STATE HEALTH POLICY

Briefing

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REAUTHORIZING SCHIP: Principles, Issues And Ideas From State Directors

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State Health Policy Briefing provides an overview and analysis of emerging issues and developments in state health policy.

With Congress debating the reauthorization of the State Children's Health Insurance Program (SCHIP), this *State Health Policy Briefing* seeks to inform the federal legislators and other policymakers working on reauthorizing legislation, as well as others who are concerned about the program's future, about the views of state SCHIP program directors. The brief, first published in April 2007, has been updated and is being re-issued to address changes in the policy landscape that have occurred since that time. The brief was developed by the National Academy for State Health Policy (NASHP) through a workgroup of state SCHIP directors, and was reviewed by all directors. NASHP's work with SCHIP directors, including the development of this brief, is made possible through the generous support of the David and Lucile Packard Foundation as part of broader efforts to provide assistance and report on state SCHIP programs since the program's inception.

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The State Children's Health Insurance Program (SCHIP) deservedly enjoys broad support as a successful program. That success rests on a legislative foundation enacted as a result of careful bi-partisan compromise. Title XXI of the Social Security Act established a federal-state partnership program with a delicate balance of state flexibility and core program requirements. SCHIP was created with the goal to provide health coverage for low-income uninsured children. This essential program, now serving over seven million annually, is again up for reauthorization this year.

Reauthorizing SCHIP, first published in April 2007, was developed to inform federal policymakers then working on legislation to renew SCHIP, as well as others concerned with the program's future, about the views of state SCHIP directors. The April 2007 brief built upon the 2005 report *"Perspectives on Reauthorization: SCHIP Directors Weigh In."* The present publication updates the April 2007 brief primarily to address changes in the policy landscape that have occurred since that time. These reports have been developed by the National Academy for State Health Policy (NASHP) in conjunction with state SCHIP directors through the generous support of the David and Lucile Packard Foundation as part of broader efforts to provide assistance and report on state SCHIP programs since the program's inception.

This document describes the views of SCHIP directors on key issues at stake in the reauthorization process. The April 2007 brief was the product of a workgroup of 15 states

representing varying SCHIP program types from across the country, convened by NASHP to identify important issues, review information and recommendations from other key stakeholders, and discuss commonly held as well as differing views. The group met by phone and communicated electronically from January through March 2007. The results of the workgroup discussions were summarized in a draft brief, shared with all SCHIP programs across the country, and discussed at a March 2007 meeting attended by the majority of state programs. The April 2007 brief was finalized based on this meeting.

With SCHIP reauthorization delayed but now again on the horizon, NASHP reconvened the original workgroup in September 2008. Members of the workgroup reviewed the April 2007 brief to recommend updates. The workgroup's recommendations were discussed with all SCHIP directors attending the Annual Preconference Meeting for SCHIP directors held by NASHP in October 2008. Final revisions were subsequently recommended by the workgroup and sent to all SCHIP directors for feedback in December 2008. This revised edition of *Reauthorizing SCHIP* is the result. This updated brief reflects added emphasis on a few issues raised in the April 2007 brief as well as a small number of new issues that have surfaced since that time. These revisions address changes in federal policy after the April 2007 brief was published. While the brief does not capture all of the views of all of the states on all issues relevant to reauthorization, it does represent the views of most state SCHIP directors on issues of priority concern to them.

1. SCHIP funding should be renewed and increased substantially to provide sufficient and predictable funds for states to effectively manage programs and reduce the number of uninsured.

States responded to federal options in implementing programs to address state objectives. State SCHIP programs now cover over 7 million individuals annually. Most enrollees are children. But some states also provide coverage to pregnant women and parents, and a number have provided coverage to childless adults. (The Deficit Reduction of Act of 2005, however, mandated that coverage of childless adults be phased out, and the Centers for Medicare and Medicaid Services (CMS) no longer approves waivers for such coverage.) Over the past decade, states have used the flexibility afforded them to cover these individuals through different pathways and on different timetables. The structure of SCHIP – including the statutory redistribution mechanism and other federal policies, such as federal encouragement to use and approval of waivers to cover more of the uninsured – strongly influenced the decisions states made. States successfully utilized the flexibility inherent in SCHIP to initiate and build programs in ways that fit the needs of their states' children and families – both when states started up their programs and as their needs changed over time. The result today is a successful program nationwide, which reflects the diversity of state responses to federal policies and to their own residents' needs and circumstances.

