Service providers, and other health providers in urban areas for purposes of conducting outreach, enrollment, and educational activities among Indian communities. CMS is reviewing 79 applications for these grants and expects to announce the awards on April 15, 2010.

Assuring Access to Quality Care for Children

Core Quality Measures. Relying on a collaboration between the Agency for Health Care Research and Quality, CMS, and a National Advisory Committee made up of experts in quality and performance measurement, HHS developed a proposed core set of child health quality measures as provided for in CHIPRA. The Committee reached agreement on 24 measures that states, health insurance issuers, and managed care entities may adopt to monitor and assess access to care and health outcomes among children served by Medicaid and CHIP. The core set of measures was published in the Federal Register on December 29, 2009, and public comments are due March 1, 2010.²⁶

Quality Demonstrations. CHIPRA also provided funding for a series of demonstration projects designed to establish and evaluate a national quality system for children's health care. In fall 2009, CMS issued a request for demonstration project proposals covering areas identified in the statute, such as:

- Promotion of the use of health information technology for the delivery of care for children covered by Medicaid/CHIP;
- Evaluation of provider-based models that improve the delivery of Medicaid/CHIP children's health care services;
- Demonstration of the impact of the model electronic health records format for children on improving pediatric health, and pediatric health care quality, as well as reducing health care costs.

Proposals were due to CMS on January 8, 2010 and CMS is in the process of reviewing 24 applications involving 31 states (several of the applications were multi-state proposals). Ten demonstration awards are scheduled to be announced on February 22, 2010.

Improving Access to Dental Care. Improving access to dental care for children is a high priority for HHS and an area of emphasis in CHIPRA. The legislation made dental services a mandatory benefit for separate CHIP programs. In addition, CMS was tasked with developing a mechanism for states to provide a listing of all participating Medicaid and CHIP dental providers through the HHS web site, www.insurekidsnow.gov, by August 4, 2009. The purpose of this requirement was to give families the opportunity to

²⁶ The Federal Register notice announcing the core set of quality measures can be accessed at:

more easily identify participating dental providers in their community. Working closely with states, CMS launched the new section of the website that included dental provider information for all 50 states and the District of Columbia on August 4. To date, the site has received more than 150,000 Web “hits.”

CONCLUSION: FIVE MILLION CHILDREN – AND COUNTING

During the 12 months since CHIPRA was enacted, there has been a great deal of activity at the federal level and in states and communities throughout the country. Most significantly, millions of uninsured children have gained coverage in Medicaid and CHIP and, as a direct result, the portion of children in America who have no health insurance continues to decline despite job losses and the difficult economic circumstances facing families. While participation rates in Medicaid and CHIP – averaging 84% nationally²⁷ – are higher than the levels achieved in most other means-tested programs, boosting participation remains the key step in closing the coverage gap for children. An estimated 5 million uninsured children are eligible for Medicaid or CHIP coverage but are not enrolled.²⁸

Further improvements in outreach, enrollment, and retention are needed if states and communities are to be successful in covering these children. Community-based outreach efforts in rural communities, among newly unemployed and uninsured families who have never before qualified for publicly funded coverage, and among adolescents and Native Americans are just some of the important areas of focus that will be critical. Partnerships with businesses and schools and enrollment efforts undertaken by governors, mayors, hospitals and clinics are also integral to bringing children to the program. A broader penetration of proven strategies as well as new strategies, such as Express Lane Eligibility and on-line applications and renewals, can help cut the red tape and ensure that children are enrolled and stay enrolled for as long as they are eligible.

Experience with these programs and corresponding data shows that it is possible to ensure that eligible children are enrolled and receive the benefits of program coverage. But these efforts will not be successful without a concerted public-private initiative. The Secretary is calling on all levels of government as well as business leaders, the faith community, and those working with children in every context – in schools, on sports teams, and in the community – to join in this challenge. The national campaign will move forward on several fronts in 2010, including partnering with the other federal departments to develop inter-agency strategies that will make it easier for states and communities to find, enroll, and retain eligible children. In addition, CMS will be sponsoring a series of continuing education webinars on topics such as messaging and communications, working with Express Lane Agencies, and school-based enrollment strategies and data-sharing opportunities between and among federal and state

²⁷ Urban Institute analysis of CPS and CMS SEDS data for FY 2008 and 2009.

