

CHIP State Team-Building Workshop on the State Children's Health Insurance Program

**Center for Substance Abuse Treatment (CSAT)
Division of State and Community Assistance**

CHIP Regional Meetings Executive Summary

Introduction and Purpose

Recognizing that outreach is crucial to connect low-income children to comprehensive health services, President Clinton directed eight Federal agencies with programs serving children and families to help enroll children in Medicaid or the State Children's Health Insurance Program (CHIP). In response to President Clinton's CHIP Outreach Initiative, these Federal agencies developed plans to educate their employees, help their employees educate families, and coordinate cross-agency and public-private efforts. The Substance Abuse and Mental Health Services Administration (SAMHSA) and its centers—the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Center for Mental Health Services (CMHS)—sponsored four 2-day State team-building workshops on CHIP to provide multidisciplinary teams from States with information about national outreach efforts and strategies for expanding mental health and substance abuse benefits under CHIP.

These events, planned and facilitated by the Treatment Improvement Exchange Project under the direction of Ms. Gayle J. Saunders, Government Project Officer in CSAT's Division of State and Community Assistance (DSCA), were held between December 1998 and May 1999 in Texas, South Carolina, Rhode Island, and Alaska. Representatives from the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA) and Health Resources Services Administration (HRSA) addressed the workshop participants, sharing current information about the CHIP program and describing national activities. Participants heard from State agency staff from public health, mental health, and human service agencies; children and family service agencies; rehabilitation, substance abuse treatment, and managed care agencies. Consumers of these services also had a voice.

Each State was asked to invite five staff members to participate in these regional workshops. DSCA supported the attendance of three of the five. When creating State teams, the Single State Alcohol and Drug Agency Directors were urged to include representatives from each of the following agencies: mental health, substance abuse, CHIP or children's health agency, Medicaid, and the National Prevention Network. Of the 180 participants at the four workshops, 32 percent were from health or mental health agencies, 43 percent were from substance abuse agencies, 10



percent were CHIP Administrators or from the State agency for children, 10 percent were from Medicaid agencies, and 14 percent were State representatives from the National Prevention Network. (Some participants represented more than one agency, thus there is some overlap in the breakout figures.)

For some States, DSCA's regional meetings actually began the process of building cross-agency teams to address CHIP planning and implementation. For many who attended the early meetings, the workshops provided vital information about the Children's Health Insurance Program and how it can expand substance abuse treatment and mental health services to uninsured children. For representatives from States where the CHIP planning process was well underway (the majority at later meetings), the workshops helped solidify and support CHIP team-building efforts by:

- Educating substance abuse and mental health agency administrators about CHIP and its potential to serve publicly funded substance abuse treatment clients
- Planning how substance abuse and mental health agency representatives could be "at the table" when CHIP plan amendments are considered in their States
- Educating administrators of affected agencies about substance abuse treatment and mental health services
- Bringing together members of agencies to comprise teams working on CHIP design and implementation
- Offering arguments for including substance abuse treatment and mental health services in CHIP plans
- Offering guidance to administrators of all affected agencies on specific substance abuse treatment services that need to be covered in benefits packages, who is best qualified to provide those services, and what the services cost

Background

In response to the President's call, SAMHSA established a steering committee to address the fact that mental health services are "additional" and substance abuse services are "optional" under CHIP legislation. Most State CHIP plans provide some mental health coverage, but this is not true for substance abuse treatment services. Through the committee, SAMHSA has undertaken a number of activities designed to meet the needs of CHIP children with or at risk for mental health and substance abuse problems. These activities include:

- Training
- Conference presentations
- "Dear Colleague" letters and updates
- Q&As to clarify the provisions of the CHIP statute relative to mental health and substance abuse treatment
- Review of State CHIP plans for mental health and substance abuse treatment components
- Standard review questions
- Tracking and monitoring CHIP plans

SAMHSA also developed an outreach plan, a paper on quality systems of mental health and substance abuse care for children and adolescents, and a CHIP web site. SAMHSA is addressing the design and cost of mental health and substance abuse benefits for children with a project that includes a literature review; an analytic report describing effective methods, settings, and treatment

modalities for low-income, uninsured children; and a framework for estimating costs associated with specific benefits and adequate coverage of mental health and substance abuse treatment services. A workbook providing technical assistance was prepared for distribution to State behavioral health officials at regional conferences held in mid-1999.

