National Association of
Community Health Centers, Inc.
1330 New Hampshire Avenue, N.W.
Washington, D.C. 20036

September, 1997

ADVOCACY GUIDANCE FOR HEALTH CENTERS AND STATE PRIMARY CARE ASSOCIATIONS ON IMPLEMENTATION OF THE NEW STATE CHILD HEALTH INSURANCE PROGRAM (SCHIP)

On August 5, President Clinton signed into law the Balanced Budget Act of 1997 (P.L. 105-33). The new law includes the State Child Health Insurance Program (SCHIP), a massive new block grant program that will provide $20.25 billion in new funding to states over the next 5 years, and $39.65 billion over 10 years. The funds are to be used to provide "child health assistance" to low income children who currently lack health insurance coverage and who do not qualify for existing forms of coverage such as Medicaid (an additional $3.25 billion over 5 years, and $7.35 billion over 10 years, is allocated to Medicaid for the costs of immediately expanding coverage to children under age 19 in families that meet current Medicaid income requirements). It is estimated that the new SCHIP program will ultimately cover between 3 and 5 million, depending on state coverage decisions, making it the single largest new federal health program since the creation of Medicaid itself. Given the strictures elsewhere in the BBA on overall federal spending levels over the next 5 years, SCHIP may well be the last big new federal health funding (except for the possible tobacco litigation settlement legislation) for years to come.

The new SCHIP program will take effect on October 1, 1997. Beginning on that date, states may submit their state implementation plan to HCFA (which has been designated as the administering agency for SCHIP within HHS). Once its plan is approved, a state may begin to implement the new program. Because of the short time frame, and since many states will need approval from their state legislature, few states are expected to have their SCHIP programs up and going before the end of 1997. Nevertheless, virtually all states have begun the development of their SCHIP plans, and thus time will be of the essence to Health Centers and State Primary Care Associations in gearing up their advocacy efforts on this matter. The simple fact is that, under the new SCHIP law, *the decisions that will have the greatest impact on Health Centers are almost wholly left up to each state, making an effective state-based advocacy effort imperative if Health Centers want to be players in the new program.*

This guidance intended to assist NACHC member Health Centers and PCAs in such efforts, by targeting the most critical issues, identifying objectives for advocacy, and providing suggestions for the strategies and tactics that will be needed for success. Issues are presented in order of importance, with a brief background for each. A comprehensive checklist is attached.

I. State Share of SCHIP Funding

Under SCHIP, the federal government will contribute to the cost of an approved state child health plan in much the same manner as it does for Medicaid, but at an "enhanced contribution" level. The federal share of total costs will equal the federal share of the state's Medicaid costs *plus* 30

percent of the state's share of such costs. Thus, for a state with a 50 percent federal Medicaid share, the federal SCHIP contribution will be 65 percent (.50 + [.30 *x* .50]); for a state with a 60 percent federal Medicaid share, the federal SCHIP contribution will be 72 percent (.60 + [.30 *x* .40]).

The federal payment system for SCHIP will work in much the same fashion as it does for Medicaid. Under this system, the state must first incur costs (spend money) and then, on a quarterly basis, submit its total spending to HCFA. After reviewing the spending for acceptability, HCFA will send the state a check equal to the federal share of total approved expenditures (subject to an upper limit - see below). *The point here is that states will have to spend their own money first, before they bill HCFA for the federal share of their costs; and even after receiving the federal payment, states will be left with their own share of those costs (that is, the balance of total state spending that exceeds the federal share).*

What separates the SCHIP program from Medicaid is that the federal SCHIP contribution is subject to an *aggregate cap* on the federal share, much the same as is true of the new federal welfare block grant (TANF). The overall federal SCHIP funds will be allocated to the states using a formula that estimates each state's share of the national estimated total of uninsured low income children. The Congressional Budget Office (CBO) has projected the distribution of the federal SCHIP funding to each state over the next 5 years (*copy attached*). If, for any reason, a state's SCHIP spending exceeds the combined total of the maximum federal share plus its state share, it will have to bear *100 percent* of all excess spending.

Clearly, states wishing to participate in the SCHIP block grant will feel *intense pressure* to come up with their share of total SCHIP costs, and *can be expected to scour their current state budgets to find and "sweep up" any and all available funding for this purpose*. However, states face a number of restrictions on their ability to tap existing state health expenditures, including: (1) they may not reduce their Medicaid income eligibility levels below those in effect on June 1, 1997; (2) in the states of FL, NY, and PA, they must maintain state spending levels for health benefits under the recognized state-based child health program at 1996 levels; (3) they may not use any other federal funds; and (4) *they may not use any funds that support "services assisted or subsidized to any significant extent by the Federal government"* (the term 'significant' is not defined, but the phrase is believed to refer to key federal-state programs like WIC and the MCH block grant). *Among the most vulnerable state funding sources will be programs that support grants or contracts for services to currently uninsured people, which in many cases are a key source of state funding for Health Centers.*

Thus, the first key objective is to make sure that states do not take current state funding away from Health Centers in order to meet their state share under SCHIP. Undoubtedly, these funds also support care for a significant number of uninsured adults, who represent 3/4ths of all uninsured Americans and who will not be assisted by SCHIP in any way. The funds may also support the cost of certain services (such as patient transportation, translation, health education, and even prescription drugs) that may not be included in the state's SCHIP benefit package (see II., below).

