

## The Children's Health Insurance Program Reauthorization Act (CHIPRA): Addressing Racial and Ethnic Health Disparities

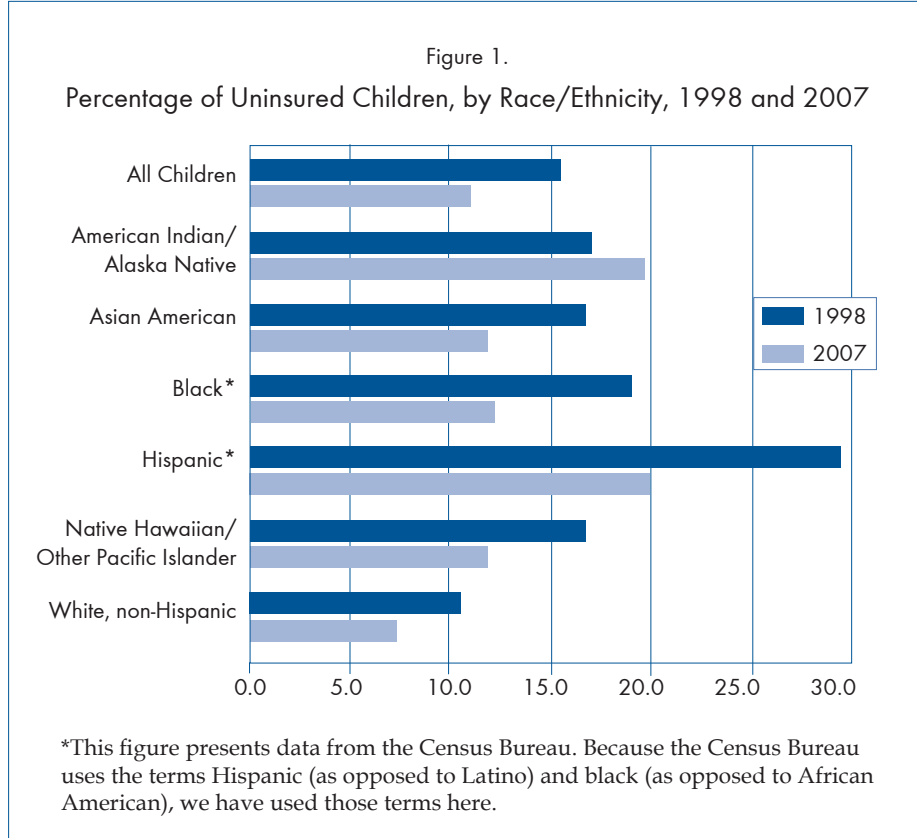
*The Children's Health Insurance Program (CHIP) was created in 1997 to provide affordable health coverage to low-income children in working families who make too much money to be eligible for Medicaid but not enough to afford private coverage. The program currently covers more than 7 million children. In February 2009, after a protracted political fight, Congress enacted, and President Obama signed, legislation that renewed CHIP through the end of 2013 and expanded its scope. This series of issue briefs examines the new provisions that were included in the reauthorization and how they will affect implementation in the coming months.*

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Since CHIP implementation began in 1998, the program has significantly reduced the number of uninsured children in the United States by expanding health coverage to many low-income children. These expansions have particularly helped children of color obtain health coverage.<sup>1</sup> The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which took effect on April 1, 2009, will allow states to cover an additional 4 million uninsured children, further closing gaps in coverage and increasing access to health care for low-income children.

CHIP has a long history of reducing disparities in health coverage among children. From 1998 to 2007, the overall rate of uninsured children decreased from 15.4 percent to 11.0 percent (see Figure 1).<sup>2</sup> And for children of color, CHIP has been even more important. For instance, in 1998, roughly 30 percent of Hispanic children; 19 percent of black children; and 17 percent of Asian, Native Hawaiian, and Other Pacific Islander children were uninsured, compared to 10 percent of white children. After CHIP had been in place for 10 years (by 2007), those numbers dropped to approximately 20 percent for Hispanic children, and 12 percent for black, Asian, Native Hawaiian, and Other Pacific Islander children, compared to 7 percent for white children<sup>3</sup> (the uninsured rate for American Indian and Alaska Native children was highly variable<sup>4</sup>). In addition to reducing gaps in coverage for minority children, CHIP has also reduced disparities in access to health care services.<sup>5</sup>

