

IV. Findings and Recommendations

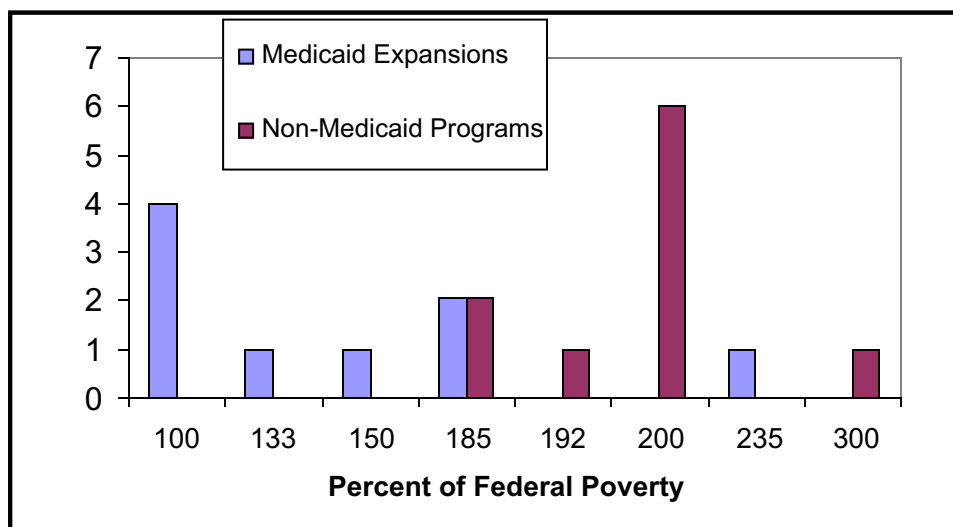
This chapter provides information from the interviews conducted with representatives from the 12 states. The first section includes general information on the states' programs/plans (e.g., program type, age and income eligibility), while the remaining sections provide findings related to the nine issue areas described in Chapter III. Included in these sections are *State Innovations and Highlights* – specific examples of how states can structure and operate their CHIP programs to ensure their maximum impact on adolescent health. Finally, we include recommendations for each of the nine areas. These recommendations are based on information gathered during the interviews, as well as previous literature, research and advocacy in the areas of adolescent health policy, financing, service delivery and program evaluation. Although these recommendations are primarily aimed at states themselves – governors, health departments, Title V programs, and CHIP programs – many will be of interest to providers, health plans, advocates, adolescents, and their families.

PROGRAM/PLAN INFORMATION

Of the 12 states we surveyed, two (N.M. and Wis.) are implementing a Medicaid expansion; three (Colo., N.C., and Utah) chose to create or expand a non-Medicaid program; and seven (Ala., Calif., Conn., Fla., Ill., Mass., and N.Y.) are implementing a combination of the two.

All 12 states are using at least some portion of their CHIP program to provide coverage to adolescents, with every state covering adolescents up to age 18 or 19. Income guidelines are significantly more generous for non-Medicaid programs than for Medicaid expansions (see Figure IV.1). For Medicaid expansions, four states (Ala., Calif., Fla., and N.Y.) set their income eligibility ceiling at 100 percent of federal poverty; one (Ill.) established a ceiling of 133 percent; one (Mass.) uses 150 percent as its limit; two (Conn. and Wis.²⁴) use 185 percent; and New Mexico covers children and adolescents with family incomes up to 235 percent of federal poverty. Income limits

Figure IV.1:
Eligibility Ceilings for 12 States CHIP Programs



²⁴ Under BadgerCare, teens must have family incomes under 185 percent to qualify initially; however, they can maintain eligibility after enrollment with family incomes up to 200 percent of federal poverty.

New and Improved or Just Newly Funded?

Before Title XXI, several states already had innovative programs in place that subsidized insurance coverage for low-income children and adolescents. These initiatives – such as the Blue Cross/Blue Shield Caring Program for Children – were provided variously through state sponsorship, the private market, or a public/private partnership, and were typically financed through a combination of state general funds, earmarked taxes, foundation or federal grants, member contributions, and private donations. Under CHIP, states can now receive federal assistance for programs such as these, as long as they meet specified criteria contained in the Title XXI legislation. Programs in Florida, New York and Pennsylvania were explicitly cited in the legislation as providing comprehensive state-based coverage and thus qualify for CHIP funding. In addition, the Colorado CHIP program is an extension of a state initiative called The Colorado Child Health Plan (CHP), which subsidizes insurance coverage for children and adolescents in families with incomes up to 185 percent of federal poverty. The CHIP program is called Child Health Plan Plus (CHP+), and builds directly on the original CHP.

It should also be noted that many states have maintained additional programs that provide health insurance coverage to children and adolescents who do not qualify for Medicaid or CHIP. In Massachusetts, for example, the Children’s Medical Security Plan (CMSP) provides preventive services on a sliding scale to all children and adolescents with family incomes above 200 percent of federal poverty, including undocumented immigrants. Although the benefit package covered under CMSP is narrow relative to Medicaid or CHIP, it is a critical component of that state’s commitment to ensuring all young people have access to primary and preventive health care services. In California, two dedicated programs – California Kids and Kaiser Permanente Cares for Kids Child Health Plan – provide coverage for defined groups of uninsured children and adolescents up to age 19 through the private market. To qualify for California Kids, teens must live in families with incomes between 200 percent and 300 percent of federal poverty guidelines and not be eligible for the state’s Medicaid or CHIP programs; the benefit package covers basic preventive and primary health care services, as well as emergency and preventive dental care. Eligibility criteria for Kaiser Permanente Cares for Kids are similar, but the income ceiling is 275 percent of poverty and the benefit package includes hospitalization. Both programs require a monthly contribution from families based on the family’s income.

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for non-Medicaid CHIP programs range from 185 percent in two states (Colo. and Ill.) to 300 percent in Connecticut. The majority of programs (Ala., Calif., Fla., Mass., N.C., and Utah) use 200 percent as their income eligibility ceiling for adolescents. Under its newly proposed Medicaid expansion, New York will cover 0-19 year-olds with family incomes up to 192

percent of federal poverty. In our sample, only two states (Ala. and Calif.) retained separate income eligibility requirements for children and adolescents.²⁵ (For more detailed information on the 12 states’ CHIP program/plans, please refer to Appendix C.)

²⁵ Medi-Cal, the state’s Medicaid program, has expanded eligibility to 200% of federal poverty for 0-1 year-olds, while 1-5 year-olds are only covered up to 133%, and 6-18 year-olds to 100%. Healthy Families, the state’s new insurance program, then covers children and adolescents up to 200%. Alabama’s Medicaid expansion goes to 133% of poverty for 0-6 year-olds but only 100 percent for those ages 7-19 years.

The Name Game

States have shown remarkable creativity in naming their Medicaid, Medicaid expansion, and CHIP programs. The 12 states in our study illustrate the range of possibilities.

- ALL Kids (Alabama)
- Healthy Families (California)
- Child Health Plan Plus (Colorado)
- Health Care for Uninsured Children and Youth (HUSKY) (Connecticut)
- Healthy Kids (Florida)
- KidCare (Illinois)
- MassHealth (Massachusetts)
- SALUD! (New Mexico)²⁶
- Child Health Plus (New York)
- North Carolina Health Choice for Children
- Utah Children’s Health Insurance Program
- BadgerCare (Wisconsin)²⁷

Although the states in this study were selected in part because they had made significant progress in implementing their CHIP programs, some have just begun enrolling children and adolescents. Several of the states have submitted amendments since the first interview, with New York recently adding a Medicaid expansion component to its official CHIP plan.²⁸

At the time of this writing, over 500,000 children had been enrolled in these 12 states’ CHIP programs; approximately 30 percent of these were adolescents (unpublished HCFA and state data). The proportion of CHIP enrollees who are adolescent ranges from 24 percent in California to 44 percent in Illinois, and reflects multiple factors, including CHIP eligibility; previous Medicaid and other program eligibility; length of time elapsed since program inception; and state population/demographics.

Most, but not all, states we interviewed are using a managed care delivery model for at least some of their CHIP enrollees. Managed care arrangements are more common in non-rural (urban and suburban) areas, with some states using managed care systems in selected counties only. With non-Medicaid programs, managed care is more likely to be mandatory than with

Medicaid, where states are still struggling with federal waivers and related regulations. Under federal law, for example, children and adolescents with special health care needs can not be enrolled in a mandatory Medicaid managed care plan without a waiver.

BENEFIT PACKAGE

Why does a benefit package matter?

Understanding the level and type of benefits covered by various health insurance programs is one way to compare and contrast these programs. For adolescents, access to comprehensive, age-appropriate services requires both that the types of services they need are covered, and that these services are available in a sufficient number. Limits on the number of services enrollees can receive (e.g., a ceiling on outpatient mental health or substance abuse visits) may lead to adolescents being “underinsured” and unable to receive the comprehensive care they need. For adolescents eligible for CHIP, certain types of services may be more critical than others. Preventive care, reproductive health, mental health, substance abuse, and dental care all provide significant benefit to this population, but are often neglected or limited in programs designed primarily for adults or children.

²⁶ SALUD! is New Mexico’s Medicaid expansion program.

²⁷ BadgerCare is Wisconsin’s name for its Medicaid expansion program.

²⁸ States can amend their plans at any time, and amendments can be effective immediately, even before they are submitted **unless** the amendment restricts eligibility or benefits, in which case there are federal and state restrictions.

Results: What do states include in their CHIP benefit packages?

Although not reflected in our sample, the trend in CHIP programs nationwide leans heavily toward Medicaid expansion; however, plans have the option to submit amendments at any time and, as implementation continues, more states are choosing to add a new child health insurance program.

The ten states in our sample that include a non-Medicaid child health insurance program model their benefit packages on a variety of benchmarks. North Carolina and Utah both base their CHIP program benefits on state employee benefit plans; North Carolina supplements its Health Choice for Children program with dental, optical and hearing services, as well as Medicaid-equivalent benefits for children with special health care needs. Using the CalPERS retirement system as its benchmark, the California Healthy Families program provides mental health coverage equal to 30 days of inpatient hospitalization and 20 outpatient visits annually; plans may, with the agreement of the subscriber or “responsible adult” if appropriate, substitute for each day of inpatient hospitalization the following: two days of residential treatment, three days of day care, or four outpatient visits. And Colorado’s Child Health Plan Plus builds on its Children’s Basic Health Plan, with benefits based on the “standard plan” defined in Colorado’s small group insurance reform law. Services are provided by HMOs willing to contract with Medicaid or through direct contracts with providers in parts of the state not covered by HMOs.

■ **Only two states (Colo. and N.M.) indicated that they included specific provisions for adolescents in their benefit packages.** Other respondents stated that they did not feel it was necessary to make special provisions for adolescents because the benefit package was so inclusive as to make special provisions unnecessary. For example, Utah reported that some services (such as those for reproductive health) were included in the package with the understanding that they would only be used by adolescent enrollees.

■ **All 12 states surveyed indicate that they include some coverage for family planning services and preventive gynecological care in their CHIP benefit package.** In states choosing Medicaid expansion, these benefits are covered automatically. However, in North Carolina, no prenatal or maternity care is included in the new state plan, as the vast majority of pregnant teens are eligible for the state’s Medicaid for Pregnant Women program. In Colorado, adolescents can access reproductive health care, treatment for sexually-transmitted infections, and prenatal care without a referral from their primary care provider.

■ **Reproductive services for adolescents were cited by five states (Ala., Calif., Colo., N.M., and Utah) as one of the most pressing issues for adolescents under CHIP.** These states expressed a desire to address the following issues: pregnancy prevention; reducing the number of low birthweight infants; increasing the availability of STI and HIV screening and treatment; and ensuring access to annual family planning exams for sexually active adolescents.

■ **All 12 states surveyed indicated that they had some level of mental health coverage in their benefit package, but the amount and type of services varied significantly from state to state.** Connecticut offers 60 visits per year for both inpatient and outpatient substance abuse treatment under its new CHIP program. A more limited package of 20 visits for outpatient substance abuse services is offered by Alabama, California, Colorado and Florida. In states with Medicaid expansion, substance abuse treatment is covered under EPSDT for adolescent enrollees.

■ **Medicaid expansion programs traditionally follow federal requirements regarding mental health coverage and substance abuse.** Based on the written descriptions of benefits, CHIP programs that choose Medicaid expansions can offer the widest range and most comprehensive coverage of mental health and substance abuse

treatment services. The coverage for inpatient mental health services in non-Medicaid programs ranges from 72 hours per episode in Alabama to 60 days in Connecticut, with Florida covering 15 days, California 30 days, and Colorado 45 days.²⁹ Generally, coverage for outpatient mental health services is also limited. In North Carolina, adolescents who require more than 26 visits per year (for both mental health and substance abuse) require pre-certification from the plan. In the other 11 states surveyed, the amount of coverage was generally limited to between 20 and 30 visits annually. Legislation that attempts to ensure parity of coverage between physical and mental health services for Medicare and other health insurers has been introduced, with potential ramifications for both Medicaid and CHIP.

- **Five states (Ala., Calif., Colo., N.M., and Utah) indicated that mental health benefits were one of the priority concerns they would like to see addressed for adolescents under CHIP.** These states identified early identification and intervention for mental health and substance abuse problems as desired outcomes for newly developed/redesigned programs.
- **Eleven states included dental coverage in their CHIP plans.** Only Colorado's new program does not include dental care. Although the state legislature recently authorized a separate dental program which would reach the CHIP-eligible population, funding for this program has not been allocated.
- **Non-Medicaid expansion programs generally include full coverage for most preventive dental services.** Five states require co-payments (generally \$5) for non-preventive dental services. Connecticut requires co-payments only for crown and bridge, root canals, dentures, and extraction under the HUSKY B program.