Alternatively, Health Centers may be able to leverage a key role for themselves in the state's SCHIP program in return for not opposing (or even supporting) the use of some

current state funding that flows to health centers in order to meet the state's SCHIP share. Achieving adequate insurance coverage for currently uninsured children who are patients of Health Centers would be a significant achievement, *so long as* Health Centers are included as providers in the SCHIP delivery system (see IV., below) and the newly-insured children are allowed and even encouraged to enroll with the Centers or with insurers that include them in their SCHIP provider networks.

Strategies:

- Health Centers and PCAs need to immediately begin gathering intelligence on what funding sources their state is looking at as potential sources for their SCHIP funding share, and to identify all sources of state funding that flow to the Centers and document the key uses of such funds.

- Where those funds support costs that will not be covered under SCHIP, key legislators and staff of the Governor's office and the state agency that will administer the SCHIP program (in most, but not all, cases the Medicaid agency) should be apprised and educated, including the effects that the removal/loss of such funding could have on the Centers' ability to continue caring for those who are and will remain uninsured, and/or to provide services that will remain unreimbursed.

- Seek out others at significant risk of losing current state funding (especially state and local health agencies) to form coalitions to oppose such action. In addition, other provider groups (such as hospitals) that could experience negative effects from such funding loss, and advocacy groups representing affected populations (seniors, minorities, homeless adults, populations with special health needs such as mental health, etc.), may be very supportive of maintaining current state funding levels and purposes.

- The development of the state's SCHIP plan must necessarily involve a public process, thus providing opportunities for Health Centers' to present their views and concerns on this and other related matters, which they should do actively (see V., below).

II. State Coverage Options (Eligibility and Benefits)

The most important and fundamental structural decision each state will have to make is which of the two major pathways it intends to take: whether to expand its current Medicaid program or to establish (or expand) a completely separate program to provide insurance for eligible children. Since most states are not likely to have enough funding to extend coverage to all potentially eligible children (defined as all children in families with incomes up to the higher of 200 percent of poverty or 50 percentage points above the state's current Medicaid eligibility levels), and since the new law restricts state flexibility in setting cost-sharing levels, this key decision necessarily must involve making trade-offs in the two areas where states *do* have greater flexibility - *eligibility and benefits*. Quite literally, each state will face the age-old dilemma of whether to do a little bit for many people or to do a lot for a few. There are no easy or perfect options here; the best decision may well be different for each state (*NOTE: a state can choose to follow both pathways, if it wants to -- Medicaid for certain groups of children, and private insurance for others).*

If a state chooses the Medicaid pathway, it will be building on an existing program with many 'knowns,' and implementing the expanded coverage should be relatively easy and quick to accomplish -- not to mention less costly to administer. *For Health Centers, the Medicaid path will mean that FQHC services are guaranteed for each newly enrolled child and that cost-based payment is also assured (including the new 'wrap-around' requirements).* At the same time, however, choosing Medicaid will mean that the state must guarantee full coverage to each enrolled child (an entitlement), and that all other Medicaid rules will apply (including rules governing eligibility). Moreover, providing coverage for the comprehensive Medicaid benefit package may well be more costly and could lead to fewer children being covered.

If a state chooses to set up (or expand) a separate program to purchase private insurance for eligible children, it will have considerable discretion in determining both eligibility rules and the benefit package, which in turn could allow it to cover more children. Under this pathway, states can limit eligibility by geographic area, by age, by duration of residency in the state, and even by disability status (as long as state standards do not restrict coverage based on disabilities). In addition, each state has several options for setting its 'benchmark' benefit package (the attached summary of the new SCHIP law details these options); in the end, however, it must cover at least inpatient and outpatient hospital services, physicians' medical and surgical services, lab and x-ray, and well child care including age-appropriate immunizations (and possibly some level of mental health, vision, and hearing services, and prescribed drugs, if these are covered in the 'benchmark chosen by the state). The state may also cover any other services up to essentially the full Medicaid benefit package (including Health Center services).

States do have a couple of other options (*not* mandates) under the private insurance pathway, one of which is to seek a waiver from HCFA to provide "alternative coverage" through a "community-based health delivery system" that could include Health Centers as major players (more on this in IV., below).

You should be aware that, while national organizations that represent various parts of state governments have not made any public statements in support of one pathway or the other, *documents from the National Governors' Association (NGA) have emphasized the "down-sides" of taking the Medicaid pathway, and they worked hardest to support the private insurance option in the new law. Other groups (such as the Medicaid Directors' association and the National Conference of State Legislators (NCSL) have been more neutral on this issue.* Thus, many Governors can be expected to favor the private insurance route (and their Medicaid Directors, who work for them, will likely not oppose this choice), whereas state legislators may well be more open to looking objectively at this question.