Despite this progress, however, disparities persist. In 2007, children of color were still more likely to be uninsured than white children: That year, more than 8 million children were uninsured, and more than 5 million of them were children of color.<sup>6</sup>



To address these disparities and strengthen the program's ability to close these gaps, CHIPRA contains several new provisions, including the following:

- Providing outreach grants to increase Medicaid and CHIP enrollment,
- Removing the five-year waiting period for legal immigrant children and pregnant women,
- Providing higher federal matching rates for interpretation and translation services, and
- Establishing new quality of care measures that are designed to track children's health outcomes.

## Investing in Outreach to Enroll Minority Children

Roughly two-thirds of all uninsured children are eligible for CHIP or Medicaid.<sup>7</sup> However, children of color are significantly more likely to be eligible for – but not enrolled in – these programs. According to the latest data, more than 80 percent of uninsured African American children and 70 percent of uninsured Latino children are eligible for public coverage.<sup>8</sup>

CHIPRA provides the opportunity to increase enrollment among eligible children and address many of the underlying barriers that children of color may face when trying to enroll in Medicaid and CHIP. Distrust of the health care system, language and cultural barriers

in the application process, and misinformation about eligibility rules are just a few of the challenges that make enrolling in public programs difficult for racial and ethnic minorities. Enrollment strategies that target minority communities, such as using community health workers and promotoras (outreach workers in Latino communities who are responsible for raising awareness of health and educational issues) to conduct outreach, have been shown to increase enrollment and reduce disparities in coverage.<sup>9</sup>

Perhaps even more importantly, CHIPRA will provide \$100 million in grant funding from 2009 to 2013 for organizations to educate specific communities about Medicaid and CHIP eligibility and the enrollment processes for these programs. In order to reach out to uninsured, eligible children and increase enrollment, CHIPRA will fund the following types of outreach activities:

- **National Outreach Campaign**

For the first time, the federal government will fund a national outreach campaign. Of the \$100 million in federal outreach funding, \$10 million will be spent on a nationwide effort to enroll underserved children. Although the details of the national outreach campaign have yet to be determined, the statute lists some possibilities, including inter-agency efforts to disseminate information about the availability of children's health coverage, additional support for telephone hotlines that provide information to families about Medicaid and CHIP, and the development of new outreach materials aimed at American Indian families or individuals with limited English proficiency.

- **Increased Outreach to, and Enrollment of, American Indians**

Another \$10 million in outreach funding will be given to the federal Indian Health Service (IHS) and to American Indian organizations for outreach to American Indian children. In addition, the law directs the Secretary of the Department of Health and Human Services (HHS) to encourage states to make it easier for American Indian children who live on or near reservations to enroll in Medicaid and CHIP. States may send trained workers to help families enroll, or they may enter into agreements with the IHS and tribal organizations to provide outreach and education on eligibility and benefits, enrollment, and translation services.

CHIPRA also makes an important change to a policy that previously placed certain limits on what states could spend on outreach and enrollment. Typically, states are limited to spending no more than 10 percent of their total CHIP expenditures on outreach or administration of the program. CHIPRA exempts expenditures that are used to increase enrollment of American Indian children from that 10 percent cap.

#### ■ State and Local Grants

The remaining \$80 million in outreach funds will be awarded to state and local organizations to conduct enrollment outreach. Priority will be given to organizations that represent geographic areas with high rates of eligible but unenrolled children, including rural areas and those with large populations of racial and ethnic minorities. Preference will also be given to organizations that work with ethnic or low-income populations in the communities where the outreach activities will be conducted. Participating organizations will have to provide specific quality or outcomes performance measures to evaluate the effectiveness of the outreach activities that are funded by the grant, conduct assessments of effectiveness relative to these performance measures, and provide the Secretary of HHS with the data that were collected for these assessments. In turn, the Secretary will make publicly available the enrollment data and other information that was collected and will submit an annual report to Congress on the outreach and enrollment activities that were conducted under the grant.

