ALL KIDS COVERED

Healthy Kids
A Healthy Colorado

# CROSSING THE FINISH LINE

*Achieving meaningful health care coverage and access for all children in Colorado*

**A REPORT BY ALL KIDS COVERED COLORADO | JANUARY 2012**

## ACKNOWLEDGMENTS

**All Kids Covered Colorado** is a statewide, non-partisan coalition dedicated to increasing access to affordable, high quality health insurance coverage and health care services for all children in Colorado. Since 2006, **All Kids Covered** has worked together with elected officials, health care leaders, state and county agency staff, and community-based organizations to improve, expand and protect health insurance options for children and families in Colorado.

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## KEY ABBREVIATIONS AND TERMS USED IN THIS REPORT

| | |
|---|---|
| **CBMS** | Colorado Benefits Management System |
| **CDPHE** | Colorado Department of Public Health and Environment |
| **CHIP** | Children's Health Insurance Program |
| **CHP+** | Child Health Plan Plus |
| **DHS** | Department of Human Services |
| **FPL** | Federal Poverty Level |
| **HCPF** | Department of Health Care Policy and Financing |

# EXECUTIVE SUMMARY

Health insurance makes a difference in kids' lives. Meaningful health insurance benefits provide access to well child visits and important preventive services as well as enable children to get the care they need if they are sick and injured. Families with uninsured children report they often do not have a usual source of care, postpone or forgo care they need because of cost and cannot afford their prescription drugs.[1]

In the last five years, Colorado has made real progress toward crossing the finish line and ensuring that all kids have health insurance and access to the care they need. In fact, data shows that between 2008 and 2010 over 40,000 children in Colorado have gained insurance.[2]

This report provides an update on the current status of meaningful health care coverage and access for all children in Colorado. It includes the most current statistics about children's health insurance coverage and access, best practices from around the nation and an analysis of where Colorado needs to focus its work to cross the finish line and get all kids covered.

Today, roughly 90% of all children in Colorado have health insurance coverage. This is significant progress and should be celebrated. State policymakers, state and local agencies, community leaders, health care providers, advocates and private foundations have worked together with a common goal and concerted effort to achieve this milestone.

***However, state and national research surveys estimate that between 8.2%[3] and 10.1%[2] remain uninsured, leaving between 112,200 and 124,128 Colorado children without the health insurance coverage they need to grow up healthy and strong.***

**All Kids Covered** has identified five key strategies for getting Colorado across the finish line and achieving meaningful health care coverage for all children in our state:

- **Leadership and accountability**
- **Coverage and access for all children**
- **Systems and practices for maximizing enrollment and retention**
- **Messaging and communications**
- **Regional adaptation**

Pursuing these strategies together, we can make sure that all our children can get the health coverage and health care services they need to have healthy and fulfilling lives.

# CHILDREN'S HEALTH INSURANCE COVERAGE IN COLORADO

*Meaningful health insurance benefits can protect family assets if a child gets sick or is injured, as well as ensure that kids get the care they need so they can get back to school and parents can get back to work.*

Over 1.2 million children live in Colorado.[4] Many children in our state do very well, but hundreds of thousands of other children live in families who live at or near poverty and struggle to meet their basic needs.

In Colorado, the number of children in families with incomes over $55,000 for a family of four is decreasing while the number of children whose families have fallen into extreme poverty, a family income of roughly $11,000 for a family of four, is growing. In 2009, over 210,000 children in Colorado lived in poverty. Additionally, hundreds of thousands of kids live in families that are near poverty and who face challenges getting basic needs met, including affordable and quality health coverage.[5]

## CURRENT STATE OF COVERAGE

Unlike many other indicators of child well-being, health insurance coverage among children has improved in recent years. The American Community Survey, a national data source for information about health insurance coverage shows that between 2008 and 2010, over 41,000 Colorado children gained health insurance coverage.[2]

However, state and national research surveys estimate that between 8.2%[3] and 10.1%[2] of Colorado children remain uninsured. Meaning, between 112,200 and 124,128 Colorado children don't have the health insurance coverage they need to grow up healthy and strong—and that is too many.