Thus, the second key objective is to make sure that the state covers the benefits most needed by low income children, either by taking the Medicaid pathway or by choosing an adequate private insurance benchmark. Only a few states are said to be considering the Medicaid pathway, even though it would offer the best deal for eligible children and for providers such as Health Centers. At the same time, since these children are now uninsured, any level of coverage is better than what they now have. However, if a state takes the private insurance path, it could mean that children in families with incomes just above the current Medicaid eligibility levels - and whose incomes fluctuate from month to month - could end up being on Medicaid one month, on the new

program the next month, and back on Medicaid the following month. Needless to say, this could create an administrative and fiscal nightmare both for the state and for participating insurers and providers.

If the state chooses as its benchmark an exceedingly skimpy private insurance package, many insurers and provider networks may refuse to participate in the program and those that do will face extremely low premium rates, which will in turn affect their payment levels to subcontracting providers. Moreover, inadequate benefit coverage will mean that enrolled children may not get all the services they need, and that participating providers may face the prospect of furnishing uncovered services and difficulties in making needed referrals. *Most importantly, this issue should allow Health Centers and PCAs to link what is best for Health Centers with what is best for their state and for its eligible children — and to take the "high road" in supporting and advocating what is best for the children (together with other advocacy groups).*

Alternatively, Health Centers may be able to convince states to provide direct funding for key services that are not in the benefit package through direct grants or contracts with the Centers. These services could include family and community outreach (see III., below), patient transportation, translation/multilingual services, health/nutrition education, and the like. This would serve to better target both the funding and the services on the children who need them most, and on the providers best able to offer those services. However, states are limited in how much they can spend for such activities: they may not use more than 10 percent of all SCHIP spending for all costs related to outreach (see III., below), administering SCHIP, and any direct services contracting.

Strategies:

- Health Centers and PCAs need to gather information on which pathway their state appears to be leaning toward, the reasons for the state's likely choice, and the process that the state intends to use in making this decision.

- Other groups, both providers and child advocates, will undoubtedly be equally interested in this issue, and may well prove to be allies in the effort to influence the state's decision.

- Clearly the choice of covered benefits will also affect decisions on which provider networks or systems of care will be chosen to deliver the covered services.

- As for the direct contracting option, Centers may find that others (such as local health or social service agencies, and even children's advocacy groups) are also interested in this option and would support a coalition effort to accomplish it.

III. State Outreach and Enrollment Activities

A critical element of each state's SCHIP program will be the efforts it undertakes or supports to provide outreach and enrollment for eligible children. Each state is required to establish both "intake" and "follow-up screening" activities to identify eligible children and to assist them in enrolling. In these efforts, the state must make sure that children who are currently eligible for Medicaid (an estimated 3 million such children across the country today) are enrolled in Medicaid and

not in SCHIP, and is subject to financial penalties should it fail to do so. However, as noted earlier, states are subject to a 10 percent overall limit on spending for the combined costs of outreach, administration, and other direct services contracting, thus limiting the amounts they will be willing to spend for this activity.

Health centers are major providers of care to uninsured children today, serving an estimated 1.3 million such children last year -- 1 out of every 5 low income uninsured children in America. They also have the confidence of their patients and communities, and are in regular communication with them. And *Health Centers (FQHCs) are already designated as outstationed enrollment sites in the Medicaid law*, something that states should seriously want to assure close coordination with under their SCHIP outreach/enrollment activities. *Therefore, Health Centers are clearly the very best sites for states to use for outreach and enrollment, both for Medicaid and for SCHIP.* If Health Centers are able to identify and enroll eligible children for SCHIP, they may also be in an excellent position to serve as their recognized providers under SCHIP.

Thus, the third key objective is making sure that Health Centers play a central role in all SCHIP outreach and enrollment activities. Health Centers have much to offer their states here, and at a critical time for most of them (since many Governors are feeling political pressure to show early success with their SCHIP efforts). Centers may be able to undertake these activities on a more cost-effective basis than the state could do directly. This may also present an opportunity for Centers to encourage states to fully implement the Medicaid outstationed eligibility activity if they have not yet done so (the costs of doing so are not subject to any limitations).

Strategies:

- Health centers should immediately gather data on the number of uninsured children served (*attached are NACHC estimates of the numbers served by all FQHCs, including look-alikes in each state, based on Health Center UDS reports and available data from the Census Bureau and EBRI on coverage rates in each state by income, age, race/ethnicity, and employment*).

- This data should be presented to key state legislators and Medicaid/SCHIP officials, as well as to advocates and other key players, in support of funding or contracting with Health Centers for outreach/enrollment activities.

IV. State Identification and Selection of Insurance 'Offerors'

The state's decision on who may offer coverage and who will provide covered services to enrolled children is probably the single most important issue affecting Health Centers, because it will determine whether and to what extent they will be able to continue caring for their currently uninsured children, as well as others in their communities, who may gain coverage through SCHIP. At the same time, it should be clear by now that it is all but impossible to get to this issue until the three previous issues have been dealt with.