### Increased Access for Legal Immigrant Children and Pregnant Women

Although public health insurance programs like Medicaid and CHIP have been successful in improving health coverage for most low-income children, the gap in health coverage between citizen and immigrant children has widened. In 1996 (before CHIP was enacted), federal law prohibited legal immigrants who were otherwise eligible for Medicaid (and subsequently CHIP) from enrolling in the programs until they had been in the United States for five years. This arbitrary waiting period has resulted in reduced access to health care for legal immigrants. For instance, Census data have shown that the percentage of uninsured immigrant children has increased since the 1996 law took effect. In 2006, about half of all low-income immigrant children were uninsured.<sup>10</sup> Lack of insurance leads to other consequences that can have a negative impact on children's health. For instance, compared to children from citizen families, immigrant children are less likely to see a physician or a dentist, or to visit an emergency room.<sup>11</sup>

CHIPRA eliminates the federal requirement that eligible children and pregnant women who are legal immigrants wait five years before they can enroll in Medicaid or CHIP. States now have the option to enroll eligible legal immigrant children and pregnant women in Medicaid or CHIP and to receive federal funding for this coverage, although they are not required to do so. (Nineteen states currently offer state-funded coverage for legal immigrant children, and 22 states and the District of Columbia offer state-funded coverage for pregnant women.<sup>12</sup>) This is an opportunity for cash-strapped states to receive new federal funding for coverage that they are already providing, and for states that do not provide this coverage to help reduce health disparities between citizen and legal immigrant children and pregnant women. More information on this topic will be available in a later brief.

## Increased Funding for Interpretation and Translation Services

Language barriers play a large role in disparities in health coverage, access, and quality for some minorities. Moreover, these barriers affect the quality of health care that people receive. In 2007, more than 55 million people in the United States (19.7 percent of the population five years old or older) spoke a language other than English at home. Of those, more than 24 million reported that they spoke English less than “very well.”<sup>13</sup> Individuals who are unable to communicate effectively in English because of a limited ability to speak, read, write, or understand the English language are referred to as limited English proficient, or LEP.<sup>14</sup>

There are a host of concerns about how people with limited English proficiency obtain appropriate health care services. For instance, medical and health insurance forms are rarely translated, so people who have limited English proficiency may not be able to understand or fill out such forms accurately, and they may not be able to adequately discuss their health issues with a health care provider.<sup>15</sup> The pervasive lack of translated materials and competent interpreters at health care facilities can force children, family members, and friends to serve as interpreters, which is inappropriate, particularly in a health care setting.<sup>16</sup>

Making language services available in health care settings can improve health care quality and reduce the risk of medical errors. According to Executive Order 13166, *Improving Access to Services for Persons with Limited English Proficiency* (issued by President Clinton in August 2000), health care providers who receive federal funds are required to provide language access services to patients that need it. The federal government will pay for interpreter services that are provided to people enrolled in Medicaid, but only if states choose to include this service in their Medicaid programs. Each state determines whether it will reimburse hospitals and other health care providers for the costs of providing language services to Medicaid and CHIP enrollees.<sup>17</sup> Currently, 12 states and the District of Columbia receive federal funding to reimburse providers for these language services.<sup>18</sup>

To encourage more states to offer interpretation and language services, CHIPRA increases the federal match that is available for interpretation services to either 75 percent or the state’s usual FMAP plus five percentage points, whichever is greater, for all CHIP enrollees and for children enrolled in Medicaid. The higher matching rate will also be available for translating outreach and enrollment documents (including outreach and enrollment forms, health information brochures, and informed consent documents) and for the use of interpreters to facilitate the enrollment process.

## Reducing Disparities by Improving Children’s Health

Research has shown that racial and ethnic minorities in the United States receive lower quality health care than whites, even when they are insured and have similar incomes. People of color are less likely to receive lifesaving, high-quality diagnostic tests, and they are also less likely to be referred to specialists.<sup>19</sup> Although these disparities are thoroughly documented in adults, there are fewer data on racial and ethnic health disparities in children.