State SCHIP programs have evolved to fit with the economies, health care systems, values, politics, and fiscal capacities of their states. Most states have been able to raise income eligibility for children up to at least 200 percent of the federal poverty level (FPL), although many eligible children in these states remain unenrolled. Six states, most of which are spending all of their allotted funds, have not yet been able to set eligibility levels high enough to reach children with family incomes up to that level. Over one-third of all states reach uninsured children in families with income over 200 percent FPL, or have covered parents or pregnant women with the intent of improving child coverage and health. State directors share a common vision and many common goals for coverage, access to quality care, and improved health for children and, ultimately, for everyone, but states are at different points along a number of possible pathways to achieving that vision.

Future funding needs to be substantially increased over the course of the next five years. SCHIP directors are united in concluding that SCHIP is a successful program that should be renewed with substantial additional funding that allows the program to grow and meet more of the need in the nation for health insurance coverage. The highest federal annual allotment provided in past years will not support the program today. Future funding levels need to be increased substantially to account for state success over the past decade in covering increasing numbers of children for whom private insurance is either unavailable or unaffordable and in enrolling greater proportions of those who already are eligible but not enrolled.

State directors also strongly agree that funding should be stable and predictable in order to allow them to adequately plan for program maintenance and growth. Annual appropria-

tions provided many states with more funds than they could spend in the early start up years, and insufficient funds later on as their programs expanded and matured. This funding structure, coupled with the different starting points and pacing of states in developing their programs, led some states to rely on redistributed funding, and more recently, short term federal relief for states experiencing shortfalls. The redistribution system provided little advance notice of amounts that would be available and just one year to spend the redistributed funds, making it very hard for states to plan and manage their programs effectively. The uncertainty surrounding SCHIP reauthorization in 2007, and the ultimate year-end action that provided a short-term extension of the program through March 31, 2009, rendered state planning and management of SCHIP in 2008 and 2009, much less future years, extremely difficult. Without stability in federal funding, states simply are more reluctant to conduct outreach or make program improvements requiring longer-term investment.

Predictability, stability, and growth over time are critical for effective program management. SCHIP directors believe that the total SCHIP appropriation should increase steadily over a five-year authorization period, taking into account population growth and cost increases, including health care cost inflation.

The funding structure needs to be reconsidered. There is fairly broad agreement among state SCHIP directors that the funding formula needs to be revisited. In particular, directors are concerned that use of the number of uninsured children within the current formula can penalize states for being effective in enrolling more children. Collectively, SCHIP directors have identified a number of factors which federal policymakers might consider for inclusion in a revised formula. These potential formula factors include enrollment levels, eligible but unenrolled populations, regional differences in cost of living, and state coverage levels for children at the time of SCHIP enactment. Directors also have concerns about the use of Current Population Survey data in the formula, as these data are often inconsistent with data that many states collect. State directors urge careful analysis and consultation with states in consideration of any alternative funding formulas and data sources.

State SCHIP directors' views vary on the extent to which and how funding should be structured in covering targeted low-income children, other children needing health insurance, pregnant women (whose coverage can improve child health outcomes), parents (whose coverage can boost rates of children's enrollment), or others. As noted previously, six states have not been able to set program eligibility as high as the target level of 200 percent of FPL, while many other states have been able to reach uninsured children above that level, and a number of states do or have covered parents or pregnant women. This variation again reflects the differing circumstances of states at the time of SCHIP enactment and over time, as well as prior federal encouragement and approval for covering parents, pregnant women, and others.

2. SCHIP and Medicaid play vital, complementary roles in covering children and adolescents, and each program needs to be maintained and strengthened.

SCHIP and Medicaid work in tandem. SCHIP was designed to build on Medicaid, to support states in covering uninsured children not eligible for Medicaid when SCHIP was enacted. States had the choice to implement SCHIP through a Medicaid expansion, a separate program that could work in conjunction with Medicaid to cover more uninsured children, or through a combination of both approaches. In 2005, approximately 29 million children were covered through Medicaid funding and 6.1 million children through SCHIP.

As the nation and states focused attention over the past decade on enrolling children eligible for SCHIP, policy and systems improvements were made in both Medicaid and SCHIP. As of January 2008, for example, almost all states (46) had eliminated the asset test and in-person interviews for children's eligibility in both programs. As more states have implemented separate programs, they also have worked to improve the coordination between Medicaid and SCHIP. As of January 2008, for example, the vast majority of states with a separate SCHIP program (31 of 39) used the same application for both Medicaid and SCHIP. Other common strategies to promote coordination between the two programs include: aligning eligibility criteria and employing the same staff to determine eligibility for both programs; expanding the locations at which, and technologies through which, families can apply for coverage; developing administrative verification capability; and adopting presumptive eligibility. State efforts to simplify eligibility and streamline the application process have been critical to improving enrollment in both programs.