- **Two states (Ala. and Utah) indicated that dental health care is a priority concern that they would like to see better addressed in their CHIP programs.** (For more information, see Appendix B.)
- **Family coverage (using CHIP funding to cover all family members) is being considered by several states as a way to extend benefits to a larger segment of the uninsured population.** Title XXI allows states to request a waiver, or "variance," for purchase of family coverage under a group health plan that includes coverage of targeted low-income children, if the state can prove that such purchase is cost-effective and family coverage will not substitute for other insurance coverage. Wisconsin's Phase II BadgerCare proposal to cover families under Title XXI was approved by HCFA in January 1999; two other states (Mass. and N.Y.) indicated that they were exploring this option.

State Innovations and Highlights

- **Florida:** Prior to the passage of Title XXI, policymakers in Florida recognized the need to provide health insurance coverage for low-income children and adolescents not eligible for Medicaid. They also recognized the need to develop creative partnerships in providing this coverage. In 1992, Florida developed the Healthy Kids program, which laid the groundwork for relationships among a wide range of interested groups. Healthy Kids is based on the concept that school systems can create large groups of children and adolescents who qualify for group health insurance. Healthy Kids currently contracts with eight private managed care organizations to provide a defined benefit package to enrolled students. A long-term program goal is to have these managed care organizations open service sites at participating schools (School Health Resource Services, 1997).

Healthy Kids offers a comprehensive benefit package that includes: well-child visits, immunizations,

²⁹ This limit increases to 90 treatment days per enrollment period when pre-authorization is obtained.

SPOTLIGHT: NEW MEXICO

New Mexico's Phase I CHIP program is an expansion of coverage for children and adolescents in families with incomes between 186-235 percent of the federal poverty guidelines in the state's Medicaid managed care program.

Under its Phase II proposal to HCFA, New Mexico would establish a wraparound program administered on a fee-for-service basis by the state. The wraparound services would cover all children and adolescents from ages 0-19. Services covered by the program would include:

- ← Developmental Disabilities Services;
- ← Behavioral Health Respite Services;
- ← Home Visiting;
- ← Medical Child Care Services;
- ← Behavioral/Physical Health Risk Reduction (early identification, assessment and intervention);
- ← School-Based/School-Linked Risk Reduction (health, mental health and substance abuse prevention services and coordination); and
- ← Preventive Dental Services.

New Mexico's decision to develop this innovative approach is based on an assessment of how to best meet the needs of its children and youth. Several issues unique to this state have further influenced the state's policy decisions. For example, family incomes in the range of 186-235 percent of federal poverty guidelines are considered middle income in New Mexico, and providing publicly funded health care services to middle-income families is somewhat controversial. However, because the population eligible for this program is fairly small, the decision was made to include the wraparound services for the entire Medicaid population. In addition, the unique needs of American Indians, who comprise a substantial proportion of the state population, necessitated that traditional medicine and healers be included in the benefit package.

primary and specialty care, physician office visits, laboratory testing, inpatient care, surgical procedures, emergency services and transportation, prescriptions, vision screening and eyeglasses, hearing screening and hearing aids, physical therapy, mental health services, prenatal care and delivery, transplants, a \$1 million lifetime maximum, and no limitation on preexisting conditions. The broad coverage encompassed in the benefit package encourages low-income families to seek preventive services as well as treatment for their previously uninsured children and adolescents. Including a wide range of services in the benefit package also helps to highlight the potential of generous insurance coverage to improve health outcomes for previously uninsured children and adolescents.

Recommendations: What should states include in their benefit packages for adolescents under CHIP?

- **Include age-appropriate clinical preventive services in the benefit package.** As discussed earlier, preventive care is important to the long-term health of adolescents. Benefit packages which encourage the use of preventive services by limiting cost-sharing will increase the likelihood that adolescents will seek health care services earlier.
- **Establish age-appropriate periodicity schedules for clinical preventive health visits.** States should update their EPSDT periodicity schedules to reflect prevailing national recommendations for annual well-adolescent exams. Although the American Academy of Pediatrics, American Medical Association, and Maternal and Child Health Bureau all recommend annual well exams for adolescents, many states' periodicity schedules for EPSDT cover these exams only every two years. These schedules should be amended to support more frequent visits for teens enrolled in CHIP programs.

- **Regardless of what type of program states implement, the available benefits should be as comprehensive as possible.** Medicaid's EPSDT program is a good model for meeting the wide range of adolescent health care needs.
- **Contraception, family planning, and other reproductive health care services are necessary components of a comprehensive benefit plan for adolescents.** These should be included in any non-Medicaid benefit package and maintained as part of Medicaid coverage.
- **Provide the same level of coverage for mental health/substance abuse services as for other forms of health care.** Historically, coverage for mental health and substance abuse has been much more limited than for other types of care. Parity of coverage is critical for adolescents under CHIP.
- **States are using a variety of creative strategies to facilitate enrollment.** Strategies include: community-based outreach workers; eligibility workers "outstationed" at provider and other community sites; and computer programs that screen for eligibility at a range of community service intake points. Statewide hotlines that facilitate enrollment have been established or are planned in all 50 states and are being used to help families with issues ranging from completing the application form to answering questions about CHIP and Medicaid. In addition to helping states centralize information and client services, hotlines enable them to combine application, eligibility, and enrollment data systems (National Governors' Association, 1999).
- **In states where more targeted outreach is being conducted, the most common efforts are flyers and/or brochures about CHIP targeted to adolescents.** Two states (Colo. and Mass.) have developed materials specifically for adolescents. Massachusetts developed a *Teen Choices* brochure that explains the importance of preventive services for adolescents and includes information about the availability of adolescent providers in the state; the state also printed flyers and posters geared towards adolescents. In Colorado, adolescents are provided with a packet of information about CHIP which was developed specifically for them.
- **Eight states (Colo., Fla., Ill., Mass., N.M., N.C., Utah, and Wis.) indicated that they had developed specific activities to target at-risk or high-risk youth.** These efforts target a range of youth, including: adolescents in homeless or runaway shelters (Colo., Fla., N.C., and Wis.); youth recently released from correctional facilities (Colo.); and teens in alternative education and GED programs (Ill.) While many states have at least initiated efforts to target at-risk youth, many of

OUTREACH AND ENROLLMENT

Why are outreach and enrollment important?

Comprehensive outreach strategies and streamlined enrollment procedures are critical to assuring that eligible adolescents are enrolled in CHIP. Outreach and enrollment efforts have been and remain a high priority for many states in the implementation phases of CHIP, as states work to identify and enroll eligible adolescents in this new program.

Results: What adolescent-specific outreach and enrollment strategies are states using?

- **As required by Title XXI, all states are conducting some form of outreach and enrollment to adolescents.** All states are using schools and school-based health centers as key sites for these efforts. Seven (Ala., Colo., Mass., N.M., Ill., N.C., and Utah) of the 12 states surveyed reported targeting outreach activities to the adolescent population, although many of these efforts also target children.

SPOTLIGHT: ALABAMA

In Escambia County, Alabama, local pediatrician Dr. Marsha Raulerson, received a \$10,000 grant from the pharmaceutical company Wyeth Lederle to conduct an outreach project that targeted adolescents. Dr. Raulerson identified seven of her adolescent patients who agreed to participate in CHIP outreach efforts to other adolescents in their county. A college student served as the director of the initiative and provided guidance for the teens. The students participated in these efforts beginning in February 1998 and continued through the summer.

The students began the outreach initiative by conducting focus groups with other adolescents in the county in order to identify local adolescents' needs and desires for health care. They also sponsored a number of receptions with local ministers and counselors in order to increase their awareness about ALL Kids and encourage them to spread the word about the program to other adolescents.

The teens distributed ALL Kids materials in numerous locations, including physicians' offices, post offices, and convenience stores throughout the county. The students also collaborated with a local hospital to obtain the names of patients under 19 years of age who were uninsured; they then attempted to reach these patients. (This information was released to the students with the understanding that the patient information would be used solely for ALL Kids outreach efforts and that their confidentiality would not be compromised.) When student athletes were at school to have their mandatory physicals prior to the school year, the teens were there to distribute information to the hundreds of student athletes about the program.

The students' efforts did not go unnoticed by community members. Local hospitals donated postage costs for mailing ALL Kids information and also donated room space to hold meetings and receptions. In addition, the Alabama Medical Association donated funds for the purchase of bright yellow tee shirts that had information printed on them about ALL Kids. The students wore these tee shirts to school to increase awareness about the program.

The outreach efforts headed by Dr. Raulerson appear to have been extremely successful. In one local hospital, the percentage of children and youth coming in without insurance dropped from 25 percent to 11 percent. The grant funds provided leverage for additional funds and support from area hospitals and other community groups. As a result, grant funds are available to support tentative plans for another outreach initiative for the summer of 1999.

SPOTLIGHT: CALIFORNIA

In California, enrollment of Latino children and adolescents in the state's Healthy Families program lags far behind need and eligibility projections. When the federal government announced its new interpretation of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (see page 20), the California Primary Care Association (CPCA) launched *It's Important!* – a TV, radio and print ad campaign aimed at enrolling Latinos in Medicaid and Healthy Families. Seeking to spread the word that receiving public health care assistance poses no threat to immigrants fearful of deportation or delayed citizenship, the campaign – funded with a private foundation grant – will feature a toll-free telephone number with 24-hour bilingual operators to guide callers to local health services, clinic posters urging families to sign up, and TV commercials that show Latino parents bringing their children to local clinics.

these are focused on outreach and enrollment and not on service delivery or improving health outcomes for members. Many states have not yet grappled with how to actually serve these teens under their new CHIP programs. However, nearly all of the states surveyed appreciated the need to target at-risk youth.

Recommendations: What can states do to improve outreach and enrollment for adolescents under CHIP?

- **Specifically target outreach and enrollment efforts to high-risk youth.** Adolescents at-risk include homeless/runaway youth, adolescents living in foster care, youth who have recently been released from correctional facilities, adolescents with limited English skills, teens in alternative education or GED programs, and other special populations, including gay/lesbian/bisexual/transgender youth. For example, states could train outreach workers to work with transitional social workers in order to ensure that young people being released from youth detention centers were screened for CHIP eligibility and enrolled if eligible.
 - **Train hotline operators to answer questions frequently posed by adolescents.** Hotline operators should be equipped to deal with questions concerning the location of convenient enrollment sites for adolescents, the availability of adolescent-oriented providers, and policies regarding confidential access to services under states' CHIP programs.
 - **Simplify application and enrollment procedures.** Wherever possible, states should combine application forms and processes with other need-based programs such as Free/Reduced Price School Lunches. States should also combine their Medicaid and non-Medicaid application forms, coordinating the review of these forms across the programs. Finally, states should waive excessive documentation requirements not mandated by federal law.
- **Develop CHIP promotional materials that are targeted to adolescents.** These materials should be developed with youth input.
 - **Locate outreach efforts and eligibility workers in areas that adolescents frequent.** Such sites might include community centers, youth-serving organizations, schools, school-based health centers, vocational schools, and community colleges.

ASSURING ACCESS TO CARE

Why is assuring access to care for adolescents under CHIP so critical?

Eligibility levels that states establish for their CHIP programs are critical to assuring access to care for adolescents; access to care for adolescents is influenced by a variety of factors beyond health insurance itself. Early reports are encouraging, indicating that states are taking advantage of the opportunities presented by CHIP to increase eligibility levels for adolescents. According to a recent report by the National Governors' Association (NGA), states have greatly increased eligibility levels for certain subgroups of children and adolescents compared with eligibility levels from 1997. The median eligibility level for children ages six and older was 100 percent of poverty in 1997, compared with 185 percent of poverty for the same group in 1998 (National Governors' Association, 1999).

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Results: What are states doing to assure access to care for adolescents under CHIP?

- **Few states identified provisions to reduce barriers to care specifically for adolescents.** Most of the states interviewed for this study address access issues for all CHIP enrollees – children and adolescents – within the state's CHIP program. Most are using managed care organizations to deliver services under CHIP, and respondents indicated that barriers to access would be addressed by the managed care organizations with which the state contracted. Few respondents, however, were knowledgeable about specific provisions included in their states' MCO contracts which might mitigate barriers to access for adolescents.
- **A major concern for states is ensuring that adolescents enrolled in CHIP establish a medical home.** In Alabama, for example, the state works with health plan contractors to identify young people who do not visit a primary care provider within the first 60 days of their enrollment. The health plans' contractors review claims data to identify possible patterns and monitor ER data, in conjunction with the health plans, to ensure that adolescents' use of emergency services is appropriate.
- **Eight states (Ala., Fla., Ill., Mass., N.Y., N.M., N.C., and Wis.) indicated that they had implemented specific provisions to reduce financial barriers to care for adolescents under CHIP.** Strategies to reduce cost-sharing include: limiting co-payments and/or premiums to families with incomes over 150 percent of federal poverty guidelines (Ala., N.C., and Wis.); maintaining a single premium (\$15/month) regardless of family size (Fla.); eliminating all co-payments (N.Y.); and establishing low average co-payments (\$5/visit) (N.M.). In New Mexico, services provided at Indian Health Service facilities, urban Indian providers, and Tribal 639 clinics are exempt from cost-sharing.
- **Nine states (Ala., Calif., Colo., Fla., Ill., Mass., N.M., N.Y., and Wis.) permit adolescent specialists to function as primary care providers (PCPs) according to the state's CHIP plan.** In these states, adolescents and their families were most frequently made aware of this option through a list of adolescent specialists in the provider roster and other materials provided by MCOs.
- **Most of the states surveyed indicated that they do not specifically identify adolescent-oriented providers.**
- **Some states are facilitating adolescents' independent access to providers.** Massachusetts has a provision that enables adolescents to select their own primary care provider independent of their parent or guardian. In Colorado, adolescents are not required to obtain a primary care provider referral for reproductive and mental health services.

