Medicaid and CHIP 101:
Medicaid and CHIP’s Foundational Role in Covering Kids and Families

Tricia Brooks
Kelly Whitener
09-24-18
Medicaid ➔ Critical Health Safety Net

Children and Families

People with Disabilities

Seniors
Focus of Today’s Webinar: Kids and Families

- Groups for which eligibility is based on income (not disability or elderly eligible for Medicaid and Medicare)
  - Children
  - Low income parents
  - Pregnant women
  - Expansion adults

- Also know as the MAGI groups
Increased Participation in Medicaid and CHIP Have Driven Uninsured Rate to Historic Low

### Participation Rates in Medicaid/CHIP

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>81.7</td>
</tr>
<tr>
<td>2009</td>
<td>84.3</td>
</tr>
<tr>
<td>2010</td>
<td>85.8</td>
</tr>
<tr>
<td>2011</td>
<td>87.2</td>
</tr>
<tr>
<td>2012</td>
<td>88.1</td>
</tr>
<tr>
<td>2013</td>
<td>88.7</td>
</tr>
<tr>
<td>2014</td>
<td>91.0</td>
</tr>
<tr>
<td>2015</td>
<td>93.1</td>
</tr>
<tr>
<td>2016</td>
<td>93.7</td>
</tr>
</tbody>
</table>

### U.S. Child Uninsured Rate

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>96.3</td>
</tr>
<tr>
<td>2009</td>
<td>94.2</td>
</tr>
<tr>
<td>2010</td>
<td>92.0</td>
</tr>
<tr>
<td>2011</td>
<td>90.8</td>
</tr>
<tr>
<td>2012</td>
<td>89.6</td>
</tr>
<tr>
<td>2013</td>
<td>88.4</td>
</tr>
<tr>
<td>2014</td>
<td>87.2</td>
</tr>
<tr>
<td>2015</td>
<td>86.0</td>
</tr>
<tr>
<td>2016</td>
<td>84.8</td>
</tr>
</tbody>
</table>

Half of Medicaid Enrollees are Children

Medicaid and CHIP Total Enrollment in June 2018

- Medicaid Adult Enrollment: 34,529,915 (49.4%)
- Medicaid Child and CHIP Enrollment: 35,411,244 (50.6%)


Note: Arizona, the District of Columbia, and Tennessee are excluded because they did not submit child enrollment data for the current period.
Medicaid Strengthens Families

- Children with Medicaid become healthier adults, have greater academic achievement, and attain greater economic success.
- Parents with Medicaid are healthier and better able to support their children’s healthy development.
- Families with Medicaid have greater economic security and are less likely to have medical debt or bankruptcy.
- Coverage provides peace of mind that reduces family stress.

The view from 30,000 feet
How It Works

FEDERAL

Congress Enacts Laws
- MEDICAID - Title XIX of Social Security Act (SSA)
- CHIP - Title XXI of SSA

CMS Promulgates Rules Subject to Public Comment
- Title 42, Chapter IV of the Code of the Federal Register
  - www.ecfr.gov

CMS Issues Sub-Regulatory Guidance
- State Medicaid Director Letters (SMD)
- State Health Official Letter (SHO)

STATE

State Develops State Plan and Submits Plan Amendments (SPA)
- MEDICAID
- CHIP

State Agency Develops Administrative Rules
- Process Varies by State

State Maintains Policies & Procedures
- Operating Manuals may be available online
Medicaid: Background

- Enacted in 1965 as companion legislation to Medicare
- Initially limited to:
  - Children
  - Single parents with dependent children
  - Aged, blind, disabled
- Expansions of eligible groups over time
- Permanently authorized with guaranteed federal funding
- Guaranteed coverage for eligible individuals
- Minimum mandatory requirements with state options
## Medicaid: Federal-State Partnership