If the state chooses the Medicaid pathway, all current rules and requirements pertaining to Medicaid will apply (including all new requirements contained in the recently-enacted Balanced Budget Act of 1997). Under this pathway, eligible providers would include those managed care organizations (and PCCM providers) that currently are recognized as Medicaid providers by the state, as well as those for which the state (under provisions contained in the BBA) has either guaranteed

solvency or (in the case of MCOs that are owned or controlled by FQHCs) set different solvency standards. Presumably, states with current section 1115 or 1915 waivers for their Medicaid populations who wish to expand their demonstration to include the new SCHIP children will have to request a modification of their current waiver to do so, perhaps presenting some new opportunities for Health Centers to re-negotiate certain points with the state.

If the state chooses the private insurance pathway, it will have wide discretion in deciding which (and which types of) insurers may participate in the program, subject only to its own state laws, definitions and rules regarding what constitutes "insurance" in the state. If a state requires its Medicaid managed care organizations to be licensed as insurers, then they should be able to participate in the new SCHIP program (along with other state-licensed insurers).

States do have a third option: the SCHIP law allows them to seek a waiver from HCFA to provide coverage for eligible children through "the use of a community-based health delivery system, such as through contracts with health centers funded under section 330..." In such cases, however, the state must satisfy HCFA that the use of such a system will (1) provide coverage for all services included in the state's 'benchmark' package, and (2) will be no more costly than the purchase of private insurance coverage. States choosing this option could presumably bypass their own insurance laws and rules, to secure federal certification of these community-based delivery systems, in much the same way as the new Provider Sponsored Organizations (PSOs) may do under the new Medicare provisions enacted in the BBA of 1997 (*here, however, only the states can request such a waiver*).

Thus, the fourth objective is to make sure that Health Centers are included as key participating providers in the state's SCHIP program. If the state requires licensure for its Medicaid managed care organizations, then these organizations should be able to participate in SCHIP, regardless of the pathway chosen by the state -- including those that were formed by or include Health Centers. If not, then the Health Center-owned MCOs or those that include Centers may need to buy or lease another insurer's license, where this is allowable. Beyond this, the state may establish additional rules or conditions of participation for insurers wishing to participate, including standards related to access and quality of care. In such cases, Health Centers would want to make sure that these rules provide plenty of incentives (or requirements) for MCOs to include them in their delivery network (see V., below for more detail).

Alternatively, Health Centers may be able to convince the state to seek a federal waiver in order to use the 'community-based health delivery system' approach, at least for some eligible groups of children. This option may be particularly relevant and important for certain critical areas (such as rural communities) and population groups (such as farmworker or homeless children, or those from immigrant families) who are not likely to be well-served, or even reached, under either major pathway; and it may be used by the state even if it chooses to use the Medicaid and/or private insurance pathways for most of its eligible children.

Strategies:

- Once Health Centers and PCAs learn which pathway the state intends to follow, they will need to determine whether the Health Center-owned MCO (if there is one) or those that include Health Centers will be eligible to participate. States in which the approval of the legislature is needed to implement SCHIP may present opportunities to ensure that such MCOs are eligible to participate in SCHIP.

- Also important is to track the state's development of any conditions of participation to ensure that they do not pose barriers to Health Center participation and, to the extent possible, that they include conditions which provide significant incentives for participating insurers to subcontract with Health Centers (see V., below for more details).

- Advocacy groups - especially those focused on key population groups (rural, farmworkers, homeless persons, immigrants, etc.) - may be especially supportive of efforts to include such conditions or to use the 'community-based delivery system' option.

IV. State Standards for Access and Quality Assurance

As with most other decision points, states will have wide discretion in establishing standards for insurer participation and for the operation of the provider networks furnishing care to enrolled children under SCHIP. Among the issues the state will confront here are those related to the size and scope of such networks, provider mix and credentialling, enrollment and disenrollment, use of default assignment systems, the accessibility of care and the quality of care provided. The Medicaid program already lays out many such conditions, but if the state chooses another pathway it will have to develop a whole new set of conditions governing its SCHIP program operations. In such cases, *the state's decisions can pose either dangers or opportunities for Health Centers and PCAs (and for other providers and advocates), depending on whether Centers are positioned to bargain well.*

Thus, the fifth objective is to make sure that the state's standards and conditions of participation for SCHIP provide the best possible climate for including Health Centers as participating providers, and do not pose any barriers to their involvement. In particular, the use of key standards for geographic, financial, linguistic/cultural, or even physical accessibility of services (or hours of operation) could encourage insurers to contract with Health Centers, even as they offer assurance to eligible children that their new coverage will truly guarantee access to care. In the same fashion, standards for the state's use of a default (or auto-) enrollment/assignment system could (like the new Medicaid provisions) require assurances that enrolled children can maintain their current provider-individual relationships or at least include traditional providers of care to previously uninsured children.

Strategies:

- As with all previous objectives, Health Centers and PCAs will need to keep abreast of the state's decision-making process and the criteria it plans to use, and to gather and use all available data on care currently provided by Health Centers for uninsured low income children in support of efforts to ensure their proper role as SCHIP providers.
- Here, as earlier, other advocacy groups are likely to be very supportive of such measures, since they offer key safeguards for the children who are eventually to be enrolled in the state's SCHIP program.