²⁸ Urban Institute analysis of CPS and CMS SEDS data for FY 2008 and 2009.

programs. Technical assistance and peer support will also focus on reaching out to target disproportionately uninsured and harder-to-reach populations such as adolescents, homeless youth, and rural communities.

A Call to Action: Measuring the Progress

As we move forward to enroll uninsured children who are eligible for Medicaid and CHIP, we are committed to measuring and reporting on the progress that is achieved. Over the course of the next 12 months, HHS will consider and regularly report on:

- Enrollment gains, looking at state administrative data reported to CMS in both Medicaid and CHIP;
- National and state-level participation rates;
- Insurance rates among children; and
- Quality of the care received, relying on various data sources and voluntary reporting by states under the new CHIPRA quality measures.

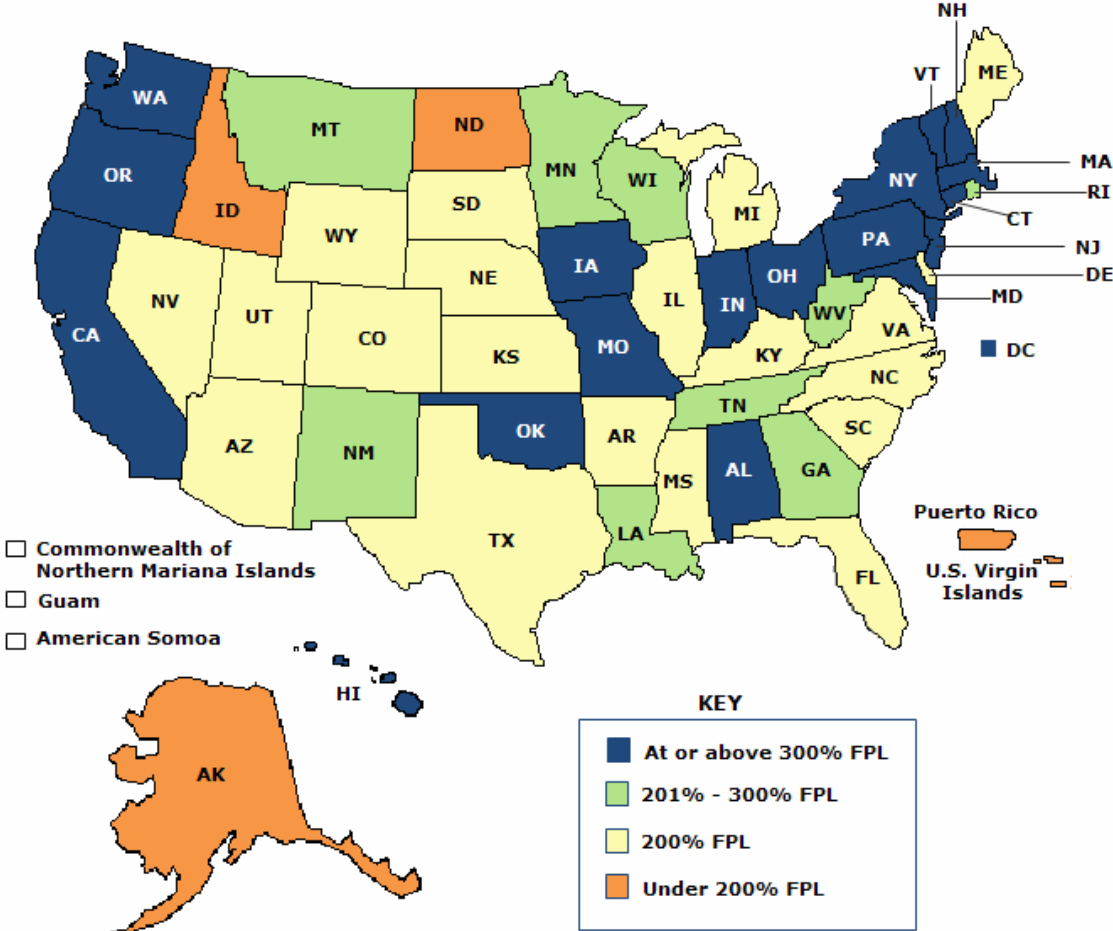
The clear goal – the challenge ahead – is to identify and successfully enroll all five million eligible children and to ensure they have access to the health care they need.