<table>
<thead>
<tr>
<th></th>
<th>Federal Government</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administration</strong></td>
<td>Oversight</td>
<td>Direct administration</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>• 50% to 83%* of benefit costs, with no cap</td>
<td>Pays non-federal share of costs</td>
</tr>
<tr>
<td></td>
<td>• 50% of administrative costs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 90% of systems development and 75% systems operations</td>
<td></td>
</tr>
<tr>
<td><strong>Program Rules</strong></td>
<td>• Minimum standards on eligibility, benefits, and access</td>
<td>• Delivery system</td>
</tr>
<tr>
<td></td>
<td>• Restrictions on cost sharing</td>
<td>• Optional services</td>
</tr>
<tr>
<td></td>
<td>• Additional rules regarding managed care</td>
<td>• Provider payment rates</td>
</tr>
<tr>
<td><strong>Coverage Guarantee</strong></td>
<td>Guaranteed enrollment, if eligible</td>
<td>Cannot freeze or cap enrollment</td>
</tr>
</tbody>
</table>

*Match varies by state and sometimes by eligibility group and service
CHIP: Background

• Enacted in 1997 to encourage states to expand coverage to uninsured children
• Block grant with capped annual allotments
• Initial authorization was limited to ten years, but funding has been extended several times
• Currently funded through 2027
• No entitlement to coverage
• CHIP legislation has helped create a culture of coverage for kids
  • Outreach requirements
  • Enrollment simplification
  • Emphasis on quality
# CHIP: Federal-State Partnership

<table>
<thead>
<tr>
<th>Administration</th>
<th>Federal Government</th>
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<tbody>
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<td></td>
<td>Direct administration</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financing</th>
<th>Federal Government</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• 65% to 85% of costs</td>
<td>All non-federal share of costs</td>
</tr>
<tr>
<td></td>
<td>• 23% point bump in 2016-2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 11.5% point bump in 2020</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program Rules</th>
<th>Federal Government</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fewer minimum standards than Medicaid</td>
<td>• Delivery system</td>
<td></td>
</tr>
<tr>
<td>• Children must be uninsured</td>
<td>• Provider payment rates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Eligibility rules, benefits, and cost sharing within guidelines</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage Guarantee</th>
<th>Federal Government</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>None required*</td>
<td></td>
<td>Can freeze or cap enrollment* or require waiting periods</td>
</tr>
</tbody>
</table>

* Except under the Maintenance of Effort
State Options for CHIP Program Design

**Medicaid**
- All Medicaid rules apply except children must be uninsured
- States can use Medicaid funds to cover children with other coverage

**Separate CHIP**
Benchmark Options:
- State employee plan,
- Federal employee plan,
- Largest HMO in state, or
- Secretary approved

**Combination**
- Medicaid expansion for certain children based on age or income
- Separate CHIP program for other children
Who’s Covered?
# Medicaid Eligibility

## Minimum Standards

- Children 0-18 with income up to 133% FPL
- Pregnant women up to 133% FPL
  - Infants born to pregnant women covered by Medicaid for first year of life (aka deemed newborns)
- Parents/caretakers at state welfare eligibility level in 1996
  - Known as 1931 parents
  - Median income ~ 50% FPL

## Optional Coverage

- Children ages 19 and 20
- Children and pregnant women with income above 133% FPL
- Parents and adults up to 133% FPL
- Medically needy or spend down programs
CHIP Eligibility

• Children above Medicaid income levels at state option
  – 200% FPL upper limit, or
  – 50 percentage points > Medicaid limit in place in 1997
  – Pre-ACA, states used income disregards and deductions to achieve higher income eligibility thresholds; those levels are grandfathered as of enactment of the ACA

• Unborn children at state option
  • Covers pregnant women regardless of immigration status

• Pregnant women
  • State must provide Medicaid at 185% FPL or higher
  • Income eligibility level cannot be higher than for children
Maintenance of Effort