STRATEGY AND TACTICS CHECKLIST
FOR HEALTH CENTERS AND PRIMARY CARE ASSOCIATIONS

1. Gather intelligence
   a. Potential sources of state share of SCHIP funding
   b. Whether state funding for Health Centers is affected
   c. What state agency will administer SCHIP
   d. Which pathway(s) the state is leaning toward taking
      i. If Medicaid (for some or all), under a waiver or a state plan amendment
      ii. If private insurance (for some or all), what 'benchmark' insurance plan is the state looking at using and what benefits are covered
      iii. Which groups (types) of children the state intends to cover under SCHIP (what income eligibility level, what types, if any (e.g., age, disability, residence, etc.)
   e. What process will the state use in developing its SCHIP plan
      i. Public (administrative) hearings or meetings
      ii. Public notice and comment process
      iii. Legislative hearings or even state enabling legislation (or amendments to existing state legislation)
   f. What system the state intends to use to identify and enroll eligible children
      i. Direct state activity or use of grants, contracts, etc.
      ii. If grants/contracts, what criteria will be used to select recipients
   g. Is the state favoring certain insurers (e.g., Blue Cross-Blue Shield, certain HMOs) to offer coverage to enrolled children
      i. What criteria will state use to secure bids, select insurers
      ii. What criteria (if any) will state use regarding adequacy of insurer delivery system (size/scope of network, access/quality standards, use of traditional/ community providers, etc.)
   h. Would the state consider seeking a waiver for 'alternative coverage' through a community-based system (if not generally, then perhaps for certain areas/populations, e.g., rural, homeless, farmworker, disabled kids)
   i. What other key players will be involved in shaping the state's decisions (legislators, key Committees, advocacy groups, etc.), and their positions on key issues

2. Gather essential data and information
   a. Number of Health Centers and sites in state, location
   b. Sources of current state funding to Health Centers, and what those funds are used for (and impact of reducing or removing such funds)
   c. Number of eligible uninsured children in state, their demographics (age, residence, race/ethnicity/language, special needs, etc.)
   d. Number of uninsured (eligible) children currently served by Health Centers, by location
   e. Capacity of Health Centers to enroll and serve additional children
   f. State insurance licensure laws and regulations, and who now holds such licenses (including MCOs that are led by or include Health Centers)
   g. Whether licensed insurers are permitted to sell or lease their license (if necessary)
   h. Current state laws and/or regulations that pertain to health insurers (including HMOs)

3. Develop a position paper presenting the Health Centers' views on key issues
   a. Why the state should (must) participate (number of uninsured kids who stand to benefit; links between insurance status, use of services, and health status; availability of federal support targeted to state, etc.)
   b. Why the state should not take away funds currently supporting Health Centers to use for its share of SCHIP costs (services, number of other uninsured persons [adults] who would lose care, etc.)
   c. The preferred approach (pathway) for the state to take and why (benefits to children and to the state)
   d. Key benefits that should (must) be covered and why (especially important if Medicaid path is not chosen)
   e. Why the state's outreach and enrollment activity for SCHIP should include Health Centers and should be linked with the Centers' Medicaid outstationed eligibility activities (or why the state should be doing/supporting outstationed eligibility at Health Centers, if they are not now doing so)
   f. Special population groups that will need special approaches and why (e.g., children in rural communities, homeless or farmworker children, immigrants, childen with special needs, etc.)
   g. Why Health Centers should be central players in the state's SCHIP program (history, experience/expertise, number of uninsured [and Medicaid] children now served, number of adults in uninsured families now served [keeping families together], etc.)
      i. Through their state-licensed HMO (if one exists or can be quickly formed)
      ii. Through an 'alternative coverage' waiver community-based system (if such a network exists or can be quickly formed)
      iii. As subcontractors to participating insurers
   h. What criteria and standards should be required of all participating insurers (especially viz access, provider paticipation, quality of care, etc.)

4. Identify and link with allies on key issues or overall
   a. Others who could lose state funding to meet SCHIP share
   b. Advocacy groups representing populations that could lose services/care if funding is cut or terminated
   c. Children's advocacy groups and groups interested in key populations (e.g., minorities, homeless, rural, immigrants, etc.)
   d. Insurer and provider organizations
   e. Providers or others interested in advocating for an 'alternative coverage' waiver (i.e., networking with Health Centers to provide care) or in direct services contracting
   f. Civic or business groups (or individuals) interested in and capable of influencing state decisions

5. Establish direct communication with key decision-makers to advance positions and influence decisions (either directly or through sources having best relationships with them)
   a. Governor's office
   b. Agency that will administer SCHIP
   c. Key state legislators and/or Committees (including staffers)
      i. Get on hearing schedule as witness(es)
      ii. Provide ideas, suggestions, or even draft legislation or amendments as necessary and appropriate
      iii. Seek and secure support from key legislators for Health Center positions
      iv. Get key legislators to call Governor's office or SCHIP-administering agency on Health Centers' behalf (message: "This issue is very important to me; please see that it is taken care of")