- **Some states are trying to ensure that eligible immigrants are able to access their CHIP programs.** In New Mexico, for example, a parent's social security number is not required on the Medicaid/CHIP application, thus eliminating this barrier for eligible adolescents with non-citizen parents.
- **Establish an adolescent "hotline" to provide information to adolescents on how to most effectively enroll for CHIP and utilize CHIP services.**
- **Establish mechanisms that enable adolescents to select and access their own primary care providers (PCPs) separate from their families.** Teens should have the option of selecting a general practitioner as their PCP. States and health plans also need to inform adolescents and family members of this option and of the roles and focus areas of various providers' practices.

Recommendations: What can states do to improve access to CHIP for adolescents?

- **Identify Board-eligible and/or Board-certified Adolescent Medicine Specialists to serve as PCPs, subspecialty consultants, and referral sources for primary care gatekeepers.**
- **Encourage adolescent providers who have training and skills in providing primary care and care coordination to act as primary care providers for adolescent CHIP enrollees.** Those with skills in providing primary reproductive health, mental health, and substance abuse treatment will be valuable as adolescent PCPs.
- **Encourage self-designation as an adolescent provider by those who are committed to working with adolescents.**
- **Clearly identify adolescent-oriented providers and services in CHIP and health plan marketing materials.**
- **Educate adolescents and their families about how to access various primary, specialty and subspecialty services (e.g., enrollment procedures, gatekeeper referrals for specialty care, grievance procedures).**
- **Do not require that parents include their social security numbers on adolescents' enrollment applications.** Such requirements only act as a barrier to immigrant families with fears of deportation. In fact, federal law states that the citizenship status of parents may not be taken into account when determining a child or adolescent's eligibility status.

CONFIDENTIALITY

Why is confidentiality important for adolescents?

As states develop and implement their CHIP programs, they have the opportunity to ensure that confidentiality protections already in place for adolescents are comprehensively utilized by the health plans and providers with which they contract. They also have the option to include language in their CHIP contracts that delineates how confidentiality for adolescents must be addressed. The ways in which states address these issues may be an important indicator of how likely adolescents will be to seek care under their states' CHIP programs.

Results: What are states doing to address confidentiality issues?

- **Five states (Calif., Colo., Conn., Fla., and Mass.) cited confidentiality concerns as a priority issue for adolescents under their CHIP programs.** Respondents from these states described wanting to respect the privacy of adolescents, their ability to access confidential services, and the need to address limits on confidentiality as a potential barrier to access for specialty services such as mental health or family planning.

SPOTLIGHT: CALIFORNIA

The goal of California’s *Medi-Cal Minor Consent Program* is to ensure that adolescents can access certain types of health care services without parental consent. The program allows youth ages 12 and older the opportunity to apply for Medi-Cal coverage for specified “sensitive services” without parental consent and specifically prohibits providers or eligibility workers from notifying parents about this coverage or the provision of related services under the program. Minor consent services include: outpatient mental health treatment/counseling, outpatient substance abuse treatment, pregnancy testing and pregnancy-related care, family planning services, and sexual assault services. Under the provisions of this program, adolescents age 12 and up can apply for individual Medi-Cal coverage based on their own assets; in other words, their families’ financial status is not used in calculating eligibility. In addition, verification procedures are much less stringent than those used to determine eligibility for full-scope Medi-Cal. Being able to apply for insurance that covers these sensitive services and that is based on their own resources provides adolescents with a valuable opportunity to receive needed services for which there might otherwise be multiple barriers.

One disadvantage of this program is that eligibility for the *Minor Consent Program* must be re-determined by an eligibility worker on a monthly basis.³⁰ This requirement creates a significant barrier for adolescents, who may not remember or be willing to come in for a monthly face-to-face meeting with the Medi-Cal Eligibility Worker. In an attempt to reduce this barrier, the Alameda County Health Care Services Agency (Alameda County is just east of San Francisco, and includes the cities of Oakland and Berkeley) has requested a waiver in regulatory procedures to allow 12-month continuous eligibility for all minor consent services in Alameda County. If granted, this waiver would significantly improve adolescents’ access to minor consent services and, as a result, it is expected that youth will better utilize these much-needed services and demonstrate improved health outcomes.

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- **Most states did not develop specific confidentiality provisions for adolescents under their CHIP programs.** States have the flexibility to establish mechanisms that protect adolescent confidentiality within the confines of state law: for example, they can require that managed care plans under CHIP not send Explanations of Benefits to the homes of adolescent enrollees. Most respondents, however, stated that their CHIP programs had not developed such mechanisms.
- **Only certain categories of adolescents – such as those who are emancipated, pregnant, parenting, or married – can apply for CHIP coverage independent of their parents.** In Illinois only, minors can apply for CHIP programs on their own; however, they must declare their parents’ income if they live at home.

³⁰ This requirement is waived for adolescents receiving outpatient mental health services. Providers who certify that a young person will benefit from outpatient mental health care without parental consent or involvement specify the estimated length of treatment, and eligibility is customarily extended for that length of time.

- **All 12 states responded that adolescents can consent for some services confidentially.** The types of services included were: family planning; pregnancy testing and prenatal care; testing and treatment for sexually-transmitted infections; and some outpatient mental health and substance abuse services. For example, New York state law allows minors to receive services related to emergency health care; family planning; STI testing and treatment; certain mental health, alcohol and substance abuse services; and HIV testing (but not treatment) without parental consent. In a recent referendum, Colorado voters passed legislation which requires parental consent for adolescents to receive abortion services, although pending legal processes have prevented this legislation from being implemented.
- **Many states are relying on managed care organizations to address adolescents' confidentiality concerns.** Health plans in the commercial market may be less aware of the need for adolescent-sensitive policies; however, contracts with MCOs can address these concerns. For example, Wisconsin has written specific language into its contracts to address confidentiality of medical records; under the MassHealth program in Massachusetts, neither managed care plans nor the PCC plan send an Explanation of Benefits (EOB) to adolescents' homes following service delivery.

Recommendations: What can states do to ensure that adolescents have access to confidential services?

Specific measures can be taken to ensure that adolescents' confidentiality concerns are addressed under new CHIP programs. Most of these measures can be explicitly written into contracts; however, their implementation will take place largely at the service delivery level. For example, providers who care for adolescents should clearly understand the scope of confidentiality protections and their limits in their respective states. Adolescent "safety net" providers may be more familiar with confidentiality laws – another reason to

include these providers in CHIP provider networks. Because confidentiality laws change over time, however, a system of continuing education and consultation for providers and health plans may need to be established (English and Knopf, 1999).

- **Establish procedures to assure confidentiality for services that minors can access without parental consent.** These services should include, at a minimum: preventive reproductive care, including screening for pregnancy, HIV and sexually-transmitted infections; family planning counseling and contraceptive options; treatment for sexually-transmitted infections; and outpatient mental health and substance abuse services. In all cases, providers should encourage adolescents to speak to a parent or other adult about their health care needs if they feel safe doing so.
- **Include specific requirements related to state confidentiality laws in CHIP contracts with MCOs and providers.** Since state programs must follow state law regarding adolescent confidentiality, explicitly re-stating those laws in contracts with providers and managed care organizations would help to increase awareness of the laws, and help assure that these laws are fully adhered to by MCOs and providers.
- **Work with health plans to increase awareness of adolescent health confidentiality laws.** Systems for training and continuing education should include those programs and staff involved in caring for adolescents under states' CHIP programs.
- **Educate adolescents about the confidentiality protections available to them.** In order to be informed consumers of health care, it is crucial that adolescents themselves be informed about the circumstances under which they may consent to their own care and other confidentiality protections available to them. This may take place through information delivered by providers or through a wider education campaign conducted by the state and its partners. Providers should also have written policies about the conditions

under which issues discussed with an adolescent client can be revealed to a parent (e.g., suicidal ideation or threats of violence). Policies should also be in place that urge adolescents to share with their parents or guardians information about their health and health care. Such policies should not only be written, but reviewed frequently at staff meetings and with new employees.

- **Allow adolescents to obtain confidential services without a referral from their primary care provider.** Teens who continue to see a family pediatrician as their PCP may be reluctant to initiate discussions about sensitive topics such as sexuality, contraception or substance use. To ensure that other providers are willing to deliver these services, states might want to reimburse them for this type of care on a fee-for-service basis.
- 40 ■ **Design and implement information systems that protect adolescent confidentiality.** For example, systems for storing, accessing and transferring medical records should ensure that confidential information is maintained in strict accordance with legal protections. Some providers use separate charts or sections in the chart for information concerning confidential services over which minors can control disclosure. Other providers maintain simple or elaborate “dummy systems” for coding sensitive information such as HIV test results.
- **Monitor providers’ and health plans’ compliance with confidentiality protections for adolescent enrollees.** Health plans and providers can be assessed for how well they follow adolescent confidentiality provisions under their CHIP contracts. Adolescents themselves can also be surveyed about this using new tools being developed by the Foundation for Accountability (see page 23).

ADOLESCENTS WITH SPECIAL NEEDS

Why is it important for states to address adolescents with special needs under their CHIP programs?

How states will serve adolescents with special health care needs and at-risk adolescents under CHIP programs is still unclear. One report written early in states’ implementation of CHIP indicates that, for the most part, states had not structured their CHIP programs with particular attention to youth with special health care needs; however, a number of states were pursuing innovative strategies in this area (Fox, 1998).

Because at-risk adolescents often receive health care services in non-traditional settings, it is important for states to consider ways to include these and other health and social service systems in their CHIP program design. Linkages to the public health, social service and juvenile justice systems are critical. Assuring that school-based health centers and other community providers such as local health departments and federally qualified health centers (FQHCs) are deemed essential community providers under state CHIP programs is also instrumental in ensuring that these youth receive high-quality, comprehensive, continuous and coordinated care.

Results: How are states addressing adolescents with special needs under CHIP?

- **All 12 states indicated that adolescents were covered under the benefit package designed for children with special health care needs.** Few states, however, indicated that there were any special provisions for these adolescents either in the state’s benefit package or in their outreach and enrollment efforts. (Appendix C contains detailed information about the 12 states’ programs for children and adolescents with special health care needs.)

- **Eligibility and care for youth with special health care needs under CHIP differs from state to state.** For example, in Florida, adolescents with special health care needs who are eligible for CHIP are served through a special managed care plan; those with mental health problems are served through a separate behavioral health plan. In California, youth with special health care needs receive primary care from the Healthy Families Program (the state’s new child health insurance program) and specialty services from the Title V children’s services program – a special carveout from the state’s CHIP plan. In Colorado and North Carolina, these adolescents receive “wraparound” specialty services for services above and beyond those covered by the state CHIP plan through a special needs component administered by the state Title V CSHCN program. In Connecticut, youth with special health care needs receive services under two separate state plans (HUSKY Plus Physical and HUSKY Plus Behavioral). And in Massachusetts, adolescents who meet the criteria for disability under the federal Supplemental Security Income (SSI) definition are eligible for Medicaid coverage regardless of their family income.
- **States’ efforts to address the needs of at-risk youth under CHIP are still in the very early stages of development.** The predominant efforts were those targeting at-risk youth through outreach and enrollment activities.
- **Several states are targeting a variety of settings where more vulnerable youth may be identified.** These settings include: youth-serving organizations (N.M.), juvenile justice systems (Colo.), youth recently released from corrections facilities (Colo.), migrant programs (Utah), homeless and runaway shelters (Colo., Fla., N.C., and Wis.), native tribal communities (Colo., N.C., and Wis.), GED and alternative education sites (Ill.), and “at-risk school districts” (Mass. and Utah). In New Mexico, social workers and other staff in the Children’s Medical Services program within the state Department of Health have been trained and certified as Presumptive Eligibility/Medicaid

SPOTLIGHT: FLORIDA

In Florida, eligible adolescents with special health needs receive services through the Children’s Medical Services (CMS) Network. The CMS Network is operated by Florida’s Children’s Medical Services – the state’s Title V program for children with special health care needs. Under CHIP, the CMS program has developed and operates integrated delivery systems that form a statewide system of care. CMS provides children and youth with special health care needs with a family-centered, comprehensive, and coordinated system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric care.

Through CMS, the state is making efforts to specifically serve adolescents with special needs enrolled in CHIP. CMS currently operates four clinics that focus on the delivery of services for adolescents with special needs: University of Miami; University of Southern Florida; University of Florida; and the CMS local office in West Palm Beach. Physicians at these clinics are internists or pediatricians who specialize in adolescent health. They are trained to be sensitive to the needs of adolescents, and are well-equipped to deal with sensitive issues such as diet, nutrition and sexuality. These physicians work as members of a team that may include social workers, dietitians and other providers with specialized training and experience with adolescent populations. Some of the clinics also sponsor special adolescent and young adult group programs and seminars that are organized and administered by medical residents. These programs provide support for adolescents with self-image and transition issues.

Case managers for adolescents with special needs refer adolescents to these clinics. Once an adolescent is seen at the clinic, the physician can serve as his or her primary care provider (PCP), ideally through the transition into adulthood. Each CMS adolescent has a transition plan as part of his/her family support plan. When appropriate, clients are referred to various community-based agencies such as the Vocational Rehabilitation School to Work Program, Centers for Independent Living, and Developmental Services.

On-Site Application Assistance (PE/MOSAA) providers, allowing them to enroll into Medicaid and CHIP the eligible children and adolescents with special health care needs with whom they work. Although, several states are addressing at-risk youth in their outreach and enrollment efforts, few have yet addressed how these adolescents will be served once they are enrolled.