Children differ from adults in their development, and they experience different patterns of illness and disability.<sup>20</sup> Research has shown that the measures of health care quality that are most meaningful for adults cannot be assumed to capture the most meaningful information for children. Therefore, tracking trends in child health and health care requires a different set of quality measures than those that are used to track adult health and health care quality.<sup>21</sup>

CHIPRA allocates \$20 million for a demonstration project to study quality measures and health information technology designed specifically for children. This will provide a unique opportunity to examine trends in child health across the United States, particularly as they relate to disparities. Collecting data that include measures that are designed especially for children will help to identify disparities, particularly those that are experienced by racial and ethnic minorities, and to monitor progress toward eliminating these disparities.

#### ■ **Quality Measures for Children's Coverage**

In order to develop a standard format for reporting data on the quality of children's health for children enrolled in Medicaid and CHIP, CHIPRA directs the HHS Secretary to develop a proposed set of core child health quality measures by January 1, 2010. After public comments are taken into consideration, the Secretary will consult with states on a revised set of measures and develop a standard reporting format.

Data that are collected from the states using this standard format will be analyzed and publicly disseminated. Every three years, the HHS Secretary will report to Congress about these data and about efforts to improve children's health. The Secretary's report will include information on duration of coverage, the availability and effectiveness of health care services, and income-related disparities in child health and health care. In addition, the Secretary will award up to 10 grants for demonstration projects that evaluate promising ideas for improving the quality of children's health care.

Although CHIPRA did not specify that these measures include indicators of racial and ethnic health disparities, collecting information in a standardized format that includes data on race and ethnicity will allow states to track trends among different populations in a more systematic way and to provide states, the Secretary, and Congress with a wealth of information on the differences in children's health across the country. It will also help facilitate the sharing of best practices.

#### ■ **Institute of Medicine Study**

The Institute of Medicine will be given up to \$1 million to prepare a report for Congress on the quality of efforts made by federal agencies to measure children's health status and the quality of children's health care. The report must be completed by July 1, 2010, and will do the following:

- Examine all of the major national, population-based reporting systems that are sponsored by the federal government and identify the information regarding health and health care quality that each system is designed to capture. Studying the data

- that are currently collected will help to identify current deficiencies in reporting systems and provide a valuable perspective on designing future population-based reporting systems that will capture disparities-related data.
- Identify gaps in knowledge related to children’s health status, the effects of social conditions on children’s health status, and the use and effectiveness of health care services. The relationship between children’s health status and family income, family stability and preservation, and children’s school readiness and educational achievement and attainment will also be examined. Studying these indicators will be particularly helpful in identifying current racial and ethnic disparities, as children of color are more likely to live in poverty and attend substandard schools.
  - Make recommendations for improving and strengthening the timeliness, quality, public transparency, and accessibility of information about child health and health care quality.

## Reducing Disparities in Access to Specific Health Services

Low-income children and children of color are disproportionately affected by certain health conditions. CHIPRA includes some key provisions that attempt to address the causes of these conditions.

### ■ Childhood Obesity Demonstration Project

Rates of childhood obesity are high overall, but for minority and low-income communities in particular, they are even higher.<sup>22</sup> Childhood obesity can lead to higher rates of conditions such as type 2 diabetes, asthma, and heart disease.<sup>23</sup>

CHIPRA includes \$25 million for an obesity demonstration project that is scheduled to start within the next year. The statute gives HHS the authority to award money to organizations and health care providers to identify and promote obesity screening methods and to help families with obese children improve their children’s health and reduce their risk for developing health problems later in life. This can be done with community or school-based activities, as well as trainings for community health workers and other health professionals. By 2013, the Secretary must submit a report to Congress that describes the project and evaluates its effectiveness. HHS has not yet announced further information about this project.