<table>
<thead>
<tr>
<th>Maintenance of Effort Requirement: What States Can and Cannot Do</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>States can:</strong></td>
</tr>
<tr>
<td>● Adopt or continue enrollment simplification initiatives</td>
</tr>
<tr>
<td>● Maintain caps or freezes that existed prior to the MOE (March 23, 2010)</td>
</tr>
<tr>
<td>● Choose not to renew waiver programs once they expire</td>
</tr>
<tr>
<td><strong>States cannot:</strong></td>
</tr>
<tr>
<td>● Eliminate CHIP or scale back eligibility for children in CHIP or Medicaid below levels in place as of March 23, 2010;</td>
</tr>
<tr>
<td>● Raise premiums for CHIP or Medicaid children;</td>
</tr>
<tr>
<td>● Impose or increase waiting periods, or the time that children must remain without group coverage before becoming eligible to enroll in CHIP. Current federal rules do not allow states to impose waiting periods longer than 90 days.</td>
</tr>
</tbody>
</table>

CHIP Outreach Requirement

• Must describe procedures to inform families of their eligibility for CHIP or other public/private health coverage programs, which may include:
  – Education and awareness campaigns
  – Enrollment simplification
  – Application assistance through community-based organizations and in combination with other benefits and services

• Receives CHIP match up to 10% cap on administration expenses
  – Including outreach expenses
CHIP Health Services Initiatives

• Allow states to use CHIP administrative funds to provide services to low-income children
  - Direct services and public health initiatives
  - Targeted to low-income children less than 19 years of age eligible for Medicaid or CHIP
  - But may also serve children of any income

• Examples
  - Poison control centers
  - MA initiative to prevent youth violence
  - MO promotion of immunizations

Where eligibility stands today
Children’s Income Eligibility: Medicaid & CHIP

Highest State Eligibility 405%
Median State Eligibility 255%
Lowest State Eligibility 175%

Breakdown of State Eligibility

<table>
<thead>
<tr>
<th>FPL</th>
<th># of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 200%</td>
<td>2</td>
</tr>
<tr>
<td>200% – 250%</td>
<td>21</td>
</tr>
<tr>
<td>250% - 300%</td>
<td>9</td>
</tr>
<tr>
<td>&gt; 300%</td>
<td>19</td>
</tr>
</tbody>
</table>

Parent’s Income Eligibility: Medicaid

- Highest State Eligibility: - 221%
- Pre-ACA Median Expansion States: 90%
- Median Non-Expansion States: 43%
- Lowest State Eligibility: - 18%

Breakdown of State Eligibility

<table>
<thead>
<tr>
<th>FPL</th>
<th># of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 50%</td>
<td>12</td>
</tr>
<tr>
<td>50% – 99%</td>
<td>4</td>
</tr>
<tr>
<td>100% - 138%</td>
<td>3</td>
</tr>
<tr>
<td>138%</td>
<td>28</td>
</tr>
<tr>
<td>&gt; 138%</td>
<td>4</td>
</tr>
</tbody>
</table>

Diving into the details of eligibility, enrollment and renewal policies for the MAGI groups
For MAGI Groups, New Rules with ACA

<table>
<thead>
<tr>
<th>Dos</th>
<th>Don’ts</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Multiple application and renewal paths (paper, online, phone, in-person)</td>
<td>• No asset or resource tests</td>
</tr>
<tr>
<td>• Coordinate eligibility between programs (account transfers)</td>
<td>• Count non-taxable sources of income (child support, SSI, etc)</td>
</tr>
<tr>
<td>• Check electronic data before asking for paper documentation</td>
<td>• Renew coverage more frequently than 12 months</td>
</tr>
<tr>
<td>• Ex parte (automated) renewals</td>
<td>• No waiting period (period of uninsurance) for CHIP longer than 90 days</td>
</tr>
<tr>
<td></td>
<td>• No signature at renewal</td>
</tr>
</tbody>
</table>
### Verifying Eligibility