6. Use public or other processes to advance Health Center positions
   a. Administrative hearings, meetings, or conferences
   b. Media events or opportunities (including media stories or reports on the vital role Health Centers now play in serving uninsured children and adults, or press conferences with other allies)
   c. State public notice and comment procedures and requirements (usually found in a state's Administrative Procedures acts)
   d. Legislative hearings or Committee sessions

7. Stay in touch with NACHC for more details, guidance, and information, and to let us know how things are going in your state

Annual State Allocations for Children's Health Insurance

Conference Agreement	Allocations based on Children under 19 & below 200% fpl and interstate cost adjustment. Years 1998-2000 Uninsd. Children; 2001 on 75% Uninsd Children & 25% low inc.; 2002 on 50% Uninsd. Children and 50% low inc.

Note: The legislation calls for updating state counts of children in need annually based on a 3-yr. average. Allocations shown for 1998-2002 assume state proportions of children in need do not change compared to 1998 allocations, due to lack of data for future years.

States & Territories	1998	1999	2000	2001	2002	Total
Alabama	$85,634,397	$85,634,397	$86,634,397	$82,895,107	$59,081,748	$358,860,045
Alaska	$5,152,005	$5,152,005	$5,152,005	$5,932,941	$4,947,043	$26,335,856
Arizona	$112,965,830	$112,965,830	$112,965,830	$106,202,321	$73,268,634	$518,388,446
Arkansas	$46,860,505	$46,860,505	$46,860,505	$46,534,135	$32,573,333	$219,689,584
California	$855,208,654	$855,208,654	$855,208,654	$822,139,682	$581,415,563	$3,968,181,256
Colorado	$43,219,361	$43,219,361	$43,219,361	$43,788,605	$32,652,592	$206,077,579
Connecticut	$36,017,176	$36,017,176	$36,017,176	$37,685,517	$25,958,387	$174,685,412
Delaware	$8,436,772	$8,436,772	$8,436,772	$8,771,954	$6,710,574	$40,792,844
District of Columbia	$14,372,424	$14,372,424	$14,372,424	$14,787,355	$11,202,487	$69,107,615
Florida	$279,202,492	$279,202,492	$279,202,492	$271,739,184	$194,729,413	$1,304,075,073
Georgia	$126,783,707	$126,783,707	$126,783,707	$124,010,008	$89,331,575	$593,692,703
Hawaii	$10,992,634	$10,992,634	$10,992,634	$12,966,222	$10,861,208	$56,705,333
Idaho	$15,694,892	$15,694,892	$15,694,892	$16,810,834	$12,514,611	$76,610,121
Illinois	$128,782,081	$128,782,081	$128,782,081	$141,355,962	$112,981,824	$640,384,030
Indiana	$73,093,951	$73,093,951	$73,093,951	$76,598,708	$59,024,180	$354,904,721
Iowa	$32,987,149	$32,987,149	$32,987,149	$33,115,908	$24,496,091	$156,573,446
Kansas	$31,433,507	$31,433,507	$31,433,507	$32,892,711	$25,312,168	$152,505,401
Kentucky	$50,701,098	$50,701,098	$50,701,098	$53,387,148	$41,317,519	$246,807,958
Louisiana	$101,768,282	$101,768,282	$101,768,282	$98,047,511	$69,503,340	$472,855,837
Maine	$12,724,728	$12,724,728	$12,724,728	$13,233,968	$10,126,628	$61,534,777
Maryland	$61,706,349	$61,706,349	$61,706,349	$63,429,694	$48,007,775	$296,556,514
Massachusetts	$45,229,971	$45,229,971	$45,229,971	$50,843,282	$41,305,713	$227,838,908
Michigan	$92,045,047	$92,045,047	$92,045,047	$104,691,307	$86,461,255	$467,287,705
Minnesota	$27,022,565	$27,022,565	$27,022,565	$32,808,060	$28,436,271	$142,314,026
Mississippi	$55,654,715	$55,654,715	$55,654,715	$54,583,482	$39,429,909	$260,977,536
Missouri	$59,288,396	$59,288,396	$59,288,396	$62,295,773	$48,133,328	$288,234,289
Montana	$9,739,680	$9,739,680	$9,739,680	$10,097,184	$7,703,481	$47,019,685
Nebraska	$15,448,224	$15,448,224	$15,448,224	$16,663,194	$13,173,577	$76,181,442
Nevada	$32,550,586	$32,550,586	$32,550,586	$30,747,597	$21,327,320	$149,726,677
New Hampshire	$10,910,008	$10,910,008	$10,910,008	$11,030,190	$8,216,064	$51,976,292
New Jersey	$91,592,766	$91,592,766	$91,592,766	$91,862,969	$67,872,904	$434,504,171
New Mexico	$56,753,577	$56,753,577	$56,753,577	$51,784,224	$34,494,383	$256,539,339
New York	$265,835,633	$265,835,633	$265,835,633	$279,089,240	$215,283,136	$1,291,959,275
North Carolina	$79,741,341	$79,741,341	$79,741,341	$82,384,272	$63,651,064	$385,769,381
North Dakota	$5,202,463	$5,202,463	$5,202,463	$5,798,706	$4,712,188	$26,118,282
Ohio	$114,442,019	$114,442,019	$114,442,019	$128,213,702	$101,679,302	$571,215,081
Oklahoma	$79,467,777	$79,467,777	$79,467,777	$72,901,998	$48,878,278	$360,183,605
Oregon	$41,881,622	$41,881,622	$41,881,622	$43,600,552	$33,396,574	$202,858,993
Pennsylvania	$123,329,744	$123,329,744	$123,329,744	$132,564,812	$104,485,730	$607,038,872
Rhode Island	$10,673,243	$10,673,243	$10,673,243	$10,367,328	$8,150,546	$51,037,602
South Carolina	$65,234,386	$65,234,386	$65,234,386	$67,539,685	$51,465,059	$314,707,981
South Dakota	$7,522,023	$7,522,023	$7,522,023	$8,452,987	$6,914,166	$37,932,903
Tennessee	$66,818,662	$66,818,662	$66,818,662	$72,750,816	$59,124,969	$332,731,571
Texas	$558,774,987	$558,774,987	$558,774,987	$603,364,231	$338,315,830	$2,623,804,883
Utah	$25,053,748	$25,053,748	$25,053,748	$27,296,150	$21,785,804	$124,222,997
Vermont	$3,969,814	$3,969,814	$3,969,814	$4,763,348	$4,102,040	$20,744,831
Virginia	$71,424,313	$71,424,313	$71,424,313	$74,478,021	$57,126,178	$345,875,137
Washington	$47,351,091	$47,351,091	$47,351,091	$50,033,521	$38,843,763	$230,930,528
West Virginia	$23,053,013	$23,053,013	$23,053,013	$23,845,497	$18,154,427	$111,158,963
Wisconsin	$37,300,536	$37,300,536	$37,300,536	$43,083,801	$36,008,228	$190,993,635
Wyoming	$7,492,707	$7,492,707	$7,492,707	$7,214,790	$5,111,337	$34,804,248
Total	$4,264,312,500	$4,264,312,500	$4,264,312,500	$4,264,312,500	$3,142,125,000	$20,199,375,000
Territories	$10,687,500	$10,687,500	$10,687,500	$10,687,500	$7,875,000	$50,625,000
Grand Total	$4,275,000,000	$4,275,000,000	$4,275,000,000	$4,275,000,000	$3,150,000,000	$20,250,000,000