### ■ Dental Benefits

Although oral health is a significant component of children’s overall health and well-being, tooth decay is the most common chronic illness among children.<sup>24</sup> Left untreated, cavities can result in the loss of teeth and impair speech, and they can lead to ear and sinus infections, diabetes, heart and lung disease, and even death.<sup>25</sup> Unfortunately for many children—even those with health insurance—dental care is their greatest unmet health care need. For children of color, this problem is even more pressing. Even among children

in families with the same income, racial and ethnic disparities persist. For instance, among low-income children, children of color are less likely to have had a dental visit in the past year and more likely to have untreated cavities than white children.<sup>26</sup>

Recognizing the importance of dental health to overall health, Congress included two new provisions in CHIPRA related to dental health. The first provision requires states to include dental coverage in their CHIP benefit packages. The second provision allows states to offer dental coverage to children who are currently enrolled in private or job-based plans that do not offer dental coverage. As long as these children are otherwise eligible for CHIP, states can enroll them in CHIP for dental coverage only.

#### ■ **Mental Health Parity**

In the United States, it is estimated that one in 10 children and adolescents suffer from a serious mental health problem, with another 10 percent suffering from a mild to moderate problem.<sup>27</sup> Research has shown that although minority communities are just as likely to experience mental illness as whites, people of color are less likely to receive the appropriate mental health services.<sup>28</sup> To help close the gap in access to mental health services, CHIPRA requires states to provide the same level of mental health services in CHIP that they provide for physical health.

## **Action Steps for Advocates**

Advocates will play a key role in ensuring that the specific provisions in CHIPRA that have the potential to reduce racial and ethnic health disparities are implemented effectively in their communities. Below we discuss several strategies that advocates can use to educate fellow advocates, the health care community, and families with children who may be eligible for CHIP.

### **Coordinate with other health care advocates to encourage your state to adopt new options that will reduce health disparities.**

- There are exciting new opportunities for states to increase health coverage for minority children, but they will need to take action to implement these provisions. Health care advocates should work together to ensure that states are taking full advantage of all opportunities to expand coverage, enroll more children, and improve access to health care.

### **Watch for more information from HHS about grant funding opportunities.**

- HHS will release information about outreach grants and the child health quality and obesity demonstration project grants in the coming months. When this information is released, share it with local health care professionals, researchers, and advocates that have a track record of working to reduce disparities. Encourage collaborative grant proposals where applicable.



### **Write, call, or e-mail your governor and state legislators to show your support for CHIPRA and its health disparities provisions.**

- Include comments on the positive effects that these provisions will have on reducing health disparities, and provide examples of other policies that would complement these provisions.
- Provide comments on specific provisions that have yet to be fully defined or implemented. Get other organizations or advocates to sign on to your letter or to send their own letters. For example, provide written feedback on the importance of collecting race- and ethnicity-specific data in children's electronic medical records.

### **Help identify what language needs exist in your community.**

- Contact your state Medicaid and CHIP offices to find out if your state reimburses for interpretation and translation services, and make sure these offices know about the higher federal matching rates that are now available for these services in Medicaid and CHIP.
- If your state does not provide reimbursement for interpretation and translation services, organize and mobilize advocates, health care providers, and residents in your community to write and call your governor, state legislators, and Medicaid and CHIP directors to emphasize the importance of providing reimbursement for these services.

### **When HHS releases the initial set of child health quality indicators, provide comments during the public comment period.**

- Encourage the Secretary to include the provisions that will best measure racial and ethnic health disparities. Encourage other advocates to do the same.

### **Collect stories from beneficiaries.**

- Success stories, as well as those that describe the difficulties people face when trying to obtain health care through CHIP or Medicaid, can be used by health advocates and the media to demonstrate the need to address health disparities and the benefits of doing so.

## **Conclusion**

CHIPRA provides the opportunity for states to cover more uninsured children and continue making strides in addressing racial and ethnic health disparities. The provisions in the new law offer concrete ways to address gaps in coverage, expand access to specific health care services, and examine disparities in health care quality on a larger scale.