Appendices:

State Map of Eligibility levels

CHIPRA Coverage Improvements in 2009 – State-by-State

Children's Health Insurance Program Upper Income Limits as of February 1, 2010



CHIPRA State Plan Coverage Improvements¹
As of January 27, 2010

State	Program	Increased Eligibility ²	Expanded Coverage of Pregnant Women	Coverage of Lawfully Residing Children	Simplified Application/Renewal Procedures ³	Reduced Cost Sharing ⁴	Premium Assistance ⁵	Expanding Dental Coverage	Mental Health Parity
AK	Medicaid				x				
	CHIP				x				
AL	Medicaid				x				
	CHIP	x							
AR	Medicaid								
	CHIP	x							
AZ	Medicaid				x				
	CHIP								
CA	Medicaid			x					
	CHIP			x					
CO	Medicaid			x					
	CHIP	x							
CT	Medicaid			x					
	CHIP			x					
D.C.	Medicaid			x					
	CHIP								
FL	Medicaid								
	CHIP				x				
HI	Medicaid			x					
	CHIP								
IA	Medicaid	x		x	x				
	CHIP	x		x				x	
ID	Medicaid				x				
	CHIP								
IL	Medicaid			x					
	CHIP			x					
IN	Medicaid								
	CHIP	x							
KS	Medicaid								
	CHIP	x							
LA	Medicaid				x				
	CHIP								
MA	Medicaid			x		x			
	CHIP								
MD	Medicaid			x					
	CHIP								
ME	Medicaid			x					
	CHIP								
MN	Medicaid					x			
	CHIP		x						
MT	Medicaid	x							
	CHIP	x							

State	Program	Increased Eligibility ²	Expanded Coverage of Pregnant Women	Coverage of Lawfully Residing Children	Simplified Application/Renewal Procedures ³	Reduced Cost Sharing ⁴	Premium Assistance ⁵	Expanding Dental Coverage	Mental Health Parity
ND	Medicaid								
	CHIP	x							
NE	Medicaid	x							
	CHIP	x							
NJ	Medicaid			x	x				
	CHIP			x	x	x			
NM	Medicaid			x	x				
	CHIP								
NY	Medicaid			x					
	CHIP	x		x					
OK	Medicaid								
	CHIP	x			x		x		
OR	Medicaid			x	x				
	CHIP	x		x					
PA	Medicaid			x					
	CHIP				x				
RI	Medicaid	x		x					
	CHIP			x					
TN	Medicaid								
	CHIP								x
TX	Medicaid				x				
	CHIP								
UT	Medicaid								
	CHIP				x				x
VA	Medicaid			x	x				
	CHIP								
WA	Medicaid			x	x				
	CHIP								
WI	Medicaid	x		x		x			
	CHIP	x							
WY	Medicaid					x			
	CHIP	x			x				
Totals:		15	1	19	17	5	1	1	2

Notes:

1. This chart reflects State Plan Amendments (SPA) submitted to CMS to expand coverage and/or implement changes to reduce barriers to enrollment in Medicaid and/or CHIP as provided under CHIPRA. This listing includes SPAs that have been approved as well as those under review.
2. State is increasing eligibility by raising the upper income limit and/or eliminating asset/resource requirements in its Medicaid and/or CHIP program.
3. State is simplifying application and/or renewal procedures by implementing: 12-month continuous eligibility (AK, NM, OR, PA); newborn deeming (AK, IA, ID, NM, OR, TX, VA, WA); presumptive eligibility (IA, ID); and express lane eligibility (AL, AZ, FL, LA, NJ, PA). Many areas of application and renewal simplification do not require a SPA; this table only documents program changes for which a SPA was submitted.
4. State is eliminating or reducing beneficiary cost sharing amounts for certain populations in its Medicaid and/or CHIP program.
5. State is implementing a premium assistance program consistent with the requirements of section 301 of CHIPRA.