Overview of CHIP's Provisions as Mandated by Law

- **Basic program design:** States can choose to provide health care to low-income, uninsured children by a Medicaid expansion, creation of a separate insurance program for children, or a combination of these two approaches.
- **Cost sharing:** Under a separate CHIP plan, cost sharing for families up to 150 percent of FPL must be the same as for the Medicaid medically needy population. Under a Medicaid expansion, no cost-sharing is allowed.
- **Eligibility:** States establish eligibility levels, which must conform to the Federal definition of a "targeted income child" as one not eligible for Medicaid or other insurance, not a patient in an institution for mental disease, not an inmate in a public institution, and with a family income up to 200 percent of FPL. CHIP benefits for children of immigrants are not subject to public charge considerations.
- **Crowd out:** States must describe their strategy for monitoring whether individuals or employers are substituting public for private insurance.
- **Outreach and enrollment:** States can enroll children in CHIP under presumptive eligibility, extend 12-month continuous eligibility, and eliminate monthly eligibility tests. To promote enrollment, States can shorten and simplify eligibility forms, use a combined form for both Medicaid and CHIP, and outstation and expand categories of eligibility workers.
- **Financing and administration:** Up to 10 percent of State and Federal expenditures may be used to fund outreach, administration, direct services to children, and other assistance. States will receive an enhanced Federal match for child health assistance. For States that create a separate program, Federal funds, premiums, and other cost-sharing cannot be used for State matching requirements. Rules on Medicaid provider taxes and donations apply. Intergovernmental transfers can be used for State matching requirements.

State CHIP Models

Medicaid Expansion Plans

Many States chose to build upon and improve existing Medicaid programs, both because the infrastructure for serving low-income children and families was already in place and because the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) feature of Medicaid is uniquely suited to the medical needs of children. In many States, Medicaid coverage was already undergoing incremental expansion to cover families with incomes up to successively higher levels of FPL, as well as older children up to age 19 and pregnant women in income-eligible families. Some programs evolved from earlier Medicaid demonstration waiver efforts.

Separate State Plans

Many States, particularly in the western United States, chose not to expand Medicaid as an entitlement program and instead used their own State health plan or a commercial benchmark

health insurance plan to create a separate children's health insurance program. In some cases, States created behavioral health carve-outs; in others, commercial providers had to grapple with serving a low-income, youth population previously unfamiliar to them. In some benchmark plans, coverage is based on adult rather than child criteria and therefore may not be as responsive as Medicaid expansions or look-alikes to children's mental health and substance abuse treatment needs. Legislatures and Governors sometimes created special commissions or task forces to deal with mental health and substance abuse treatment services in this context. The greatest challenge for separate State plans has been to effect public-private partnerships and to develop links and resources to provide for children with special needs. Coverage of substance abuse treatment under separate State plans may be limited, as are reliable outcome data on the CHIP population.

Combination Plans

States that chose to combine Medicaid expansion with a separate health care plan for CHIP children usually made expanded Medicaid coverage Phase I, then added additional private coverage in later phases. This approach allowed them to "reserve" CHIP funding and submit amendments to their original CHIP plans after they had added coverage for older children or children in higher-income families, who were phased in gradually.

Presentations

DSCA invited speakers from States that were well along in the CHIP planning and implementation process to present a summary of their experiences, the challenges they encountered, and the approaches they had taken in response. Regardless of which model States chose, those with the most successful operations and the most ample benefit packages recommended the following steps:

- Make planning a very visible process in which all public (e.g., relevant local, State, and Federal agencies) and private (e.g., insurance plans; hospital, doctor, nurse, pharmacist, and social service associations; faith community) stakeholders are at the table for every meeting, including substance abuse treatment advocates and consumers. This is how necessary relationships are developed and maintained.
- Define "medical necessity" broadly to mean medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of a health-related condition, including such services necessary to prevent a detrimental change in either medical or mental health status.
- Make programs member-focused, not provider-focused. Benefits that are accessible to the member should be the issue, not maintaining the income of providers.
- Focus programs on benefits, not providers. Be specific; name the benefits to be included. Use the language of access, standards, and timely response and include these provisions in the contract.
- Recognize that clients and advocates may have more clout than providers on policy issues.