#### Verification Policies
- Must verify citizenship or qualified immigration status
  - Must provide 90 reasonable opportunity period to provide documents if electronic verification
- Must verify income but can do so post-enrollment
  - Reasonable compatibility option
- May accept self-attestation
  - State residency, household size, age/date of birth

#### Verification Data Sources
- Federal Data Services Hub
  - Social Security Administration*
  - Dept. Homeland Security*
  - Internal Revenue Service
  - Commercial wage data base*
- State wage / unemployment compensation databases
- State tax agency
- State verification plan details must be submitted to CMS**

* - States may connect directly to these sources
** - Source: [https://www.medicaid.gov/medicaid/eligibility/verification-plans/index.html](https://www.medicaid.gov/medicaid/eligibility/verification-plans/index.html)
Ex Parte Renewal Process for Medicaid/CHIP

State reviews ongoing eligibility based on:
1) Crosschecks of enrollee record against electronic sources of eligibility information,
2) Case characteristics,
3) Express Lane Eligibility, or
4) SNAP renewal strategy.

If data does NOT confirm ongoing eligibility:
Send pre-populated renewal form containing information available to the agency that is needed to renew eligibility.
Notice should give enrollee 30 days to provide information online, over the telephone, in person, or by mail.

If enrollee does not respond in 30 days:
If information is not provided in 30 days, terminate coverage and send notice of disenrollment.

If enrollee responds within 90-day reconsideration period:
State must reconsider eligibility without requiring a new application.

If enrollee responds with updated or new information:
State verifies reported information or requests explanation/documentation and makes eligibility redetermination.

If NOT eligible:
Send notice of disenrollment and transfer account to the Marketplace.

If enrollee does not report inaccuracies or changes:
The renewal eligibility decision stands. Importantly, the enrollee cannot be required to sign and return the form.

If data CONFIRMS ongoing eligibility:
Send notice of ongoing eligibility explaining the basis for the determination and requesting that the enrollee report inaccuracies or updates.

If eligible:
Send notice of ongoing eligibility.

Children’s Policy Options

• Coverage for lawfully residing immigrant kids
• Coverage of former foster youth from other states
• 12 month continuous eligibility
• Presumptive eligibility
• Express Lane Eligibility
• Unborn child coverage
Benefits
Medicaid and CHIP-Funded Medicaid Expansions (M-CHIP)

- Comprehensive services through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit
  - Screenings (developmental, hearing, vision, etc)
  - Diagnostic services
  - Treatment
- All services “medically necessary” to correct and ameliorate physical and mental health conditions
- Cannot impose hard limits; must provide wrap-around services if premium assistance or managed care limit benefits
EPSDT Includes Coverage of All Services... whether listed as mandatory or optional

**Mandatory Services**
- Family planning services and supplies
- Federally Qualified Health Clinics and Rural Health Clinics
- Home health services
- Inpatient and outpatient hospital services
- Laboratory and X-Rays
- Medical supplies and durable medical equipment
- Non-emergency medical transportation
- Nurse-midwife services
- Pediatric and family nurse practitioner services
- Physician services
- Pregnancy-related services
- Tobacco cessation counseling and pharmacotherapy for pregnant women

**Optional Services**
- Community supported living arrangements
- Chiropractic services
- Clinic services
- Critical access hospital services
- Dental services
- Dentures
- Emergency hospital services (in a hospital not meeting certain federal requirements)
- Eyeglasses
- State Plan Home and Community Based Services
- Inpatient psychiatric services for individuals under age 21
- Intermediate care facility services for individuals with intellectual disabilities
- Optometry services
- Other diagnostic, screening, preventive and rehabilitative services
- Other licensed practitioners’ services
- Physical therapy services
- Prescribed drugs
- Primary care case management services
- Private duty nursing services
- Program of All-Inclusive Care for the Elderly (PACE) services
- Prosthetic devices
- Respiratory care for ventilator dependent individuals
- Speech, hearing and language disorder services
- Targeted case management
- Tuberculosis-related services
## Separate CHIP Benefits