State Innovations and Highlights

- **Connecticut.** Connecticut's HUSKY Plan includes a "HUSKY Plus" component that provides two supplemental benefit packages to provide services to children and adolescents with intensive physical and/or behavioral health needs. Special physical needs are addressed through the state's Title V centers and the state contracts with the Yale Child Study Center to provide special services related to behavioral health needs.

Recommendations: What can states do to address adolescents with special needs in their CHIP programs?

- **Establish higher income eligibility ceilings for youth with special health care needs.** As described earlier, states can provide more generous CHIP coverage for adolescents with special health care needs, or enroll youth with higher family incomes in their Medicaid programs.
- **Use risk adjustment methods to ensure that health plans and providers enroll and serve adolescents with special needs.** If providers and managed care organizations are not compensated for the additional costs of serving populations with special needs, they will tend to avoid enrolling or providing care to these populations. Methods to adjust risk include enhanced capitation rates; incentive payments; and other provisions that spread the risk of high-risk populations among providers and health plans equitably. As states become increasingly sophisticated purchasers of care, they can help to support the development, testing and implementation of more advanced risk adjustment methods.

SPOTLIGHT: COLORADO

In Colorado, Rocky Mountain Youth MNC, Inc., a local nonprofit health organization based in Denver, is conducting outreach efforts to enroll at-risk youth to the Child Health Plan Plus (CHP+) program, Colorado's non-Medicaid CHIP program. The organization conducts outreach to runaway and homeless youth who live at Urban Peak, a Denver-based shelter.

Urban Peak is a daytime drop-in center and emergency overnight shelter for homeless and runaway youth. It provides a safe haven from the streets, in addition to counseling, food, clothing, housing assistance, job referrals, education assistance, medical care, legal aid, HIV testing and counseling, street outreach, recreation, and other services.

Providers from Rocky Mountain Youth began delivering services to youth at Urban Peak in the early 1990s. Rocky Mountain Youth had identified Urban Peak as a site where adolescents did not understand how to be consumers of health care; many of them were using the emergency room as their source of primary care. Since that time, an on-site clinic has been developed at Urban Peak and youth are now able to receive health services at the shelter as well as at the main Rocky Mountain Youth clinic.

When CHP+ was implemented, Rocky Mountain Youth began efforts to enroll Urban Peak youth into the program. At the start of the CHIP program, Urban Peak youth were referred to the main Rocky Mountain Youth clinic to enroll; however, there were numerous barriers to this process. Soon thereafter, Rocky Mountain Youth committed to sending an outreach worker to Urban Peak for a few hours once a week. The outreach worker helps Urban Peak youth with applying for and enrolling in CHP+.

In Spring 1999, Rocky Mountain Youth began tracking numbers of youth enrolled in CHP+ based on this partnership. Although preliminary reports suggest that the partnership has been successful, it is still too early to determine the success of the outreach program.

- **Ensure access to a broad range of specialty services, especially mental health and substance abuse services, with reasonable or no cost-sharing.** Other important specialty services include case management, respite care and nutritional services.
- **Ensure that provider networks established under CHIP include providers with the specialized expertise necessary to serve adolescents with special needs.**
- **Establish more generous benefits for adolescents with special health care needs.** Expanded benefit packages could include higher spending limits for durable medical equipment and coverage of home visiting and respite care; greater allowable numbers of occupational and physical therapy visits; and greater allowable numbers of inpatient and outpatient mental health and substance abuse services.
- **Assure that case managers and care coordinators are trained and knowledgeable about transition programs for adolescents with special health care needs.** As they approach adulthood, these teens may need assistance in making the transition from pediatric to adult health care systems. Such assistance has become a primary focus of states' Title V CSHCN programs, and CHIP programs should take advantage of this special emphasis.
- **In states where mental health services are provided as a separate program or carveout from the basic CHIP program, develop mechanisms to assure that care is coordinated between the two systems.**
- **Establish relationships with providers and community-based organizations that serve at-risk youth (e.g., homeless and runaway shelters).**
- **Build or enhance coordination and linkages between CHIP and other systems that serve adolescents with special needs.** These systems include public health, education, mental health, social services, juvenile justice, vocational rehabilitation, and transition programs for adolescents with special needs (programs that assist adolescents who may need assistance making the transition from pediatrics to adult health care).
- **Assure that community providers (e.g., school-based health centers, family planning clinics, local health departments and federally qualified health centers (FQHCs)) are deemed essential community providers.** These "safety net" providers have traditionally served low-income adolescents, who may be familiar and comfortable with them. This comfort will help to encourage utilization of cost-effective primary care and preventive services.
- **Involve at-risk adolescents and adolescents with special health care needs, as well as their families, in key areas of CHIP design and implementation, including outreach and enrollment, benefit package, and quality assurance.** Input from these stakeholders is critical to assuring a responsive, effective program that meets the needs of adolescents with special needs.

SCHOOL-BASED/SCHOOL-LINKED HEALTH CENTERS

Why are school-based/school-linked health centers (SBHCs) important for CHIP?

SBHCs are a valuable resource in states' arsenals for reaching and serving adolescents under their CHIP programs. Every state interviewed for this brief had at least some school-based health centers and was utilizing these centers in some capacity. And yet, it appears that many states are underutilizing SBHCs in their CHIP strategies.

Results: What are states doing about SBHCs under CHIP?

All 12 of the states interviewed were home to some SBHCs, ranging from three in Utah to 158 in New York. All of the respondents also noted that they were including schools and SBHCs in their CHIP outreach and enrollment efforts. On the other hand, there were significant discrepancies in the extent to which states were using or planning to use SBHCs as delivery sites for services under their CHIP programs and/or including SBHCs as essential community providers (ECPs) in these programs.

With respect to SBHCs, states seem to be following similar strategies under CHIP as they did with Medicaid managed care. Although this "mirroring" approach may allow for consistency and ease of implementation, it often neglects the important role that SBHCs could play in new, more flexible programs. States that merely encourage managed care organizations to collaborate or contract with SBHCs may find that health plans are reluctant to do so. Barriers to MCOs' contracting with SBHCs include lack of knowledge about the role of SBHCs and the scope of services they provide; a belief that the existing provider network is adequate; unwillingness to invest the administrative and contracting resources in a small, "niche" provider; concerns about the quality of care provided at SBHCs; and/or strict requirements that SBHCs can not always meet (e.g., 24-hour, year-round medical coverage).

There are many possible explanations for this phenomenon. Given the very rapid progression from legislation to planning to implementation, many states have not had time to consider, debate and include language that specifically addresses SBHCs beyond a very basic level. Others may be hesitant to promote the use of SBHCs given that there have been controversies regarding their delivery of reproductive health care services and because parents are not on-site when their children receive services. Still others may be unsure of ways to use contracting language or other tools to promote the inclusion of SBHCs. Finally, it is clear that some of the individuals and agencies charged with planning and implementing state CHIP programs are not familiar with SBHCs or their role in delivering health care services.

- **All 12 states are proactively engaging schools and SBHCs in outreach and enrollment efforts for their CHIP programs** (see *Outreach and Enrollment*). For example, a television station in Illinois aired a segment on SBHCs, their function, and how parents can get an application package for KidCare – the state's Medicaid look-alike plan – at their local school-based health center. SBHC staff are also given presentations on KidCare by CHIP staff. In Massachusetts, family planning providers who conduct outreach for CHIP are working closely with SBHCs and the state Department of Public Health to identify and enroll eligible youth. In New Mexico, school and SBHC staff have been trained and certified as Presumptive Eligibility/Medicaid On-Site Application Assistance providers, and thus can enroll adolescents directly into Medicaid and CHIP.
- **Few states are actively assuring SBHC participation in their CHIP networks.** Six of the states interviewed indicated that SBHCs could be included in CHIP plans' provider networks, either as primary care or adjunct providers, *at the health plans' discretion*. Many states have followed a similar path with their Medicaid managed care programs – deferring to the health plans with respect to their provider networks and allowing, or

perhaps encouraging, but not requiring, that SBHCs be represented or included. In Illinois, MCOs are required to contract with SBHCs only to share and coordinate information on common clients; no payment/reimbursement relationship is explicitly mandated. Similar provisions are in place in Alabama and California.

- **Some states are encouraging CHIP plans to contract with SBHCs.** In Massachusetts, for example, health plans are “strongly encouraged” to establish contracts with SBHCs and to set quality assurance and improvement goals jointly with the state in the area of school-based health. The state has developed quality standards for SBHCs, which SBHCs must meet in order to be reimbursed by MassHealth for services delivered. MCOs can make their own reimbursement arrangements with SBHCs, but have been informed that they have to comply with the state’s quality standards.
- **Only five states (Colo., Conn., Ill., N.C., and Wis.) are including SBHCs as essential community providers (ECPs).**
- **Only two states are requiring that managed care plans under CHIP contract with school-based health centers.** On January 1, 1999, New York joined Connecticut in its requirement that managed care insurers under Medicaid and its new child health insurance program, Child Health Plus, contract with SBHCs. The goal of this requirement is to promote a seamless system of coverage for enrolled members. Managed care plans contracting with Connecticut under HUSKY A are required to contract with SBHCs as ECPs.
- **Reimbursement practices for SBHCs appear to vary by state, type of plan (Medicaid expansion vs. new child health insurance program), managed care vs. fee-for-service arrangement, health plan/insurer, county/locality, and provider/service type.** The primary types of reimbursement described for SBHCs were fee-for-service and capitation, with some variation in each category. Although this was far

from an exhaustive survey of states, in general, it appears that SBHCs that are contracted as primary care providers are paid on a per-member per-month (capitated) basis, while SBHCs that act as supplemental or adjunct providers receive primarily fee-for-service payments. Contracts that cover only specified services, such as immunizations, EPSDT, or case management, are also more likely to be fee-for-service than those that include the entire continuum of primary and specialty outpatient care.

- **Some states are “carving out” school-based health care from the CHIP benefit package and capitation rate paid to health plans, allowing SBHCs to bill the state directly on a fee-for-service basis.** In Illinois, for example, certified SBHCs can acquire a special status that allows them to bill directly for their services. This arrangement is similar to the one many states use under Medicaid managed care.
- **Four states (Ala., Colo., Mass., and N.M.) indicated that they would like to explore and potentially expand the role of SBHCs in their CHIP programs.** For example, school-based and school-linked services will be included in New Mexico’s Phase II wraparound program. Active involvement in CHIP by staff from the state’s Office of School Health increases the likelihood that the role of SBHCs will be expanded. Representatives from Colorado indicated that they would like to address HMOs’ reimbursement of SBHCs and inclusion in their provider networks.

State Innovations and Highlights

- **Colorado.** In Colorado, collaboration between managed care plans and school-based health centers has a long history. Under Medicaid managed care and CHP+, SBHCs are essential community providers, with which health plans must make a “good faith effort” to contract; prospects for contracting are therefore more contingent on good relationship-building than on legislative requirements.

Colorado's health department was actively involved in designing CHIP legislation – including the benefit package and enrollment strategies – and in the process, the department educated other agency staff about the role that SBHCs could play within CHIP. Under the state's Child Health Plan, the child health insurance plan that preceded CHIP, year-round SBHCs serving as full-service Primary Care Providers (PCPs) were eligible to receive the same capitation rate as other network PCPs.

For years, Kaiser Permanente – one of the largest HMOs in the state – has been working in partnership with local SBHCs and has established its own child health insurance program known as *School Connections*. Assuming a role as one of Colorado's CHIP plans, Kaiser is contracting with SBHCs that are capable of providing services, coordination and data. In return, SBHCs will receive a portion of the capitation rate for primary care and mental health services.

- **New York.** Of all states, New York State has the largest number of SBHCs and provides the highest level of state funding to SBHCs (Guiden, 1998). In addition to its historical financial commitment to the centers, New York has also worked hard to integrate school-based health with managed care delivery systems. Under Medicaid managed care and now CHIP, state officials have issued guidelines for contracts between managed care organizations and SBHCs, requiring that contracts be in place by March 21, 2000.
- **Connecticut.** Connecticut is implementing both a Medicaid expansion program and a new child health insurance product. The two programs are known as HUSKY Part A and Part B, respectively. Managed care plans contracting with the state under HUSKY A are required to contract with SBHCs as essential care providers. Although there is no equivalent mandate for HUSKY B, there is a clear policy expectation that this too will occur with time.

- **Massachusetts.** Most SBHCs in Massachusetts are licensed as primary care providers through community health centers or local hospitals. The Department of Public Health establishes contracts with SBHCs to provide adolescent health services. These contracts require that the centers provide 24-hour coverage and an on-site adolescent specialist, and that they participate in the state's quality improvement program.

Although SBHCs are licensed as PCPs, they can also act as satellite sites under both Medicaid and CHIP. The state is working to improve the ability of the MassHealth Primary Care Clinician (PCC) Plan to coordinate with SBHCs by facilitating meetings between PCCs and SBHC staff.

- **North Carolina.** After months of debate, the North Carolina legislature eventually determined that SBHCs are eligible to be reimbursed by Health Choice, the state's new child health insurance program. The ability of advocates to overturn the initial decision is testament to the powerful alliance that has been forged in this state between schools, families and health care providers in serving children and adolescents "where they are."

Recommendations: How can states include school-based/school-linked health centers in their CHIP plans and programs?

- **In contracts with managed care organizations (MCOs), states should include requirements that MCOs include SBHCs and other adolescent safety net providers in their provider networks.** This is especially true in underserved areas, where services such as reproductive health and mental health/substance abuse services may not be widely available. SBHCs are more likely to play a role in CHIP when there is a strong state agency that requires or encourages the contracting process and an effective state SBHC association that can educate both its members and health

plans about how the two can complement one another. Connecticut and Colorado fit the above model because they have sophisticated SBHC networks and substantial managed care penetration, as well as strong health departments that can educate health plans, the state Medicaid agency and SBHCs about how to include SBHCs in provider networks and CHIP programs.