NUMBER AND PROPORTION OF UNINSURED CHILDREN SERVED BY HEALTH CENTERS, BY STATE, 1995

STATES	NUMBER OF UNINSURED CHILDREN (000)*	CHILDREN SERVED BY HEALTH CENTERS (000)**	HEALTH CENTER CHILDREN WHO ARE UNINSURED (000)	PERCENT OF ALL UNINSURED CHILDREN SERVED BY HEALTH CENTERS
Alabama	228	105	38	17
Alaska	23	18	5	22
Arizona	265	115	41	15
Arkansas	123	28	10	8
California	1,604	598	179	11
Colorado	141	88	28	20
Connecticut	80	66	18	23
D.C.	24	17	5	21
Delaware	25	9	3	12
Florida	649	242	87	13
Georgia	286	67	17	6
Hawaii	22	52	17	77
Idaho	41	27	9	22
Illinois	297	186	48	16
Indiana	188	26	8	4
Iowa	104	19	5	5
Kansas	73	11	3	4

Kentucky	145	61	16	11
Louisiana	239	45	15	6
Massachusetts	136	105	23	17
Maryland	144	68	22	15
Maine	35	32	9	26
Michigan	230	100	24	10
Minnesota	69	58	16	23
Missouri	180	82	25	14
Mississippi	140	125	38	27
Montana	25	21	7	28
Nebraska	41	8	2	5
Nevada	84	17	6	7
New Hampshire	16	11	3	19
New Jersey	237	89	23	10
New Mexico	143	84	30	21
New York	572	363	87	15
N. Carolina	202	69	18	9
N. Dakota	12	8	2	17
Ohio	285	120	34	12
Oklahoma	178	32	12	7

Oregon	86	58	14	16
Pennsylvania	273	153	43	16
Puerto Rico	N/A	241	72	N/A
Rhode Island	29	57	11	38
S. Carolina	155	70	24	15
S. Dakota	16	17	5	31
Tennessee	209	85	19	9
Texas	1,234	216	97	8
Utah	71	21	7	10
Vermont	16	5	1	6
Virginia	157	44	11	7
Washington	121	113	29	24
W. Virginia	39	78	20	51
Wisconsin	100	49	15	15
Wyoming	20	3	1	5
U.S. Totals	**9,795**	**4,382**	**1,334**	**14**

* Source: Employee Benefits Research Institute (EBRI), Children's Health Insurance, 1995, March 27, 1997 (using data from March 1996 Current PopulationSurvey, U.S. Bureau of the Census).