There should be greater consistency and more options for SCHIP and Medicaid eligibility. SCHIP's successes have been built on the shoulders of the Medicaid program, and SCHIP has driven system improvements in both programs. State directors need continued flexibility to use and combine Medicaid and separate program approaches and to make the interface between them work smoothly for children and families.

State directors see elimination of inconsistent and inequitable federal eligibility rules as important to states and families. Currently, states cannot enroll uninsured children whose parents are state employees in their separate SCHIP programs, although they can enroll such children in Medicaid and they can enroll children of federal employees in both programs. States would like the eligibility rules for separate SCHIP programs aligned with those of Medicaid expansion programs to allow for consistent and equitable treatment of children of state and federal employees.

States also would like the option to cover all legal resident children. The federal welfare reform law barred coverage of such children for the first five years of their residency. Some states cover these children with state funds; other states do not. Including these children as an optional group would enable more states to cover them and promote better health for all children.

Additional flexibilities are needed to enroll or retain specific groups of children who are eligible for Medicaid, in order to make the two programs as seamless as possible for families. Fluctuations in family income mean that children frequently move between the two programs. Policies and procedures to avoid or diminish breaks in coverage are essential to ensuring that children and families maintain access to critical preventive and treatment services, and directors would like increased flexibility to ensure continuity of coverage for children whose family incomes change.

States also would like the option to give families who have children eligible for both programs the choice to enroll all children in a family in one program – either Medicaid or SCHIP – in order to keep the children together in one plan and reduce the burdens on parents. Since states get a higher federal matching rate for children enrolled in SCHIP, state directors propose that they receive the lower Medicaid match for children who are Medicaid-eligible but opt for enrollment in SCHIP. This would eliminate any financial incentive that states might have to encourage families to choose SCHIP over Medicaid. Finally, some states have raised the possibility of having the option to cover youth up to age 21 with SCHIP funds, something that is permitted under Medicaid.

States which expand Medicaid coverage of children should have the option to use SCHIP funds or their regular Medicaid matching rate and funds. States have the option to draw down federal funds from their SCHIP allotment by expanding coverage of children under their Medicaid program or by establishing a separate program. Due to limited SCHIP funds, some states have sought to expand coverage to children under Medicaid and claim regular Medicaid federal funding at their regular federal match, thereby leaving more SCHIP funds available to cover children at incomes higher than the Medicaid levels. The Centers for Medicare and Medicaid Services (CMS), however, recently has interpreted the statute to require that states which expand Medicaid coverage of children above the level covered as of June 1997 (when SCHIP was passed), must draw down funds for such children from their SCHIP allotment. This interpretation has limited these states' ability to cover greater numbers of uninsured children. SCHIP directors believe that CMS' interpretation is inconsistent with the purpose of the program, and states should have the option to use either federal Medicaid or SCHIP funding streams in order to make most effective use of both programs in covering uninsured children.

3. The progress that states have achieved in simplifying enrollment for children and families should be supported and not hampered by federal program requirements.

Simplification is a state success story. Some of the greatest state success stories in SCHIP are about the simplifications in enrollment and renewal processes for families. As noted, nearly all states have eliminated the asset test and in-person interview requirement. Over two-thirds of all states allow mail-in applications for children, and increasing numbers accept faxed applications, take applications over the phone, or are developing electronic applications and administrative verification. The majority allow families to apply at provider locations, and a growing number permit providers and other qualified entities to determine whether children are presumptively eligible for coverage, pending a complete review by the state. Most programs also have lengthened the period between renewals to the least frequent (12 months) permitted under federal law,

thereby reducing the likelihood that children will lose coverage for failing to complete required paperwork.

New documentation requirements for citizens threaten to reverse this enrollment progress. Provisions in the Deficit Reduction Act (DRA) of 2005 require citizens to prove their identity and citizenship in order to obtain Medicaid. The regulations implementing this law include the need to present original (not photocopied) documents, a provision that particularly undermines the effectiveness of mail-in applications and the elimination of the in-person interview. In many states, the new requirements have resulted in major delays, and some states have documented a significant decline in enrollment in public coverage.