- **For states that do not want to impose subcontracting requirements on MCOs, consider “carving out” SBHC services or a subset of these services and reimbursing SBHCs for serving CHIP enrollees on a fee-for-service basis.**
- **For states that do not do so at present, consider supporting SBHCs through Title V or other state programs.** These resources can be used to expand or maintain services, create additional programs that address critical health issues, and to help ensure and document the quality of care provided at the centers.
- **States should ensure that CHIP funds are not used to subsidize services supported by other federal programs such as the Individuals with Disabilities Education Act.**

QUALITY ASSURANCE

Why is quality assurance an important component in CHIP programs?

Two distinct but related activities, quality assurance (QA) and program evaluation, help to ensure: (1) that programs are implemented as planned; (2) that target populations are identified and enrolled; (3) that enrolled members utilize covered services appropriately; and (4) that the services delivered are comprehensive, effective and clinically appropriate. These activities, and the way they are designed and implemented, are especially important for adolescents given their historic underutilization of services and unique developmental needs. Information from QA and pro-

gram evaluation efforts can also be used to modify and improve health insurance programs throughout and beyond CHIP implementation. Finally, evaluation results and quality measures permit comparisons among health plans that can inform consumer choices, state purchasing decisions, and allow plans to identify deficiencies and implement improvements over time.

Results: What are states doing in the area of quality assurance?

At the time of the interviews, few states were highly advanced in their planning or implementation of quality assurance for adolescents under CHIP. On the other hand, there is reason for hope – several states are planning more ambitious adolescent-focused initiatives, and almost all respondents acknowledged the need for such targeted systems. Specific findings include the following:

- **Most states relied on service providers and advocates to speak for adolescents in their planning processes.** Unlike children, who are often too early in their cognitive development to understand abstract concepts related to health care, adolescents are an important source of information regarding barriers to access and other factors in designing a health insurance program. And yet, this population was almost entirely overlooked in the mandatory public input process that states underwent prior to submitting their CHIP plans to HCFA. To represent adolescent concerns, states requested input from adolescent providers, advocates and parents. Some states, including Colorado and Utah, have maintained this voice in an ongoing advisory capacity.
- **Most states are taking advantage of established measures for quality assurance within health plans.** California and Connecticut are using HEDIS, for example, and California may use the new Adolescent Health Survey being developed by FACCT when it becomes available.

Table IV.1:

States' Use of Preventive Services Guidelines for Adolescents under CHIP

State	Require	Encourage	Neither require nor encourage	Guidelines/Notes
Alabama	X			American Academy of Pediatrics (AAP)
California	X			AAP; Advisory Committee on Immunization Practices (ACIP) schedule
Colorado		X		Providers receive additional \$30 for using Guidelines for Adolescent Preventive Services (GAPS) or similar questionnaire
Connecticut			X	
Florida		X		AAP
Illinois		X		GAPS
New Mexico			X	GAPS is included in proposed Phase IIA amendment
Massachusetts	X			AAP
New York:				
- Periodicity for well-child visits	X			AAP
- Content of care		X		GAPS and Bright Futures
North Carolina			X	Trying to implement GAPS for Medicaid
Utah:				
- Medicaid	X			Bright Futures
- Child Health Insurance	X			ACIP
Wisconsin		X		Bright Futures/GAPS
TOTAL STATES: ³¹	6	5	3	

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Other states are developing their own practice guidelines for CHIP. For example, officials in New York are developing a special screening tool for adolescents which incorporates GAPS and Bright Futures guidelines. The Massachusetts EPSDT schedule was developed in conjunction with the state chapter of the American Academy of Pediatrics. Health officials in that state are conducting a broad-based campaign to encourage parents, providers and purchasers to follow the EPSDT visit schedule, which requires one health visit per year for adolescents and emphasizes

anticipatory guidance. The state Title V program in Wisconsin has taken a leadership role in disseminating and facilitating training for Bright Futures, and publishing a strong recommendation that adolescent health care delivery should follow Bright Futures and/or GAPS. In Alabama, the use of preventive services guidelines for adolescent members will be one performance measure used to rank providers and health plans under the ALL Kids program. Finally, Colorado's CHIP program reimburses providers an additional \$30 for each GAPS type visit they provide to adolescents.

³¹ Two states (New York and Utah) are included twice because they support two different policies within their CHIP programs.

- **Many states are building on QA systems established under Medicaid.** For example, the North Carolina Medicaid agency is responsible for QA under the state's new child health insurance program, and is working with the state Title V agency to develop a new QA system for this program.
- **Most states are encouraging or requiring the use of preventive service guidelines.** Five states (Ala., Calif., Mass., N.Y., and Utah) are **requiring** that health plans and/or providers use preventive service guidelines with their adolescent patients; five (Colo., Fla., Ill., N.Y., and Wis.) are **encouraging** their use; and only three states (Conn., N.M., and N.C.) have not specifically addressed preventive service guidelines under their CHIP programs. The most frequently cited guidelines were Guidelines for Adolescent Preventive Services (GAPS) and American Academy of Pediatrics (5 each), followed by Bright Futures (3) and the Advisory Committee on Immunization Practices (ACIP) (2).
- **Several states identified the development, use and promotion of guidelines as a priority issue for future years.** In Florida, for example, respondents stated that they would like to promote the use of GAPS within Healthy Kids. New Mexico hopes to establish standards of care for adolescents based on GAPS, and North Carolina is trying to implement GAPS for its Medicaid population.
- **Most states are relying on managed care plans to assure quality for adolescents within their CHIP programs.** In Illinois, for example, enrollment in managed care under CHIP is voluntary; therefore, the rate of members disenrolling from various health plans will serve as an indicator of quality. Wisconsin respondents state that MCOs are responsible for identifying members who under- or over-utilize services and for conducting outreach to these members.
- **Very few states are using contract terms as a mechanism for quality assurance.** Specifying standards for providers and/or health plans in contracts, together with sanctions for non-compliance, is one way states can ensure quality in their CHIP programs. Only respondents from Massachusetts and Illinois in our sample, however, were using contract terms in this way. Massachusetts specifies contractual standards of care, and Illinois includes AAP guidelines in managed care contracts. Wisconsin's Division of Health Care Financing conducts on-site audit reviews of quality indicators specified in its contracts, but has not yet implemented penalties for non-compliance.
- **Many states are planning to incorporate adolescent satisfaction measures in the future.** Massachusetts is pilot testing a survey to assess adolescents' satisfaction with their CHIP providers and/or health plans. This survey was developed based on the Consumer Assessment of Health Plans (CAHPS). California is researching various tools in an effort to design a new instrument focused on adolescents. Alabama plans to survey members directly regarding access to care and, with the health plans, interview program drop-outs to determine their reasons for leaving ALL Kids.
- **Although the fact that states are beginning to view adolescents as discriminating consumers is commendable, adolescent satisfaction measures may fail to illuminate underlying access and outcome issues, especially in an underserved population.**³² In addition, adolescents, even more than adults, may base their assessments of quality on factors such as provider communication skills which, while important aspects of quality, may not be directly related to clinical quality of care. Finally, adolescents often lack benchmarks with which to compare their health care experiences.

³² Studies have revealed that member satisfaction in privately insured populations is highly correlated with access to care, but that lower-income persons and Medicaid recipients do not exhibit such a clear correlation (Ladenheim, 1999; Love, 1999). This suggests that the adolescents targeted for CHIP may not be as sensitive to access barriers when ranking health plans and providers.

SPOTLIGHT: MASSACHUSETTS

Health officials in Massachusetts have operated according to principles of quality assurance and continuous quality improvement (CQI) for years. The state Medicaid agency applies a “quality-focused management approach” to managing its health plans and providers, using data from various sources as the basis for contracting decisions and making this information available to consumers on an annual basis. The state’s underlying philosophy is that regulation and legislation are limited in their ability to improve quality, and that enhanced quality requires using information as a tool in the role of purchaser.

Health plans that contract with the state must participate in the state’s quality improvement program. Each year, the Division of Medical Assistance (DMA) works with plans to establish performance standards, QA goals and quality improvement projects. Together they identify specific areas for improvement both statewide and by plan based on data reported from previous years and comparisons to national benchmarks. This year, three out of six plans have chosen to work on improving well-child care; *two of the three plans are focusing specifically on adolescents*. The state has updated its EPSDT schedule to include annual visits for teens and expects 85 percent of adolescent members to receive annual visits.

In addition, the agency issues a health plan performance report every year that includes information on member satisfaction and outcome measures; this report is intended to help members select plans and help plans improve their performance. One outcome measure is adolescent-specific: the percent of members aged 12-18 who had one or more well visits within the past two years. *In 1997, 73 percent of 12-18 year-olds enrolled in MassHealth³³ had had a well-child visit in the past two years. This compares very favorably to the 32 percent national average for this age group enrolled in private, non-Medicaid HMOs (Matthews, 1999).* Other indicators include access to care (e.g., how easy it is to get an appointment when sick) and cultural competence of providers. Measures are rotated on an annual basis, so the adolescent measure is not included every year.

Massachusetts takes its role as an expert purchaser for the Medicaid and CHIP populations very seriously. In recent years, a contract with a major health plan was not renewed because the plan could not meet the state’s timeframe for enhanced MCO contract standards for mental health/substance abuse services.

The state has also assembled a Child and Adolescent Advisory Group, composed of representatives from the Department of Public Health, DMA, providers, and child/adolescent advocates. This group is actively engaged in quality improvement activities and is currently working to improve the ability of primary care providers to deliver anticipatory guidance to children and adolescents. They will also be sending various adolescent risk assessment tools to providers to help them screen patients and requesting that they document these efforts.

³³ MassHealth refers to the programs administered by the Division of Medical Assistance.

SPOTLIGHT: CALIFORNIA

California's new child health insurance program, Healthy Families, has established a Quality Improvement Work Group (QIWG) to help ensure that the services designed, offered and provided to eligible children and adolescents are appropriate, accessible and high-quality. Funding for the QIWG has been provided primarily by the California HealthCare Foundation; this funding helps to support meetings, travel costs for participants, and the services of a consultant who specializes in health care quality assurance/improvement. Participants include physicians, psychologists and dentists; representatives from private and county-based health plans; local health departments; and advocates. The group also hopes to add a consumer representative (i.e., adolescent and/or parent).

Since August 1998, the QIWG has been developing recommendations on implementing a Quality Accountability Framework for Healthy Families. These recommendations address four key areas: dental quality, HEDIS reporting, consumer satisfaction, and health status assessment. They have also been asked by the Managed Risk Medical Insurance Board (MRMIB), the agency that administers Healthy Families, to consider how cultural and linguistic variables might be incorporated into quality monitoring efforts for Healthy Families. The QIWG has established four subcommittees to address these issues, one of which is focused on adolescent measures. In recognition of the inadequacy of the current HEDIS measures for adolescents, the latter group has been charged with developing adolescent health-related measures, a survey, and/or a focused chart review instrument.

The group has established a framework for purchasing higher quality care for Healthy Families members (children and adolescents); this framework attempts to create clinical quality accountability among both providers and health plans. Detailed measures have been proposed by the consultant for review by the work group. Standards include health plan accreditation by the National Committee for Quality Assurance or the Joint Commission on Accreditation of Healthcare Organizations; use of specified preventive service guidelines; application of a standardized health survey for enrollees; and systematic integration with schools and other community institutions. The group hopes to create incentives for various levels of performance (e.g., to measure provider compliance with evidence-based guidelines for well-child visits and specific conditions). One guiding principle is that quality should be measured across the continuum of care (i.e., monitoring will include those who are very healthy, those who are very ill, and everyone in between).

Although the QIWG is recommending the use of existing instruments where available, they are planning to modify others in order to ensure their relevance. For example, they are recommending that MRMIB require contracting health plans to report the five categories of HEDIS 3.0 measures relevant to children and adolescents one through 19 years old, but that MRMIB replace the adolescent immunization measure included in HEDIS 3.0 with a new measure that addresses counseling services for risk behaviors such as pregnancy, STIs and substance abuse that should occur during an office visit. They are also recommending that Healthy Families automatically incorporate the adolescent satisfaction survey being developed by FACCT and NCQA when it becomes available. It is expected that this survey will be used for members ages 13 through 19 years to complement the use of CAHPS for parents of children one through 12. As with CAHPS, the survey will need to be translated into Healthy Families' 11 threshold languages. In addition, the work group hopes to add questions on behavioral health and assistive services, such as transportation and language interpretation.

Final recommendations from the group will be submitted to MRMIB. They will be available for public comment, after which MRMIB will make decisions about how to proceed. In November 1999, the Board will consider changes to its current contracts based on the QIWG recommendations.

- **Quality assurance is a “work in progress.”** From Colorado to North Carolina, respondents noted that quality assurance was a priority to be addressed at a later date. Mechanisms to ensure quality, including ones that focus on adolescents, were simply not in place at the time of the interviews.
- **Use data from the QA process.** States should be prepared to use this information to help adolescents and their families select health plans and providers; to encourage competition and quality improvement; to shape contracts and contract decisions; and to adjust subsidies, benefits, contracts, and enrollment procedures so that their CHIP programs best meet the needs of eligible adolescents.

State Innovations and Highlights

- **New York:** Health plans that contract with the state through CHIP are required to submit Quality Assurance Reporting Requirements (QARR) on an annual basis. This system captures some adolescent-specific themes and monitors several health indicators relevant to adolescents. In addition, the state is exploring the possibility of conducting focused reviews to assess compliance with elements identified in GAPS.
- **Establish a clearinghouse of materials for states to use in designing and implementing quality assurance activities.** This clearinghouse could include the standardized resources described above, as well as specific tools used in various states to assure quality in CHIP programs for adolescents.