## Endnotes

- <sup>1</sup> Families USA, *SCHIP and Children's Health Coverage: Leveling the Playing Field for Children of Color* (Washington: Families USA, December 2006, updated June 2007), available online at <http://www.familiesusa.org/assets/pdfs/schip-leveling-the-playing.pdf>.
- <sup>2</sup> U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2005* (Washington: U.S. Census Bureau, August 2006), available online at [www.census.gov/prod/2006pubs/p60-231.pdf](http://www.census.gov/prod/2006pubs/p60-231.pdf); U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2007* (Washington: U.S. Census Bureau, August 2008), available online at <http://www.census.gov/prod/2008pubs/p60-235.pdf>.
- <sup>3</sup> U.S. Census Bureau, *Current Population Survey, 1998 to 2008 Annual Social and Economic Supplements*, and personal communication with Census Bureau staff in May 2009.
- <sup>4</sup> The uninsured rate decreased for all racial and ethnic groups during this 10-year time frame, with the exception of American Indian and Alaska Native children, which rose from 17.0 percent to 19.7 percent. During this period, there was significant variability in the rate of uninsured American Indian and Alaska Native children, which may be due in part to the small sample sizes that were used to calculate the uninsured rates for this group. Because of limited sample sizes, the Census Bureau uses three-year averages to estimate single-year uninsured rates for American Indian, Alaska Native, Native Hawaiian, and Other Pacific Islander children. The uninsured rates for American Indian children include those living on and off reservations during this time period. Other reasons for the variability in uninsured rates for American Indian and Alaska Native children include the following: Children who are members of federally recognized tribes are able to receive health care services through the Indian Health Service (IHS, which provides health care services but is not considered to be true "health coverage") and may not have been enrolled in CHIP. In addition, IHS and tribal facilities may be inconsistent in enrolling and billing for third party payments. For more information on uninsured rates for this group, contact the Minority Health Initiatives Department at Families USA.
- <sup>5</sup> Families USA, op. cit.
- <sup>6</sup> U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*, op. cit.
- <sup>7</sup> Kaiser Family Foundation, *Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)* (Washington: Kaiser Family Foundation, February 2009), available online at <http://www.kff.org/medicaid/upload/7863.pdf>.
- <sup>8</sup> Urban Institute, *Going without: America's Uninsured Children* (Washington: Robert Wood Johnson Foundation, August 2005).
- <sup>9</sup> Glenn Flores, Milagros Abreu, Christine Chaisson, et al., "A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children," *Pediatrics* 116 (December 2005): 1,433-1,441. A definition of promotoras is available online at [http://encarta.msn.com/dictionary\\_701708964/promotora.html](http://encarta.msn.com/dictionary_701708964/promotora.html).
- <sup>10</sup> Leighton Ku, *Restoring Medicaid and SCHIP Coverage to Legal Immigrant Children and Pregnant Women: Implications for Community Health and Health Care for Tomorrow's Citizens* (Washington: The George Washington University School of Public Health and Health Services, Department of Health Policy, January 13, 2009), available online at [http://gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/SCHIP-MedicaidDoc\\_01-14-2009.pdf](http://gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/SCHIP-MedicaidDoc_01-14-2009.pdf).
- <sup>11</sup> Kaiser Family Foundation, *Immigrants' Health Care Coverage and Access* (Washington: Kaiser Family Foundation, August 2003), available online at [www.kff.org/uninsured/upload/Immigrants-Health-Care-Coverage-and-Access-fact-sheet.pdf](http://www.kff.org/uninsured/upload/Immigrants-Health-Care-Coverage-and-Access-fact-sheet.pdf).
- <sup>12</sup> National Immigration Law Center, *Talking Points: SCHIP Reauthorization Legislation Can Help Ensure that Children Receive Timely Health Care Coverage* (Washington: National Immigration Law Center, January 13, 2009), available online at [http://www.nilc.org/immspbs/cdev/ICHIA/ICHIA\\_Talking\\_Points\\_Final\\_1-8-09.pdf](http://www.nilc.org/immspbs/cdev/ICHIA/ICHIA_Talking_Points_Final_1-8-09.pdf).
- <sup>13</sup> U.S. Census Bureau, *American Community Survey 2007*, Table S1601, "Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over," available online at <http://factfinder.census.gov>.
- <sup>14</sup> U.S. Department of Health and Human Services, Office of Civil Rights, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons* (Washington: HHS, February 2002), available online at <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>.
- <sup>15</sup> Kaiser Family Foundation, *Disparities in Health Coverage, Access, and Quality: The Impact of Citizenship Status and Language on Low-Income Immigrants* (Washington: Kaiser Family Foundation, August 2003), available online at <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22107>.