Employer-sponsored coverage remains the largest source of coverage for children in Colorado, with 58.5% of children covered by employer-sponsored insurance. Public coverage programs, including Medicaid and the Child Health Plan *Plus* combined, provide 23.4% of children in Colorado with health insurance coverage.[3] Family Medicaid is a public health insurance program for Colorado kids (age 0-18) and for parents with dependent children. The Child Health Plan *Plus* (CHP+) is low-cost, public health insurance for Colorado's uninsured children and pregnant women who earn too much to qualify for Medicaid. Both programs are funded with federal and state dollars and administered by the Department of Health Care Policy and Financing (HCPF).

An in-depth analysis of the 2009 American Community Survey by the Colorado Health Institute showed that an estimated 78,437 of the 134,508 uninsured children at that time were eligible for public insurance benefits, but not participating.

- 39,550 children were estimated to eligible, but were not enrolled in Family Medicaid.

- 38,887 children were estimated to be eligible, but were not enrolled in CHP+.

Due to documentation or citizenship status, 18,248 of the uninsured kids were estimated to be ineligible for Medicaid or CHP+ in 2009.[6]

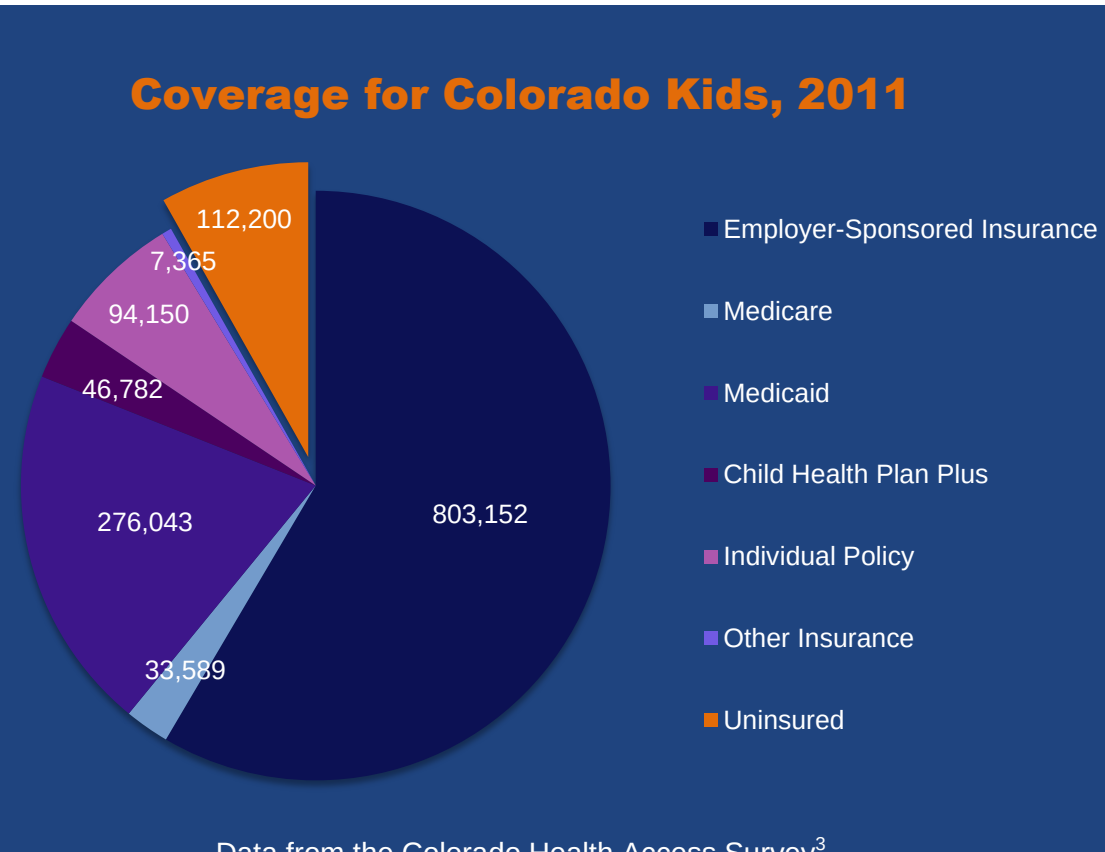
In May of 2010, the eligibility for the Child Health Plan *Plus* was expanded to accept families that make up to $55,000 a year, creating a new health insurance option for nearly 11,000 uninsured children. As of November 2011, an additional 10,493 children have been covered by the eligibility expansion of this program.[7]

Rates of health insurance coverage vary across the state. The highest percentage of uninsured children in Colorado is found in the five most northwestern counties of Jackson, Moffat, Rio Blanco, Garfield and Routt.[5]

In 2009, five rural counties had the highest percentages of children who are eligible but not enrolled in available public health insurance programs.