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Recommendations: What should states do to ensure that eligible adolescents are enrolled in CHIP and receive high-quality health care services?

- **Incorporate adolescent-specific professional guidelines for preventive services such as GAPS and Bright Futures.** Mechanisms to accomplish this include legislation, regulations, and contracts with health plans/providers.
- **Establish QA measures and systems that pay specific attention to adolescents and their unique needs.** In developing new measures, states might want to identify a few sentinel issues specific to their adolescent Medicaid and CHIP populations (e.g., injuries, substance abuse, chlamydia, depression) and gather baseline data for the target population.
- **Assure collaboration between Title V, CHIP and Medicaid agencies.** State Title V agencies in particular have valuable experience with data surveillance systems and MCH performance measures.

EVALUATION

Results: How are states planning to evaluate their CHIP programs for adolescents?

Not surprisingly, it appears that states have paid more attention to program design and start-up than to ongoing needs for program evaluation. Even less attention has been paid to mechanisms which specifically ensure that eligible adolescents are enrolled, served, retained, and receive quality services that meet their multiple needs. On the other hand, there are some encouraging findings from several states.

- **Several states have shown ingenuity in partnering with other agencies to help support their evaluation activities.** In California, for example, the Packard Foundation is expected to contribute funding and in-kind resources, while faculty at the University of Alabama at Birmingham will help to conduct the ALL Kids evaluation. North Carolina is working with Sheps Center at University of North Carolina (UNC)-Chapel Hill for the overall evaluation of NC Health Choice for Children, and with UNC-Charlotte to conduct an extensive consumer survey for the program. In New Mexico, a major amendment to the original CHIP plan, together with an extensive evaluation

plan (see *Spotlight*), was developed by a state-wide collaborative group including interagency staff, providers, parents, volunteers, advocates, and school staff.

- **Few states have developed detailed evaluation plans that include adolescent-specific measures.** In many cases, decisions and plans were made quickly, with little opportunity to weigh competing alternatives. Where an existing infrastructure was in place, states often used this, even if it had been designed exclusively or primarily for younger children. And where strong evaluation elements are included, they often fail to address adolescents as a unique population with different needs than younger children or adults.
- **Many states are planning more sophisticated evaluation efforts after their programs are operational.** For example, Alabama will convene an advisory group, together with university experts, to design and implement its CHIP evaluation. As a component of this process, they will compare the enrollment distribution from the first several months of the program with their target demographic profile to ensure that eligible adolescents are accessing and being retained in the program.
- **Most states are planning to evaluate their programs at a much more detailed level than HCFA requires.** For example, states are planning to report enrollment and encounter data in one-year age intervals rather than the wider 4-6 year groupings requested by HCFA.

State Innovations and Highlights

- **Utah:** This state's CHIP program is collaborating with public health agencies to conduct surveillance and community health assessment. The health data authority, a separate office within the Department of Health, collects data for assessment and evaluation purposes. This is expected to be a strong partnership with the ability to provide detailed information on various age groups, including adolescents eligible for the state's CHIP program.

- **California:** The Managed Risk Medical Insurance Board is working with partners, including universities and private foundations, to design and implement a comprehensive evaluation that will include a strong adolescent focus.

SPOTLIGHT: NEW MEXICO

An extensive evaluation plan has been developed for this state's CHIP program. The plan includes outcome measures for adolescents in the areas of risk factor reduction; decreased education-related problems (suspensions, expulsions, course failures, disciplinary action); early and continuous prenatal care; reduced out-of-home placements; oral disease prevention; and others. Adolescent client and provider satisfaction surveys will also be utilized. Findings from this evaluation will be very useful to other states and to the field in general as researchers and policymakers attempt to measure the impact of health insurance coverage and access to care on broad social, behavioral and educational indicators.

Recommendations: How should states structure their program evaluations to focus on adolescents?

- **Build evaluation efforts on existing measures, tools and systems.** In the past several years, as state agencies have increasingly enrolled their Medicaid populations in managed care systems, these agencies have become sophisticated purchasers of health care services for low-income populations, devising complex contracts that specify service delivery, access and other expectations. Rather than reinventing the wheel, states that create new child health insurance programs under CHIP should leverage and build on this valuable experience.
- **Implement evaluation strategies that are feasible.** When constructing evaluation plans for adolescents under CHIP, states should consider whether baseline data (or reasonable proxies) are available from existing sources or can be created for the targeted medical, behavioral, epidemiological, enrollment and service delivery goals. The

challenge for states is to design simple but effective measures that can be easily tabulated and efficiently used to indicate strengths and weaknesses in their CHIP programs.

- **Develop comprehensive measurement tools that emphasize health and wellness across the continuum of care.** A wide range of methods should be used, including practice guidelines, satisfaction surveys, performance measures, internal quality improvement systems, external quality reviews, accreditation of plans, credentialing of providers, and consumer protections. Through the use of complementary data collection strategies, a more thorough evaluation profile will emerge, providing planners with the information they need to more effectively target various populations and program objectives.
- **Involve adolescents, families, advocacy organizations, providers and other stakeholders in program evaluation.** Input from these individuals and groups can help to ensure that the evaluation design is authentic and responsive to the needs of various constituents.
- **Conduct periodic evaluations.** These should measure and report comparisons with baseline information and among subgroups by age, gender, race/ethnicity, household income, region, provider, and health plan.
- **Track adolescents' enrollment, disenrollment and use of services within CHIP and other systems of care.** States need to track when and where adolescents enter health care systems so that critical opportunities for improving enrollee health are identified and optimally utilized.
- **Create partnerships.** Working alliances between state Medicaid and public health agencies, including state Title V MCH/CSHCN programs, will help CHIP programs build expertise and maximize the use of data that states are already collecting.

LINKAGES WITH OTHER HEALTH AND SOCIAL SERVICE PROGRAMS

Why are linkages with other programs important for adolescents under CHIP?

Because the range and number of federal, state and community programs addressing adolescent needs are vast and complex, coordination is essential to reduce costly fragmentation and duplication. States are required by federal law to coordinate Title XIX (Medicaid) and Title V (MCH/CSHCN Block Grant Services); Title XXI requires states to evaluate CHIP coordination with both of these programs. Coordination with other key federal, state and local programs such as schools, employers, family planning agencies, mental health and substance abuse centers, and special education programs is also important. Most state Title V programs and health agencies already have linkages with many of these programs and can facilitate further coordination. However, CHIP provides additional opportunities to enhance and formalize such relationships.

Results: How are states linking CHIP to important health, social and education systems?

- **All 12 states surveyed are working with local schools and school districts to provide information about CHIP to families.** States are engaging in multiple partnerships and creating linkages with other services and programs in a variety of ways. Most notable at this stage of CHIP implementation are the linkages states have developed with other agencies and systems for outreach and enrollment. In Illinois, as in several other states, much of the outreach effort is being conducted in partnership with local school systems. In Fall 1998, Illinois sent CHIP information home with every student's report card. Similarly, eligibility for Florida's Healthy Kids program is coordinated with its school lunch program: students who qualify for subsidized lunches automatically qualify for Healthy Kids.

SPOTLIGHT: NORTH CAROLINA

In North Carolina, local outreach coalitions are playing a primary role in conducting outreach for CHIP to eligible children and families. These local coalitions are comprised of county health and social services agencies, community groups, and other grassroots organizations. The state is providing a great deal of support to these coalitions through print and electronic materials and media, toll-free hotlines, and technical assistance offered through monthly coalition letters, regional consultants and workshops/meetings. The state has also been able to provide a small amount of funding to local coalitions to support their efforts.

The state requested that county health departments and departments of social services convene initial meetings between various organizations and community groups in their respective counties. Based on these meetings, outreach coalitions were formed in each county. Due to the wide range of resources and needs across the state's counties, the types of groups included in each coalition vary. Coalitions include, but are not limited to:

- Community and migrant health centers
- Health care providers
- Public schools
- Child care/Head Start programs
- Family support networks for children with special health care needs
- Media groups
- Churches
- Local businesses
- Chamber's of Commerce
- Housing authority
- Non-profit organizations
- Smart Start³⁴
- Consumer groups

Local coalitions have targeted their initial CHIP outreach efforts to schools, child care providers, health providers, and the former Caring Program³⁵ and Medicaid recipients. In order to reach all those who are eligible for CHIP, groups that represent a wide spectrum of the community are being encouraged to participate in the coalitions' outreach efforts.

Although the coalitions' efforts vary, many of these groups indicate that one of the most successful outreach strategies is sending CHIP information to homes with school report cards and with children in child care. Other efforts include informing local media about the program, including information in utility mailings, posting information on Cable TV Community Bulletin Boards, and distributing CHIP materials door-to-door and in post office boxes.

The coalitions' outreach efforts appear to have been quite successful. Since the implementation of the CHIP program in October 1998, over 50 percent of the population estimated to be eligible for CHIP has enrolled in the program. The state is currently planning several evaluation efforts to determine the effectiveness of the coalitions' outreach efforts.

³⁴ Smart Start is a public-private initiative whose programs provide children under age six with access to high-quality and affordable childcare, health care and other family services.

³⁵ The Caring Program was a 501(c)(3) sponsored insurance program, primarily sponsored by Blue Cross/Blue Shield, which raised funds to purchase ambulatory health insurance for children. When *Health Choice* was implemented, the Caring Program terminated its coverage in favor of the more comprehensive coverage provided through *Health Choice*.

■ **Most states have established linkages between their Medicaid agencies and Title V programs.** Current activities resulting from these linkages include conducting outreach and enrollment to eligible populations, and establishing service delivery systems under CHIP for children and adolescents with special health care needs. For example, the CHIP program in California requires that children and adolescents with special health care needs be referred to the state Title V agency for specialized medical services. In Colorado, the Medicaid contract requires that referrals be made in both directions between Medicaid and the Title V Health Care Program for Children with Special Needs. Other linkages were created prior to the passage of Title XXI and have provided states with an important foundation for further collaborative efforts.

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■ **All 12 states indicated that their CHIP plans specify some type of ongoing collaboration between the state's CHIP program and state and local public health agencies.** This collaboration varied and in many cases was planned for the future. Several states intend to collaborate or continue to collaborate on outreach and enrollment efforts; several will collaborate on planning and related policy development; and many plan to collaborate around community assessment and surveillance.

State Innovations and Highlights

■ **New York:** The Child Health Plus program makes a special effort to coordinate with the state's Medicaid managed care program. The intent is to have children and adolescents move between programs with relative ease and also maintain relationships with their primary care providers. New York uses a joint application process for Medicaid, Child Health Plus and WIC to help solidify this connection.

Recommendations: What can states do to build or strengthen linkages with other programs and systems?

■ **Develop linkages between the state's CHIP program and other community-based programs that serve adolescents,** including school-based/school-linked health centers, local health departments, federally-qualified health centers, and other youth-serving organizations such as Boys and Girls Clubs and recreation centers. Through active integration and collaboration, the various systems that serve low-income youth can attempt to achieve a seamless system of care that meets adolescents' multiple needs.

■ **Create linkages between state CHIP programs and other state agencies and programs.** Linkages should be established with Title V programs, social services, family planning, mental health, substance abuse, and education agencies.

■ **Ensure that clear, uniform processes are established and/or maintained which link adolescents to needed community-based services.** Mechanisms should also be in place to provide appropriate coordination and follow-up.

■ **Ensure that managed care organizations (MCOs) have developed linkages to public health agencies, social services, education systems, and essential community-based providers.** In states where services for adolescents are delivered through managed care arrangements, this can be achieved through the use of specific contract language that specifies the relationships MCOs are expected to maintain.

V. Discussion and Implications

The State Children's Health Insurance Program offers tremendous promise in efforts to improve the health of America's adolescents. The legislation that created Title XXI of the Social Security Act was enacted with bipartisan support from the U.S. Congress. Since then, virtually every state, district and territory has invested resources in programs to provide health insurance coverage to adolescents at incomes up to and above federal poverty guidelines.

As this report highlights, states are responding to the challenge of implementing CHIP with a great deal of creativity and innovation. Particularly encouraging are efforts in the areas of outreach and enrollment; relatively comprehensive benefit packages; and collaborations between a multitude of public, private and community-based partners. These findings are particularly notable as many states were in the early stages of implementation at the time of this study and therefore had not yet had significant time to more fully develop their efforts. Clearly, more programmatic changes will continue to emerge as states submit amendments to HCFA and refine their existing programs. By all indications, most states recognize that the unique health needs of low-income adolescents require targeted efforts and expressed intentions to further address this population.

While the states interviewed for this publication represent a broad geographic and demographic distribution, there were no significant differences in CHIP implementation across states that might be explained by geography or demographics. Furthermore, while these states were selected for being more advanced in CHIP implementation and/or adolescent health services, overall this did not seem to result in any one state or region being further along in its efforts to address the health needs of adolescents under CHIP.

While most states recognize that adolescents require special focus and efforts under CHIP, major challenges remain in addressing the needs of this unique population. For example, in spite of the experience that state Title V programs, state adolescent health coordina-

tors and others can bring to the table, these individuals and groups have not been consistently involved in CHIP planning and implementation. Future efforts to target adolescents under CHIP could benefit from the expertise of these programs and groups.

Many of the states we interviewed had at least begun to simplify their application processes and to utilize eligibility workers outstationed at provider and other community sites. While a few states have broadened their outreach efforts beyond education agencies to include other sites such as homeless and runaway shelters – places where at-risk youth might be found – more comprehensive and targeted outreach efforts that involve adolescents, that consider where and how adolescents access and utilize services, and that address the needs of at-risk adolescents, are needed to ensure that the adolescents who need services the most are enrolled in their states' CHIP programs.