<table>
<thead>
<tr>
<th>Actuarially Equivalent to Benchmark Plan</th>
<th>Services must include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HMO with state’s largest enrollment</td>
<td>• Well child; preventive care</td>
</tr>
<tr>
<td>2. State Employee Plan</td>
<td>• Immunizations</td>
</tr>
<tr>
<td>3. Federal Employee Plan, or</td>
<td>• Emergency care</td>
</tr>
<tr>
<td>4. Secretary Approved</td>
<td>• Inpatient and outpatient hospital services</td>
</tr>
<tr>
<td></td>
<td>• Physician services</td>
</tr>
<tr>
<td></td>
<td>• Lab and x-ray</td>
</tr>
<tr>
<td></td>
<td>• Dental services</td>
</tr>
<tr>
<td></td>
<td>• Mental health parity</td>
</tr>
</tbody>
</table>

Georgetown University Health Policy Institute Center for Children and Families
Total premiums and cost-sharing limited to aggregate 5% of family income cap for all members enrolled. Applies to all groups in Medicaid and CHIP.
## Premiums and Cost-Sharing in Medicaid

<table>
<thead>
<tr>
<th>Premiums</th>
<th>Cost-Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td><strong>Children</strong></td>
</tr>
<tr>
<td>None below 150% FPL</td>
<td>None below 133% FPL</td>
</tr>
<tr>
<td>None for preventive care</td>
<td>None for family planning, emergency, pregnancy-related services</td>
</tr>
<tr>
<td><strong>Adults</strong></td>
<td><strong>Adults</strong></td>
</tr>
<tr>
<td>None below 150% FPL (without waiver)</td>
<td>Nominal below 100% FPL</td>
</tr>
<tr>
<td></td>
<td>Twice nominal 100% – 150% FPL</td>
</tr>
</tbody>
</table>

## Maximum Allowable Medicaid Cost-Sharing Varies by Income

<table>
<thead>
<tr>
<th></th>
<th>&lt; 100% FPL</th>
<th>&gt; 100% – 150% FPL</th>
<th>&gt;150% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services</td>
<td>$4</td>
<td>10% of what state pays*</td>
<td>20% of what state pays*</td>
</tr>
<tr>
<td>Non-Emergency ER</td>
<td>$8</td>
<td>$8</td>
<td>No limit</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Preferred: $4</td>
<td>Preferred: $4</td>
<td>Preferred: $4</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred: $8</td>
<td>Non-Preferred: $8</td>
<td>Non-Preferred: $8</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>$75 per stay</td>
<td>10% of total cost state pays*</td>
<td>20% of total cost state pays*</td>
</tr>
</tbody>
</table>

*Up to 5% aggregate cap.

### Premiums and Cost-Sharing in CHIP

<table>
<thead>
<tr>
<th>Premiums</th>
<th>Cost-Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• State flexibility subject to 5% aggregate cap</td>
<td>• None for preventive care</td>
</tr>
<tr>
<td>• States may impose monthly or quarterly premiums or annual fees</td>
<td>• Limited cost-sharing for children with income between 133% – 150% FPL*</td>
</tr>
<tr>
<td>• Can impose lockouts up to 90 days for nonpayment</td>
<td>• State flexibility subject to 5% aggregate cap for children with income &gt; 150% FPL</td>
</tr>
<tr>
<td></td>
<td>• Can impose deductibles and co-insurance (few do)</td>
</tr>
</tbody>
</table>

* Cost-sharing limits in CHIP for children with income equal to or below 150% FPL vary based on type of service and the cost the state pays for the service as described in 42 CFR 457.555.
How do states deliver care?