These rules directly affect SCHIP Medicaid expansion programs, which must follow federal Medicaid policy. But they also have a major impact on separate SCHIP programs. As noted earlier, most states with separate programs have one application form for both SCHIP and Medicaid. This means that any new requirements attached to Medicaid affect the application process for SCHIP-eligible children, unless the state reverses progress and develops separate applications for each program. In addition, SCHIP programs must refer children potentially eligible for Medicaid to that program, so that these children are affected. Most SCHIP directors believe the citizenship documentation requirements should be rescinded or modified substantially, and should not be applied to separate SCHIP programs.

States need tools to carry out essential outreach, enrollment, and retention activities. State experience has shown that outreach, enrollment, and retention activities are integral to effective program management in achieving the goal of insuring children. Ongoing attention to these functions is critical, as the need to reach, enroll, and retain children and families is continual. Families move in and out of state; they change jobs; their incomes fluctuate; and their access to employer sponsored insurance changes. To ensure effective ongoing strategies, state programs need access to funding, research, and best practices. To effectively manage their programs within capped funding, states need the flexibility to determine when outreach should be increased, and when slowed down. While it should not come at the expense of funding for coverage, funding for outreach is critical. For this reason, state SCHIP directors recommend that outreach funding not be subject to the current 10 percent administrative cap.

Additionally, the directors seek flexibility to implement "express lane" or "auto enrollment" systems that allow enrollment in or income determinations from certain other public programs to count as proof of eligibility for SCHIP. If accompanied by assurances that such "deeming" will not be disallowed in federal audits, such a streamlined approach holds great promise for improving enrollment and retention.

State flexibility in specific areas of program design has been an important component of SCHIP's success and should be supported and enhanced.

4. State flexibility was part of SCHIP's design and has contributed to its wide base of support.

The state flexibility that was an integral part of the SCHIP program's design has been key to its success. States have tailored marketing, enrollment, benefits, service delivery systems and other key features of their programs to the circumstances and culture of their states. This state tailoring has led to broad based support at the state and national levels. State directors believe maintaining such flexibility is vital to the continued support and success of SCHIP.

More flexibility to coordinate with private coverage could meet more of children's needs. State SCHIP directors are very concerned with the erosion in employer-based coverage, as well as market trends toward limited-benefit health insurance products that may not address children's needs for preventive developmental services. Additionally, directors are keenly aware of substantial unmet service needs, particularly in the areas of oral health and mental health benefits. The directors would like to have more options to help families keep children and youth enrolled in the private market and have critical health needs met.

One option is providing assistance to families in paying private coverage premiums. While the SCHIP law does allow states to provide such premium assistance, numerous programmatic and administrative requirements make it very difficult to operate a successful and cost-effective program. In 2005, most of the states which had premium assistance programs paid for by SCHIP funds did so through federal waivers; no separate state SCHIP program operated a premium assistance program under a state plan.

States also would like the option to provide benefits that often are not covered for children enrolled in private plans. This could be accomplished by amending the definition of "targeted low income child" to include children with creditable but less-than-comprehensive coverage, or by allowing states to offer supplemental benefits for children with private coverage that does not include important services, such as dental, mental health, vision, hearing, or prescription drugs. Another option would be to allow states to offer supplemental benefits as a health services initiative, but as a category that is exempt from the 10 percent cap.

Flexibility to set income standards and methodologies appropriate for state circumstances should be maintained. When the federal legislation authorizing SCHIP was first enacted, only eight states provided coverage for children above the levels mandated under Medicaid (133 percent FPL for children under age 6; 100 percent FPL for children ages 6 – 18). Today, all but six states provide coverage for children in families with income up to 200 percent FPL, and over one-third of all states provide coverage at incomes above that level. The varying eligibility levels reflect variations in family income, cost of living, and health care costs across states. As experience with SCHIP has matured and the cost of health insurance has risen, states are finding that private group and individual health insurance coverage is unavailable or unaffordable even for many more moderate-income families. States also are finding that covering children at higher income levels is proving to be an effective strategy to reach eligible but unenrolled children at lower income levels.

Policies announced by CMS during 2007 and 2008, including the August 17, 2007 directive addressing substitution of public for private coverage, have created significant roadblocks to state efforts to ensure that more uninsured children have access to affordable coverage. While SCHIP directors agree that preventing substitution of coverage is a worthwhile goal, the anti-crowd out measures imposed by the August 17 directive are not grounded in an evidentiary base and were not developed in consultation with states. Most SCHIP directors believe that the August 17 directive should be rescinded; that state flexibility to adopt income standards and methods that best fit state circumstances and achieve federal program purposes should be maintained; and that states and the federal government should work together to examine and develop effective strategies for reducing crowd out of private coverage as public coverage is expanded.