<sup>16</sup> The National Health Law Program and the Access Project, *Language Services Action Kit: Interpreter Services in Health Care Settings for People with Limited English Proficiency* (Washington: National Health Law Program, August 2003, revised February 2004), available online at <http://www.healthlaw.org/library/item.70355>. A trained medical interpreter can ensure confidentiality, prevent conflicts of interest, and guarantee that medical terminology is appropriately and accurately translated, all of which can be compromised when a child, friend, or family member is translating for a patient.

<sup>17</sup> National Association of Public Hospitals and Health Systems, *Medicaid and SCHIP Funding for Language Services* (Washington: National Association of Public Hospitals and Health Systems, April 2007), available online at <http://www.naph.org/Publications/medicaidandschipfundingforlanguageservices.aspx>.

<sup>18</sup> Mara Youdelman, *Medicaid and SCHIP Reimbursement Models for Language Services: 2007 Update* (Washington: National Health Law Program, May 2007), available online at <http://www.healthlaw.org/library/item.142454>.

<sup>19</sup> Alliance for Health Reform, *Racial and Ethnic Disparities in Health Care* (Washington: Alliance for Health Reform, November 2006), available online at [http://www.allhealth.org/Publications/pub\\_38.pdf](http://www.allhealth.org/Publications/pub_38.pdf).

<sup>20</sup> Sabrina Zadrozny, et al., *Executive Summary: Child Healthcare Quality Measurement and Reporting* (Washington: National Quality Forum, 2004), available online at [http://www.qualityforum.org/pdf/reports/child\\_health.pdf](http://www.qualityforum.org/pdf/reports/child_health.pdf).

<sup>21</sup> Ibid.

<sup>22</sup> Shiriki Kumanyika and Sonya Grier, "Targeting Interventions for Ethnic Minority and Low-Income Populations," *Childhood Obesity* 16 (Spring 2006): 187-207.

<sup>23</sup> Stephen R. Daniels, Donna K. Arnett, Robert H. Eckel, et al., "Overweight in Children and Adolescents: Pathophysiology, Consequences, Prevention, and Treatment," *Circulation* 111 (April 19, 2005): 1,999-2,012.

<sup>24</sup> Julia Paradise, *Dental Coverage and Care for Low-Income Children: The Role of Medicaid and SCHIP* (Washington: Kaiser Family Foundation, July 2008), available online at <http://www.kff.org/medicaid/upload/7681-02.pdf>.

<sup>25</sup> Ibid.

<sup>26</sup> Ibid.

<sup>27</sup> American Psychological Association, *Increasing Access and Coordination of Quality Mental Health Services for Children and Adolescents*, available online at <http://www.apa.org/ppo/issues/tpacoord.html>, accessed on March 2, 2009.

<sup>28</sup> U.S. Department of Health and Human Services, Office of the Surgeon General, Substance Abuse and Mental Health Services Administration, *Executive Summary: Mental Health: Culture, Race, Ethnicity*, Supplement to *Mental Health: A Report of the Surgeon General* (Rockville, MD: SAMHSA, Center for Mental Health Services, 2001), available online at [http://download.ncadi.samhsa.gov/ken/pdf/SMA-01-3613/exec\\_summ.pdf](http://download.ncadi.samhsa.gov/ken/pdf/SMA-01-3613/exec_summ.pdf).

# Acknowledgments

**This brief was written by**

*Sherice Perry,  
Program Manager  
Minority Health Initiatives, Families USA*

**with**

*Rachel Klein,  
Deputy Director of Health Policy, Families USA*

*Rea Pañares,  
Director of Minority Health Initiatives, Families USA*

*Jennifer Sullivan,  
Senior Health Policy Analyst, Families USA*

**Assistance was provided by the following Families USA staff:**

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