To encourage enrollment in CHIP by eligible families, State outreach efforts used technology and imagination to think "outside the box." States did the following:

- Created a catchy name for the CHIP program with a logo that appeared on all promotional materials
- Radically shortened and simplified the application form and, in some cases, used color to differentiate it from Medicaid and public assistance

- Eliminated face-to-face requirements, instituted mail-in applications, and made applications and assistance filling them out available in as many locations as possible throughout the State
- Created a web site through which applicants can input information requested; download, print, and sign the application; and send it in (by either electronic or surface mail)
- Adopted presumptive and/or continuous eligibility policies
- Used the media to make a big splash at program launch and to publicize the program continuously with public service announcements
- Produced materials in the languages spoken by the target populations
- Used the schools and grassroots organizations to contact parents
- Used national organizations (e.g., March of Dimes, USDA child nutrition and feeding programs) to help mobilize local participation
- Involved government departments and private organizations in outreach that are not automatically associated with health programs or programs for youth, such as senior services, banking and insurance entities, division of taxation, State lottery, and public transportation companies.
- Created advertisements in a variety of media that were shown or distributed at nontraditional sites, such as laundromats, movie theaters, cable television, outdoor advertising (e.g., billboards, sides of buses and trains), or enclosed with other mailings (e.g., motor vehicle license and tag renewal notices).

Consumer Viewpoint on CHIP

Consumers spoke at each of the four meetings. They urged attendees in government to “take off their administrator hats and think of themselves as family members” of a child for whom CHIP represented a breakthrough in access to services. They advocated for family involvement in CHIP planning, arguing that only families can teach providers and administrators what families need. They pressed for the inclusion of mental health and substance abuse services for children in CHIP and in Medicaid.

One presenter described how her family, which has moved from low to upper middle-income status during the childhood and adolescence of her sons, “struggles beyond reason to provide for a child with a disability.” In her campaign to get needed services for a son with Asperger’s syndrome, depression, and ADD, her son was denied benefits 10 times. She was obliged to challenge her private insurance company, SSI, Medicaid, and her State departments of education, social services, mental health, disabilities and special needs, and vocational rehabilitation, among other entities. After repeated experiences of “falling through the cracks” of various service systems and regulations, she contacted her State senators, which resulted in rule changes that allowed her son to get the services he needed in his home State. But what about parents who are not able to negotiate these systems successfully on behalf of their children, a process she called “overwhelming” for working parents?

Based on her experience as a parent advocate, she recommended the following:

- Expand Medicaid, with special exemptions for families with children with disabilities
- Adopt Medicaid look-alikes or expansions for State CHIP benefits packages
- Eliminate the stigma of Medicaid as a program for poor people
- Establish a protocol for data sharing across State agencies that respects patient privacy

State Reports to the Larger Group

On Day 2 of every workshop, State teams were asked to meet in small groups and discuss action steps to be taken upon returning home. One person from each team then reported to the larger group. A "State Team Review of CHIP Implementation" form was developed and distributed at later meetings to help States focus their discussion and to furnish a written record. The forms covered three categories of information: Current CHIP Plan/Services Covered; Future Plans/Funding Issues, Outreach, and Amendments; and Technical Assistance/Support Sought from SAMHSA.

Informally, State representatives were asked to think about the following issues:

- What substance abuse and mental health services are covered in your benefits package?
- What is missing from your current benefits package? Will it be expanded?
- Are you planning an amendment, and if so, where are you in the process?
- How can SAMHSA help?

Common Themes and Concerns

- Attendees appreciated the opportunity to share their experiences and learn from representatives from other States. For some, the regional meeting was the first time they had met potential CHIP team members from other agencies.
- Community forums are invaluable to explore aspects of the application process and benefits package features, as well as effective outreach and enrollment campaigns.
- Many States expected funding to come from tobacco settlements.
- Adolescent services can be difficult to access and provide.

Technical Assistance Requests

- How to increase well-child screenings and use of EPSDT
- Models and evaluations of treatment for inhalant and methamphetamine abuse
- How to use the Federal 10-percent-of-administration-fund allowance for outreach
- Identify and implement a standard substance abuse severity assessment tool for youth
- Contract language standards for HMO agreements
- Outreach activities
- Comparable State information exchange