** Includes 1995 data reported by federally-assisted health centers from HHS Bureau of Primary Health Care, and 1995 estimates for other Federally-Qualified Health Centers from NACHC.

A Summary of the State Child Health Insurance Plan (SCHIP)

Issue	State Children's Health Insurance Program (SCHIP) (P.L. 105-33)
1. General Approach	• Federal grant-in-aid program (Title XXI of the Social Security Act), which entitles participating states with approved plans to annual aggregate amounts of federal financial assistance to identify and enroll targeted low income children in available public and private health insurance arrangements provide child health assistance to targeted children who are ineligible for any other coverage. • State child health assistance plans established under Title XXI may utilize one or more of the following approaches: expanded Medicaid coverage; establishment of new, subsidized state insurance programs; or subsidized enrollment into employer health plans or comprehensive community based programs (with federal waivers). States may use up to 10 percent of their annual allotments for administration costs and to pay for health services directly from individual providers.
2. General Eligibility Requirements	• Targeted low income children are children under 19 with family incomes below 200% of the FPL or 50 percentage points higher than a state's Medicaid eligibility levels. • States which elect to expand Medicaid must adhere to all applicable federal eligibility rules related to treatment of income and resources, statewideness, residency duration of coverage, and other conditions of eligibility. • States that elect to use funds to establish new Title XXI insurance programs have broad flexibility to establish conditions of eligibility (including residency, statewideness, age, disability, rules for valuation of income and resources, duration of coverage, and other conditions of eligibility) but may not exclude children with pre-existing conditions or discriminate in enrollment against children with certain diagnoses.
3. Treatment of children who are not citizens	• SCHIP is not excepted from the citizenship requirements for recipients of federal public assistance under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (welfare reform). Assistance is available to legally resident children who are not citizens only to the extent that a state's SCHIP plan entails Medicaid expansions and children fall into one of the exceptions categories for Medicaid coverage.
4. Entitlement status of children's coverage	• States that use SCHIP funding to expand Medicaid must adhere to all federal Medicaid eligibility requirements (subject to waiver of such requirements by the Secretary under Section 1115 of the Social Security Act). Children who apply and are found eligible are entitled to assistance. • States that use SCHIP funds to establish Title XXI insurance plans may limit coverage to a defined number of children, thereby potentially denying coverage to eligible children. States may establish entitlement under state law by guaranteeing coverage under their new programs to all children who apply and are found eligible.
5. Benefits and cost sharing	• States that use SCHIP funds to expand Medicaid are bound by all federal benefit and cost-sharing rules (subject to waiver of such requirements by the Secretary under Section 1115 of the Social Security Act). • States that use SCHIP funds to establish new insurance programs may limit benefit coverage to a benchmark (or benchmark equivalent) plan and have additional cost-sharing flexibility in the case of children with family incomes at or greater than 150% of the FPL.
6. Provider participation and payment	• States that use SCHIP funds to expand Medicaid must comply with all federal Medicaid conditions of participation for providers including

	managed care entities. Conditions include beneficiary protections and consumer safeguards for enrollees of managed care plans • States that use funds to establish new insurance programs may establish their own conditions of participation for insurers, including managed care organizations.
7. Outreach and enrollment	• States must identify and screen for eligibility under any insurance program targeted low income children who may be eligible for SCHIP. States may offer presumptive (i.e., temporary) Medicaid eligibility to children while their eligibility for insurance benefits is being determined
8. Federal funding levels and effective date	• Funding for SCHIP allotments to states equals $20.3 billion between FY 1998 and FY 2002. • Authorized and appropriated funding levels over the 10-year authorized life of the program exceed $40 billion. • Federal funds available to states with approved plans as of October 1, 1997.
9. Federal contributions to state programs	• States (including the District of Columbia) are entitled to federal financial contributions for the cost of child health assistance furnished to eligible children up to an annual aggregate cap. State aggregate caps based on a formula that takes into account the percentage of uninsured low income and low income children who reside in a state, adjusted by medical care costs. No state receives less than $2 million. • The federal financial contribution rate equals a state's federal medical assistance percentage plus 30% of the difference between 100 minus the FMAP. No state may receive an FMAP under SCHIP greater than 85%. • Medicaid prohibitions against provider taxes and donations apply to state Title XXI programs as well. States may not derive their state share from federal funds or from state service programs that receive substantial federal financial assistance. States must maintain Medicaid eligibility levels at their June 1, 1996, levels.
10. State and federal administration	• States must submit state plans for approval and receive approval in order to qualify for federal payments. The Health Care Financing Administration (HCFA) Office of State Operations administers SCHIP • State plans must be developed in accordance with a public process and eligibility levels may not be reduced without notice and hearing
11. Application of federal waiver authority	• States may apply for and receive federal waivers of the requirement that 90 percent of SCHIP funds be spent either on Medicaid or on health insurance in order to use funding to pay family contributions to employer plans or offer children enrollment in community based health delivery systems. • States may apply for waivers of Title XXI provisions under Section 1115 of the Social Security Act to conduct demonstrations that are consistent with the purposes of SCHIP.