Respondents expressed their states' intentions to address mental health and substance abuse coverage under the CHIP benefit package and to expand these services through amendments, if necessary. Unfortunately, reproductive health services, while a covered benefit in most states in this sample, still appear to be impacted by ongoing political debate and struggles over the perceived need for these services.

Except for a few isolated efforts, little comprehensive attention has yet been placed on adolescents with special health care needs in most states' planning and implementation efforts; even less seems to have been done for at-risk adolescents. Policymakers may consider adolescents with special health care needs to be a population that has already been addressed under the state's Title V program for children with special health care needs. Further work to identify adolescent-oriented specialty providers, target outreach efforts to these populations, assure continuity of coverage, and create connections to other critical social services are urgently needed. Few states, moreover, have established a means by which to ensure continuous eligibility for at-risk adolescents who may be mov-

ing in and out of various living, health and social service systems.

There is a need to build on existing data and surveillance systems in state health agencies, many of which are already collecting child and adolescent health-related information that can contribute to a greater understanding of CHIP's overall impact. Title V performance measures, which all states are required to collect and annually submit to HRSA, could prove useful in states' evaluation efforts. Unfortunately, states have little funding through CHIP to devote to evaluation and monitoring activities – activities which are often costly and time-consuming – due to statutory limits on spending for administrative functions. Because states can not expend more than 10 percent of their total federal and state CHIP allotment on outreach, enrollment, evaluation, and other administrative activities, these efforts are likely to suffer. Similar data issues are being addressed by multiple entities, including states themselves, HCFA, HRSA, and others. However, leadership, support and collaboration at the federal level, particularly from HCFA and HRSA, will continue to be needed.

Although not directly addressed in much of this document, maintaining and utilizing a sufficient and comprehensive cadre of providers that are trained in adolescent health and sensitive to adolescent needs is central to the premise that CHIP can improve the health of adolescents. Even if all adolescents were covered by health insurance, states would need to continue their efforts to build and support systems that are responsive to adolescent needs.

Our study indicates that few states are assuring that adolescent-oriented providers are identified and available under their CHIP programs. This may be attributable, in part, to the fact that few health care providers specialize in adolescent health, and that most medical providers are inadequately trained to recognize adolescent health problems whose origins may be primarily psychosocial instead of physical. Providers' reluctance to ask their adolescent clients questions about certain topics further reduces their ability to respond to the unique needs of these clients. In the absence of

more specially trained clinicians, continuing education and training of traditional health care providers becomes even more essential.

Safety net providers – including local health departments, community health centers, and school-based health centers – have historically served as key health care delivery sites for low-income adolescents and their families. In general, states do not appear to have fully leveraged the opportunities presented by CHIP to involve safety net providers in a comprehensive system of care for their adolescent enrollees.

Experts disagree about whether managed care arrangements primarily benefit or primarily harm adolescents. Certainly, the core principles that managed care has traditionally embraced – including prevention, wellness, population-based planning, and health promotion – are principles that, if operationalized, stand to serve adolescents well. On the other hand, some studies suggest that managed care plans impose restrictions on care that threaten teens' access to needed services, and that these barriers are even greater for those with special needs.

Despite significant legal and regulatory tinkering, managed care is likely to remain a permanent fixture in the U.S. health care delivery system. Given this reality, states and advocates for adolescents might want to focus their efforts on making managed care organizations more responsive to the needs of adolescents, particularly the underserved adolescents now eligible for state CHIP programs. They should also work to ensure that capitation rates paid to health plans and providers are sufficient to cover the comprehensive range of services needed by adolescents, especially those with special needs. As competition and competitive pressures rise, reimbursement levels tend to fall, creating an incentive for MCOs and providers to withhold services or enroll and serve only low-risk clients. Given the generous federal match available to states for their CHIP expenditures, it is critical that policymakers and program administrators balance the desire to hold down costs with appropriate incentives for providing high-quality, accessible care to eligible adolescents.

The Big Picture

Finally, CHIP will not resolve larger issues regarding access to care and health insurance coverage for a large number of adolescents and young adults who will not be reached by this program. The Society for Adolescent Medicine, for example, defines adolescence to include individuals ages 10-25; CHIP and other public health insurance programs, however, frequently establish eligibility cutoffs at age 18 or younger. And yet, in 1996, almost 30 percent of 18-24 year-olds were not covered by any public or private health insurance (U.S. Bureau of the Census, 1998).

CHIP also does little to improve access for those whose family incomes exceed eligibility cutoffs. It is estimated that 41 percent of uninsured children and adolescents live in families with incomes greater than 200 percent of federal poverty guidelines and therefore will not qualify for CHIP coverage in most states (Klerman, 1999). Although some of these teens may be able to afford necessary medical services, others are likely to forego the preventive care that could help them to establish healthy behaviors and reduce the impact of undetected conditions.

Indeed, those who are over 19, whose family incomes exceed state eligibility ceilings, or who face other barriers to coverage, are not well-served by CHIP; nor are the millions of adolescents with private insurance that omits or limits coverage for the services they need most. Short of enacting a universal health insurance system, covering these teens will require ongoing creativity and resources from states, territories and the federal government. For example, states should endorse, sponsor or otherwise support public or private initiatives that provide health insurance coverage for adolescents with family incomes too high to qualify for Medicaid or CHIP programs. They should ensure that eligibility for public programs is consistent across age groups so that younger children in families will not be eligible for programs for which their adolescent siblings are not. Finally, states might want to experiment with other approaches, such as subsidizing employers for providing dependent coverage, providing tax credits to families that purchase health insurance for their children, or creating scaled-back state-run programs that cover all child and adolescent residents.

The State Children's Health Insurance Program provides states with an unprecedented opportunity to extend and expand health insurance coverage for low-income, uninsured adolescents. To maximize the potential of Title XXI in reaching and serving adolescents, the gaps and challenges outlined in this report will need to be addressed. No single state or entity possesses all the answers as to how CHIP can best meet the health needs of low-income adolescents. But as this report illustrates, several existing state efforts can prove useful to other state policymakers, health plans, providers, and advocates.

Each state has its own unique set of issues and circumstances which must be considered as CHIP is further implemented. However, our interviews suggest that states would benefit from more formal opportunities to share information, strategies and peer-to-peer technical assistance. In addition to ongoing federal leadership and support from national organizations such as the National Governors' Association, National Conference for State Legislatures, Association of State and Territorial Health Officials, AMCHP, Policy Center and NAHIC, a national clearinghouse focused on best practices in serving adolescents under CHIP would be extremely effective. Finally, continued inter- and intra-agency collaboration will be crucial to the ultimate success of this exciting new program.

References

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American Academy of Pediatrics. (1998). State Children's Health Insurance Program Evaluation Tool. American Academy of Pediatrics: Elk Grove Village, IL.

American Medical Association. (1999). AMA Policy Compendium. American Medical Association: Chicago, IL.

American Medical Association. (1992). AMA Guidelines for Adolescent Preventative Services (GAPS). American Medical Association: Chicago, IL.

Association of Maternal and Child Health Programs. (1999). The Title V Maternal and Child Health (MCH) Services Block Grant. Association of Maternal and Child Health Programs: Washington, DC.

Association of State and Territorial Health Officials. (1999). Children's Health Insurance Implementation: Beginning the Discussion on Quality and Performance Measurement. ASTHO Access Brief VII. Association of State and Territorial Health Officials: Washington, DC.

Association of State and Territorial Health Officials. (1998). Children's Health Insurance Implementation: Resources on Innovative School-Related Programs. Association of State and Territorial Health Officials: Washington, DC.

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Bilchik, S. (1999). Juvenile Offenders in Residential Placement, 1997. OJDP Fact Sheet. U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention: Washington, DC.

Blum, R.W. and L.H. Bearinger. (1990). Knowledge and attitudes of health professionals towards adolescent health care. Journal of Adolescent Health Care. 11: 289-294.

Blum, R.W., Garell, D., Hodgman, C.H., and G.B. Slap. (1993). Transition from child-centered to adult health-care systems for adolescents with chronic conditions: A position paper of the Society for Adolescent Medicine. Journal of Adolescent Health. 14: 570-576.

Brindis, C. and A. Wolfe. (1997). Trends in Adolescent Population Growth in California and in the United States, 1995-2005. University of California, San Francisco, National Adolescent Health Information Center and Center for Reproductive Health Policy Research: San Francisco, CA.

Brindis, C. (1998). Financing Adolescent Health Services. In S. Friedman, M. Fisher, K. Schonberg, and E. Alderman (Eds.), Comprehensive Adolescent Health Care. Mosby-Year Book, Inc.: St. Louis, MO. (pp. 114-118).

Brown, T. (1999). The Impact of the State Child Health Insurance Program (CHIP) on Title V Children with Special Health Care Needs Programs. Association of Maternal and Child Health Programs: Washington, DC.

Butts, J.A., Snyder, H.N., Finnegan, T.A., Aughenbaugh, A.L., and R.S. Poole. (1996). Juvenile Court Statistics 1993. Office of Juvenile Justice and Delinquency Prevention: Washington, DC.

Centers for Disease Control and Prevention. (1998). Facts About Adolescents and HIV/AIDS. <http://www.thebody.com/cdc/hivteen.html>.

Centers for Disease Control and Prevention. (1999). An Ounce of Prevention...What are the Returns? 2nd edition. Centers for Disease Control and Prevention: Atlanta, GA.

Cheng, T., Savageau, J., Sattler, A., and T. DeWitt. (1993). Confidentiality in health care: A survey of knowledge, perceptions, and attitudes among high school students. JAMA. 269: 1404-1407.

Children's Defense Fund. (1999). Health Problems Among Children and Working Age Adults. <http://www.childrensdefense.org/health>.

Downs, S.M. and J.D. Klein. (1995). Clinical preventive services efficacy and adolescents' risky behaviors. Archives of Pediatric and Adolescent Medicine. 149: 374-379.

Edelstein, B. (1998). Oral Health Services in the Child Health Insurance Program (CHIP). Children's Dental Health Project: Washington, DC.

Edmunds, M. and M.J. Coyle. (Eds.). (1998). Systems of Accountability: Implementing Children's Health Insurance Programs. National Academy Press: Washington, DC.

Elster, A. B. and N.J. Kuznets. (Eds.) (1994). AMA Guidelines for Adolescent Preventive Services: Recommendations and Rationale. Williams and Williams: Baltimore, MD.

Eng, T.R. and W.T. Butler (Eds.). (1997). IOM Committee on the Prevention and Control of STDs. The Hidden Epidemic: Confronting STD's. National Academy Press: Washington, DC.

English, A., Matthews, M., Extavour, K., Palamountain, C., and J. Yang. (1995). State Minor Consent Statutes: A Summary. Center for Continuing Education in Adolescent Health, University of Minnesota, Division of Adolescent Medicine: Cincinnati, OH.

English, A. and D. Knopf. (1999). Adolescents and Confidentiality: A Brief Guide for Managed Care. Center for Adolescent Health and the Law and the University of California, San Francisco, National Adolescent Health Information Center: San Francisco, CA.

English, A. (1999). The new Children's Health Insurance Program: Early implementation and issues for special populations. Clearinghouse Review. January-February 1999: 429-449.

English, A., Kappahn, C., Perkins, J., and C. J. Wibbelsman. (1998). Meeting the health care needs of adolescents in managed care. Journal of Adolescent Health. 22: 278-292.

Families USA. (1999). State Children's Health Insurance Program: Resources for Advocates. Families USA: Washington, DC.

Federal Register. (1999). 64: 13428-13430.

Finberg, J. (1998). California Launches "Healthy Families," New Children's Insurance Program. XIX Youth Law News 6. Nov/Dec 1998: 1-7.

Florida Healthy Kids Corporation. (1997). Healthy Kids Annual Report. Florida Healthy Kids Corporation: Gainesville, FL.

Fothergill, K. (1998). Update 1997: School-Based Health Centers. Advocates for Youth: Washington, DC.

The Foundation for Accountability Website. (1999). <http://www.facct.org/measures/CHMI>.

Fox, H. and L. Wicks. (1994). Serving Medicaid Eligible Adolescents through Managed Care. National Academy for State Health Policy: Portland, ME.

Fox, H., Graham, R., and M. McManus. (1998). States' CHIP Policies and Children with Special Health Care Needs. Maternal and Child Health Policy Research Center: Washington, DC.

Fox, H.B., Graham, R.R., McManus, M.A., and C.Y. Chen. (1999). An Analysis of States' CHIP Policies Affecting Children with Special Health Care Needs. Maternal and Child Health Policy Research Center: Washington, DC.

Fox, H., McManus, M. Graham, R., and R. Almeida. (1998). Plan and Benefit Options Under the State Children's Health Insurance Program. Maternal and Child Health Policy Research Center: Washington, DC.

Friedrich, M.J. (1999). 25 years of school-based health centers. JAMA. 281: 781-782.

Goldberg, C. (1999). Many Dentists Won't Fix Poor Children's Bad Teeth. New York Times. June 26, 1999.

Graham-Lear, J. (1999). The Role of School-Based Health Centers in Medicaid and CHIP. Presentation at Medicaid, CHIP and Children's Health Care, National Conference of State Legislatures, Forum for State Health Policy Leadership. Austin, TX.

Green J.M., Ringwalt, C.L., and J.E. Kelly. (1995). Youth with Runaway, Throwaway, and Homeless Experiences: Prevalence, Drug Use, and Other At-Risk Behaviors. U.S. Department of Health and Human Services, Administration on Children, Youth and Families: Washington, DC.

Green, M. (Ed.) (1994). Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. National Center for Education in Maternal and Child Health: Arlington, VA.

Grumet, J. (1998). Children's Health Insurance Program: State Options for Children With Special Health Care Needs. National Center for Education in Maternal and Child Health: Arlington, VA.