- Routt – 54.2% of eligible children are enrolled in Medicaid and CHP+
- Pitkin – 57.9% of eligible children are enrolled in Medicaid and CHP+
- San Miguel – 61.5% of eligible children are enrolled in Medicaid and CHP+
- Elbert – 62.6% of eligible children are enrolled in Medicaid and CHP+
- Rio Blanco – 67.0% of eligible children are enrolled in Medicaid and CHP+

Statewide 80.4% of eligible children are enrolled in Medicaid and CHP+.[6]




Data from the Colorado Health Access Survey[3]

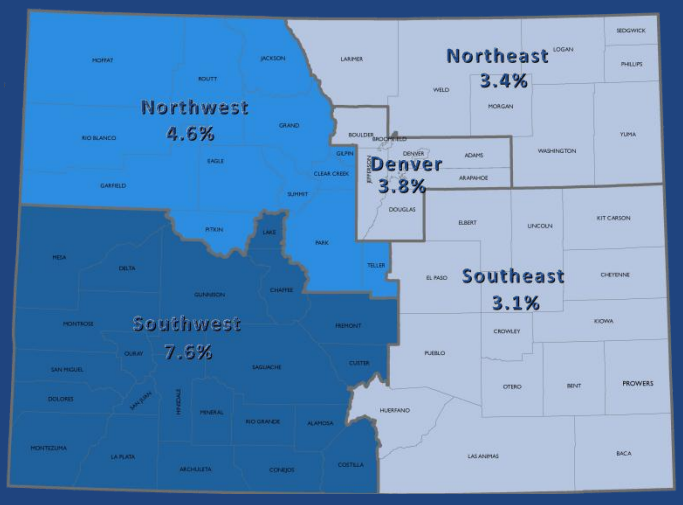
## CURRENT STATE OF ACCESS

Health insurance coverage is only one piece of the equation that ensures children in Colorado get the care they need. Access to health care services is another important variable. Across Colorado, families rely on a variety of provider types to meet their medical care needs including school-based clinics, pediatric clinics, private physicians, community health clinics, federally qualified health centers, and rural health centers.

Each of these provider types serve as a medical home for children, a recognized place for families and children to get their health care. Colorado has been and continues to be a recognized leader in developing medical homes for children. The Colorado Medical Home Initiative is a statewide effort to build systems of quality health care for all children, while increasing the capacity of providers to deliver care to children. Medical homes ensure that care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally responsive. The initiative was established in statute in 2007 to provide a medical home model of care for children enrolled in Medicaid and CHP+. Currently, 237,000 children who are enrolled in Medicaid and all children enrolled in CHP+ get care in a medical home.[8]

There are times that children need specialty care services to ensure they are growing up healthy and strong. Unfortunately, access to specialty care services can be a challenge for children, especially children enrolled in public health insurance programs. A recent national study trained volunteers to use a standard script to attempt to make appointments for children at specialty care clinics. When researchers indicated the children had public health insurance, 57% of calls resulted in an appointment being denied while a privately covered child obtained an appointment at the same clinic for the same medical condition.[9]

Across the state, access to care for children varies widely. Fewer than 5% of children in metro Denver (3.8%), the Eastern Plains (3.1%-3.4%), and Northwest Colorado (4.6%) report they do not have a usual source of care. In contrast, nearly 1 in 13 children (7.6%) in Southwest Colorado do not have a usual source of care.[3]




**Colorado Kids with No Usual Source of Care, 2011**

- More than 4.9%
- 4.0%-4.9%
- 3.0%-3.9%

Data from the Colorado Health Access Survey[3]

## PROGRESS AND MOMENTUM

*Colorado has made significant policy changes that have improved health insurance options for children.*

In the last five years, Colorado has made significant investments to improve health coverage and access for our children. We have improved our public health insurance programs and reduced red tape, making the programs more efficient for families, community agencies and providers. Our state has also taken steps to improve private health insurance coverage for children and pregnant women.