- **Fee-for-service (FFS)** – state contracts directly with providers and pays them for covered services
- **Managed care** – state contracts with managed care organizations (MCOs) to deliver services
- **Premium assistance** – Medicaid and CHIP funds used to purchase private insurance that is cost-effective and comparable
  - Provide benefit and cost-sharing wraps to achieve comparability
- **Combination of these approaches**
Movement toward Value-Based Purchasing

- Traditional Fee for Service (FFS)
- FFS with Link to Quality and Value
- Shared Savings with or without Shared Risk
- Population Based Payment

Financing
Medicaid Financing

• The federal government matches state spending on an open-ended basis.

Federal Medical Assistance Percentage (FMAP)
Formula based on per capita income, recalculated annually

\[1 - (0.45 \times \left(\frac{\text{state per capita income}}{\text{U.S. per capita income}}\right))\]

<table>
<thead>
<tr>
<th>Statutory Rates</th>
<th>2019 FMAP Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>Maximum</td>
<td>83%</td>
</tr>
<tr>
<td></td>
<td>76.4%</td>
</tr>
</tbody>
</table>
Medicaid is the Largest Source of Federal Funds for States

Federal Fund Expenditures, FY 2016

- Medicaid: $319 Billion (56.7%)
- All Other Programs: $250 Billion (43.3%)

This includes public assistance; elementary, secondary and higher education; corrections; transportation, and other

CHIP Financing

- Block grant with capped annual allotments
  - Unused allotment available for up to 2 years
  - Redistribution dollars available for federal funding shortfalls
  - Contingency fund covers shortfalls related to increased enrollment
- CHIP bump = 23 percentage points up to 100% in FFY 2016-2019; 11.5 percentage points in FFY 2020

**eFMAP Formula**

\[ \text{eFMAP} = \text{FMAP} + (0.3 \times (1 - \text{FMAP})) \]

<table>
<thead>
<tr>
<th></th>
<th>Statutory Rates</th>
<th>2019 eFMAP Rates</th>
<th>2019 eFMAP with Bump</th>
<th>2020 eFMAP with ½ Bump*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimum</strong></td>
<td>65%</td>
<td>65%</td>
<td>88%</td>
<td>76.5%</td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td>85%</td>
<td>83.5%</td>
<td>100%</td>
<td>96.5%</td>
</tr>
</tbody>
</table>

* Based on statutory minimums and maximums. Actual 2020 matching rates have not been released.
A Closer Look at How Medicaid Could Be Restructured
Restructuring Medicaid – Legislative

**Block Grant/Per Capita Cap**
- Limit federal funding to a specific amount
- Fundamental change in entitlement and benefit structure
- To achieve federal savings, states would receive less money
- Major implications for beneficiaries, providers, states, and managed care plans

**Legislative Process**
- Only need simple majority in the House, but typically would require 60 votes in the Senate
- To avoid 60-vote threshold in the Senate, would need to pass a budget resolution with reconciliation instructions
- This has not happened (yet) for the current fiscal year
Restructuring Medicaid – Administrative

Section 1115 Waivers

- Allow HHS to waive federal Medicaid requirements for a state to do an innovative project
- Must be experimental and must promote the objectives of Medicaid
- Historically used to do coverage expansions, managed care, family planning
- Now being used to limit coverage
- State and federal comment periods allow the public to weigh in
Potential Risks to Children in Restructuring Proposals

• Cuts to Medicaid in exchange for state flexibility could eliminate core protections for children in federal standards:
  – Guarantee of coverage
  – Comprehensive benefits through EPSDT
  – Cost-sharing limitations

• Even without explicitly eliminating these protections, children’s coverage would be at risk as federal funding declines
Questions?
For More Information

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Kelly Whitener
• kdw29@georgetown.edu

Center for Children and Families website
• ccf.georgetown.edu

Say Ahhh! Our child health policy blog
• http://ccf.georgetown.edu/blog/