5. States should be supported in their efforts to improve program performance and promote access to quality care.

The federal-state partnership is the foundation for program improvement. States are committed to effective program management and accountability, operating within the capped funding and program flexibility of SCHIP. The SCHIP statute provides a good framework for state reporting, and states worked cooperatively with the federal government to develop a standard reporting format which has been improved over time. States also worked with the federal government to develop core performance measures to be reported on a voluntary basis. While standard performance measures raise challenging technical and resource issues, within two years a majority of states were reporting on all four core measures. Beginning in FY 2006, states also now report on quality improvement initiatives.

States are implementing quality improvement strategies tailored to their states' systems. States also have implemented various policies to ensure that program participants have access to quality care. These strategies differ by state, and by delivery system: managed care, Primary Care Case Management (PCCM)-based, and fee-for-service. Most SCHIP programs that deliver services through managed care systems consider factors related to access and quality when selecting contractors; have contract provisions, including cultural and linguistic requirements that promote access to quality care; and monitor contractor performance to ensure that program expectations are met. Many of these programs also use program performance data to help participants make a choice of health plans, produce public reports on health plan performance, and conduct quality improvement projects. PCCM-based programs use various reimbursement and provider requirements strategies to promote access. To ensure quality, programs with PCCM-based systems may conduct enrollee surveys to assess access and quality. States with fee-for-service based systems have adopted a variety of strategies to improve quality as well – e.g., surveying participants to gather information about access and quality and promoting medical homes.

Federal oversight is overly focused on payment errors, draining state resources. Recent new federal requirements under the Payment Error Rate Measurement (PERM) system have directed limited administrative resources and state focus toward measuring errors. State directors believe that program

accountability should continue to focus on performance in reaching and enrolling eligibles, reducing numbers of uninsured, and improving access and outcomes, and not disproportionately on the burdensome and bureaucratic federal payment error measurement system.

PERM has not been implemented through a federal-state partnership approach. Methods were not developed in consultation with SCHIP directors, and have been implemented with little advance notice or technical assistance. As currently structured, PERM represents a significant administrative burden on state SCHIP programs, which is further exacerbated in the current fiscal climate. States have received conflicting and confusing guidance from the Centers for Medicare and Medicaid Services (CMS) and its Regional Offices. Auditors often are unfamiliar with program rules and policies established for SCHIP programs. Definitions of errors often are inconsistent with, and threaten to undermine, progress made in simplifying the program. The rules also do not provide adequate adjustment for services provided in a capitated versus a fee-for-service environment.

SCHIP directors believe that in implementing PERM, CMS has used a bureaucratic hammer in an area where significant problems have not been documented, and implementation has been burdensome and expensive. In the case of SCHIP, which has an administrative cost cap, the resources that must be devoted to PERM audits take away from administrative efforts in outreach, enrollment, quality measurement, and improvement. The costs of PERM audits should be 100 percent federally-funded and outside the 10 percent administrative cap. PERM reviews also should be temporarily suspended and CMS should be required to revisit the PERM implementation requirements, in consultation with state SCHIP directors, and to issue clear, uniform guidance to all states. The different incentives in capitated versus fee-for-service environments should be taken into account in the guidance. CMS also should be prohibited from requiring a uniform sampling platform, as has been required. States included in the 2007 or 2008 reviews should not be penalized for high error rates found as a result of a faulty PERM review process.

States want assistance to strengthen measurement and improve performance and quality. State directors found the federal technical assistance for SCHIP performance measurement that was provided for several years to be very important in helping states develop and improve reporting of core performance measures. Technical assistance, which was discontinued, should be reinstated; the federal-state partnership for performance measurement needs to be renewed. The directors also believe the federal government should strengthen leadership and resources for working in partnership with states to review and develop optional new child health quality measures. These measures should be relevant to and used not only by SCHIP, but also by Medicaid and other programs which fund or provide health services for children. Currently, standard measures are not available, and federal agencies do not have a well-funded or coordinated effort in place to develop them. State SCHIP directors are ready and interested in working with other state and federal partners and experts to develop strategies to improve measurement of child health care quality.

Conclusion

State SCHIP directors are committed to working with federal and state policymakers, the private sector, advocates, and other key stakeholders to promote successful reauthorization of the SCHIP program. SCHIP has been resoundingly successful over the past decade in providing coverage to uninsured children, and reauthorization that provides sufficient, stable, and predictable funding and retains and expands the kinds of flexibility that have contributed to SCHIP's success is essential. For more information about state SCHIP programs, go to www.chipcentral.org, or call NASHP at 202-903-0101.

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The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

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