Guiden, M. (1998). School-Based Health Centers and Managed Care. State Legislative Report. National Conference of State Legislatures: Denver, CO. 23: 1-11.

Halfon, N., Inkelas, M., DuPlessis, H., and P. W. Newacheck. (1999). Challenges in securing access to care for children. Health Affairs. 18: 48-63.

Health Care Financing Administration Website. (1999). <http://www.hcfa.gov>.

Health Resources and Services Administration. (1999). Public Charge Fact Sheet. Health Resources and Services Administration, Office of the Administrator: Washington, DC.

Heffron, J., Chamberlain, K., and C. Miller. (1999). The State Children's Health Insurance Program: An Analysis of the Mental Health/Substance Abuse Benefits and Cost-Sharing Policies of Approved State Children's Health Insurance Program Plans. National Mental Health Association: Washington, DC.

Heffron, J. (1998). Strategies for Advocacy and Public Education Related to the State Children's Health Insurance Program. National Mental Health Association: Washington, DC.

Hess, C. (1997). Focusing on Results: How State Title V and Children's Health Insurance Programs Can Work Together for Healthier Children. Association of Maternal and Child Health Programs: Washington, DC.

Institute for Health Policy Studies. (1995). Street Youth at Risk for AIDS. Institute for Health Policy Studies, University of California at San Francisco: San Francisco, CA.

Irwin, C.E., Brindis, C., Holt, K., and K. Langlykke. (Eds.). (1994). Health Care Reform: Opportunities for Improving Adolescent Health. National Center for Education in Maternal and Child Health: Arlington, VA.

Irwin, C.E., Igra, V., Eyre, S., and S. Millstein. (1997). Risk-Taking Behavior in Adolescents: the Paradigm. In Jacobson, M.J., Rees, J.M., Golden, M.H., and C.E. Irwin. (Eds.) Adolescent Nutritional Disorders: Prevention and Treatment. The New York Academy of Sciences: New York, NY.

Johnston, J.D., O'Malley, P.M., and J.G. Bachman. (1998). National Survey Results on Drug Use From the Monitoring The Future Study, 1975-1997. US Department of Health and Human Services, Public Health Service, National Institute on Drug Abuse: Rockville, MD.

Kann, L., Warren, C., Harris, W., Collins, J., Douglas, K., Collins, B., Williams, B., and L. Kolbe. (1996). Youth Risk Behavior Surveillance, 1995. Surveillance and Evaluation Research Branch, Division of Adolescent and School Health. Centers for Disease Control and Prevention: Atlanta, GA.

Kann, L., Warren, C.W., Harris, W.A., Collins, J.L., Douglas, K., Collins, B., Williams, B., and L.J. Kolbe. (1998). Youth Risk Behavior Surveillance - United States, 1997. Surveillance and Evaluation Research Branch, Division of Adolescent and School Health. Centers for Disease Control and Prevention: Atlanta, GA.

Kaplan, D.W., Calonge, B.N., Guernsey, B.P., and M.B. Hanrahan. (1998). Managed care and school-based health centers: Use of health services. Archive of Pediatrics and Adolescent Medicine. 152: 25-33.

Kaplan, D., Brindis, C.D., Phibbs, S.L., Melinkovich, P., Naylor, K., and K. Ahlstrand. (1999). A comparison study of an elementary school-based health center. Archive of Pediatrics and Adolescent Medicine. 153: 235-243.

King, M.P. (1999). Insuring More Kids: Options for Lawmakers. National Conference for State Legislatures: Denver, CO.

Klein, J.D. (1994). Adolescents, the Health Care Delivery System, and Health Care Reform. In Irwin Jr., C.E., Brindis, C., Holt, K., and K. Langlykke (Eds.), Health Care Reform: Opportunities for Improving Adolescent Health. National Center for Education for Maternal and Child Health: Arlington, VA. (pp. 17-28).

Klein, J., Slap, G.B., and A.B. Elster. (1992). Access to health care for adolescents. A position paper for the Society of Adolescent Medicine. Journal of Adolescent Health. 13: 162-170.

Knopf, D. and T. Gordon. (1997). Adolescent Public Health. In J. Kotch (Ed.) Maternal and Child Health: Principles and Practice in Public Health. Aspen: Gaithersburg, MD.

Koppelman, J. and J. Graham-Lear. (1998). The New Child Health Insurance Expansions: How Will School-Based Health Centers Fit In? Making the Grade, George Washington University: Washington, DC.

Ku, L. and T. Coughlin. (1997). The Use of Sliding Scale Premiums in Subsidized Insurance Programs. The Urban Institute: Washington, DC.

Ladenheim, K. (1999). A Primer on Quality. National Conference for State Legislatures Conference on Medicaid, CHIP and Child Health Insurance. National Conference for State Legislatures, Austin, TX.

Leaf, P.J., Alegria, M., Cohen, P., Goodman, S.H., Horwitz, S.M., Hoven, C.W., Narrow, W.E., Vaden-Kiernan M., and D.L. Regier. (1996). Mental health service use in the community and schools: Results from the four community MECA study. Journal of the American Academy of Child and Adolescent Psychiatry. 35: 889-897.

Lieu, T., Newacheck, P., and M. McManus. (1993). Race, ethnicity and access to ambulatory care among US adolescents. American Journal of Public Health. 83: 960-965.

Love, D. (1999). National Conference for State Legislatures Conference on Medicaid, CHIP and Child Health Insurance. National Conference for State Legislatures, Austin, TX.

Making the Grade Website. (1999). <http://www.gwu.edu/~mtg>.

Making the Grade. (1998). National Survey of State SBHC Initiatives: School Year 1997-1998. George Washington University: Washington, DC.

MacTaggart, P. (1999). National Conference for State Legislatures Conference on Medicaid, CHIP and Child Health Insurance. National Conference for State Legislatures, Austin, TX.

Matthews, P. (1999). National Conference for State Legislatures Conference on Medicaid, CHIP and Child Health Insurance. National Conference for State Legislatures, Austin, TX.

McCabe, M.A. (1996). Involving children and adolescents in medical decision making: Developmental and clinical considerations. Journal of Pediatric Psychology. 21: 505-516.

McPherson M., Arango, P., Fox, H., Lauver, C., McManus, M., Newacheck, P., Perrin, J., Shonkoff, J., and B. Strickland. (1998). A new definition of children with special health care needs. Pediatrics. 102: 137-140.

Monheit, A.C., and P.J. Cunningham. (1992). Children without health insurance. The Future of Children: US Health Care for Children. 2: 154-170.

National Adolescent Health Information Center. (1998). Assuring the Health of Adolescents in Managed Care. University of California, San Francisco, National Adolescent Health Information Center: San Francisco, CA.

National Academy of Sciences. (1998). Opportunity and Risk: Studies of Adolescents. National Academy Press: Washington, DC.

National Academy for State Health Policy. (1998). CHIP Implementation Brief: Early Lessons Learned: Cost Sharing and Premiums. National Academy for State Health Policy: Portland, ME.

The National Campaign to Prevent Teen Pregnancy. (1997). Whatever Happened to Childhood? The National Campaign to Prevent Teen Pregnancy: Washington, DC.

National Governors' Association. (1999). State Children's Health Insurance Program: 1998 Annual Report as of June 29, 1999. National Governors' Association: Washington, DC.

National Governors' Association. (1999). States Have Expanded Eligibility Through Medicaid and the State Children's Health Insurance Program. National Governors' Association: Washington, DC.

National Governors' Association. (1998). State Challenges and Opportunities in Rural and Frontier Health Care Delivery. National Governors' Association: Washington, DC.

National Network for Youth. (1998). Toolkit for Youth Workers. National Network for Youth: Washington, DC.

National Research Council. (1993). Losing Generations: Adolescents in High-Risk Settings. National Academy Press: Washington, DC.

Newacheck, P., Hughes, D., and M. Cisternas. (1995). Children and health insurance: An overview of recent trends. Health Affairs. Spring 1995: 244-254.

Newacheck, P.W., Brindis, C.D., Cart, C.U., Marchi, K., and C.E. Irwin, Jr. (1999). Adolescent health insurance coverage: recent changes and access to care. Pediatrics. 104: 195-202.

Office of Inspector General, Office of Evaluations and Inspections, Region V. (1999). The Children's Health Insurance Program. States' Application and Enrollment Processes: An Early Report From the Front Lines. Office of Inspector General, Office of Evaluations and Inspections, Region V.

Office of National AIDS Policy. (1996). Youth & HIV/AIDS: An American Agenda. A Report to the President Prepared by the Office of National AIDS Policy, March 1996. Office of National AIDS Policy: Washington, DC.

Olson, K., Perkins, J., and T. Pate. (1998). Children's Health under Medicaid: a National Review of the Early and Period Screening, Diagnosis and Treatment Program. National Health Law Program: Los Angeles, CA.

Ozer, E.M., Brindis, C.D., Millstein, S.G., Knopf, D.K., and C.E. Irwin, Jr. (1998). America's Adolescents: Are They Healthy? University of California, San Francisco, National Adolescent Health Information Center: San Francisco, CA.

Permanente Medical Group, Inc. (1996). Clinical Practice Guidelines: Prevention and Health Promotion. The Permanente Medical Group, Inc.: Oakland, CA.

Pourat, N., Brown, E.R., and R. Wyn. (1997). 1.6 Million California Children Are Uninsured. The UCLA Center for Health Policy Research: Los Angeles, CA.

Roberts, R.E., Lewinsohn, P.M., and J.R. Seeley. (1995). Symptoms of DSM-II-R major depression in adolescence: Evidence from an epidemiological survey. Journal of the American Academy of Child and Adolescent Psychiatry. 34: 1608-1617.

Rowland, D., Rosenbaum, S., Simon, L., and E. Chait. (1995). Medicaid and Managed Care: Lessons from the Literature: A Report to the Kaiser Commission on the Future of Medicaid. Henry J. Kaiser Family Foundation: Washington, DC.

Russell, S. (1999). Legal Immigrants Promised Public Benefits Without Penalty. San Francisco Chronicle. May 26, 1999.

Satcher, D. (1998). Healthy People 2000 Progress Review: Adolescents and Young Adults. Department of Health and Human Services, Public Health Service: Washington, DC. July 9, 1998.

School Health Resource Services. (1997). Florida's Healthy Kids, a Model for the New Federal Child Health Insurance Legislation. University of Colorado, Health Sciences Center, School Health Resource Services: Denver, CO.

Selden, T., Banthin, J., and J. Cohen. (1998). Medicaid's problem children: Eligible but not enrolled. Health Affairs. 17: 192-200.

Society for Adolescent Medicine. (1992). Access to health care for adolescents: A position paper of the Society for Adolescent Medicine. Journal of Adolescent Health. 13:162-170.

Sonenstein, F., Stewart, K., Duberstein-Lindberg, L., Pernas, M., and S. Williams. (1998). Involving Males in Preventing Teen Pregnancy: A Guide for Program Planners. The Urban Institute: Washington, DC.

Stein, M. (Ed.). (1997). Guidelines for Health Supervision, Third Edition. American Academy of Pediatrics: Elk Grove, IL.

U.S. Bureau of the Census. (1998). Statistical Abstract of the United States: 1998 (118th edition). US Bureau of the Census: Washington, DC.

U.S. Congress Office of Technology Assessment. (1991). Adolescent Health Volume I: Summary and Policy Options. U.S. Government Printing Office: Washington, DC.

U.S. Department of Health and Human Services. (1991). Healthy People 2000. U.S. Government Printing Office: Washington, DC.

66

U.S. Department of Health and Human Services. (1999). Children's Health Insurance Program reaches 1998 target: Nearly one million children enrolled. HHS News. U.S. Department of Health and Human Services: Washington, DC.

U.S. General Accounting Office. (1999). Children's Health Insurance Program: State Implementation Approaches Are Evolving. General Accounting Office, Report to Congressional Committees: Washington, DC. (GAO/HEHS-99-65).

U.S. General Accounting Office. (1997). Health Insurance Coverage Leads to Increased Health Care Access for Children. General Accounting Office: Washington, DC. (GAO/HEHS-98-14).

U.S. Preventive Services Task Force. (1996). Guide to Clinical Preventive Services, Second Edition. International Medical Publishing: Alexandria, VA.

U.S. Public Health Service. (1998). Clinician's Handbook of Preventive Services: Put Prevention into Practice, second edition. International Medical Publishing: Alexandria, VA.

VanLandeghem, K., Sonosky, C.A., and J. Kagan. (1998). Maternal and Child Health Principles in Practice: An Analysis of Select Provisions in Medicaid Managed Care Contracts. Association of Maternal and Child Health Programs: Washington, DC.

Ventura, S.J., Anderson, R.N., Martin, J.A., and B.L. Smith. (1998). Births and deaths: Preliminary data for 1997. National Vital Statistics Reports. Centers for Disease Control and Prevention, National Center for Health Statistics: Hyattsville, MD.

Weinick, R.M., Weigers, M.E., and J.W. Cohen. (1998). Children's health insurance, access to care, and health status: New findings. Health Affairs. 2: 127-135.

Weist, M.D., Ginsberg, G., and M. Shafer. (1999). Progress in Adolescent Mental Health. In Fisher, M., Juszczak, L., and L.V. Klerman. (Eds.) Prevention Issues in Adolescent Health Care. Adolescent Medicine: State of the Art Reviews. Hanley and Belfus, Inc.: Philadelphia, PA.

Weithom, L.A. and S.B. Campbell. (1982). The competency of children and adolescents to make informed treatment decisions. Child Development. 53: 1589-1599.

Ziv, A., Boulet, J.R., and G.B. Slap. (1999). Utilization of physician offices by adolescents in the United States. Pediatrics. 104: 35-42.