These changes have had a real impact on children. The American Community Survey, a national data source for information about health insurance coverage shows that between 2008 and 2010 over 41,000 Colorado children gained health insurance coverage.[2]

### STATE POLICY CHANGES

The decrease in both uninsured children overall and eligible but not enrolled children can be attributed to several factors, such as the increase in the poverty rate for Colorado kids, meaning that more now qualify for public insurance than before, as well as improved local outreach and a federal and state commitment to covering more kids. One major factor in the decrease is significant policy and regulatory changes. Since 2007, fourteen state laws and numerous regulatory changes have been enacted that strengthen and protect children's health insurance coverage in Colorado.

#### INCREASING COVERAGE

**HB09 1293: Health Care Affordability Act** (Ferrandino, Riesberg, Keller, Boyd)

- Increases payments to hospitals by maximizing provider payments based on federal regulations, increasing payments under the Colorado Indigent Care Program to 100% of cost and by paying a new quality incentive payment.
- Provides more families with access to public health coverage by increasing eligibility for children in CHP+ from 205% to 250% of the Federal Poverty Level (FPL) and increasing eligibility for parents in Medicaid from 60% to 100% of the FPL, both of which have been implemented.
- Ensures uninterrupted access to services for kids by providing 12 months of continuous eligibility for children enrolled in Medicaid, which will be implemented in 2012.
- Expands Medicaid to include a buy-in option for disabled children and working adults with disabilities.

**HB09 1353: Medicaid Coverage for Legal Immigrants** (Miklosi, Foster)

- Waives the 5-year waiting period for Medicaid and CHP+ benefits if applicants meet eligibility criteria other than citizenship.
- Implementation awaiting receipt of gifts, grants or donations.

**HB10 1021: Required Coverage for Maternity Care** (Frangas, McCann, Foster)

- Requires, among other things, that all newly-issued or renewed insurance policies in the individual market provide coverage for maternity care starting January 1, 2011.

**SB11 128: Child-Only Health Insurance Plans** (Newell, McCann, Summers)

- Requires health insurance companies that choose to participate in the individual health insurance market to offer child-only insurance products through two open enrollment periods per year, where child-only products must be sold on a guaranteed-issue basis, meaning children cannot be denied coverage based on medical history or current health status.
- The first 30-day open enrollment period occurred in August 2011.

**SB11 200: Colorado Health Benefit Exchange** (Boyd, Stephens)

- Establishes the governance structure and implementation process for the Colorado Health Benefit Exchange, a new health insurance marketplace that will begin operation on January 1, 2014.
- The board and legislative committee were appointed on July 1, 2011, and the two groups began meeting shortly thereafter.

## IMPROVING PROGRAMS

**SB07 211: Health Care for Children** (Hagedorn, McGihon)

- Establishes presumptive eligibility for children applying for Medicaid or CHP+, allowing coverage of children while their application is being processed.
- Requires an annual report on quality, access, and health outcomes.
- Allows for continuous enrollment for CHP+ kids moving to Medicaid.
- Decreases barriers for enrollment in public programs by clarifying the identity documentation required for pregnant women and 18-19 year olds applying for CHP+.
- Required that all provisions be implemented by January 1, 2008.

**SB08 161: Medicaid and CHP+ Enrollment** (Boyd, Merrifield)

- Reduces barriers to enrollment in Medicaid and CHP+ by eliminating the requirements for families to submit paycheck stubs; instead allows the state to verify a family's income using data that is already available. Interfaces with other systems holding relevant data were implemented August 2011.

- Allows for easy re-enrollment of children at the end of their eligibility period, thus avoiding interruption in coverage.

**HB09 1020: <u>Expedite Medical Program Re-enrollment</u>** (Acree, Spence)

- Establishes a process for telephone and online re-enrollment into Medicaid and CHP+, which would ensure that children receive continuous coverage. Both re-enrollment avenues are in the process of being fully implemented, although counties have the option of implementing telephone re-enrollment.

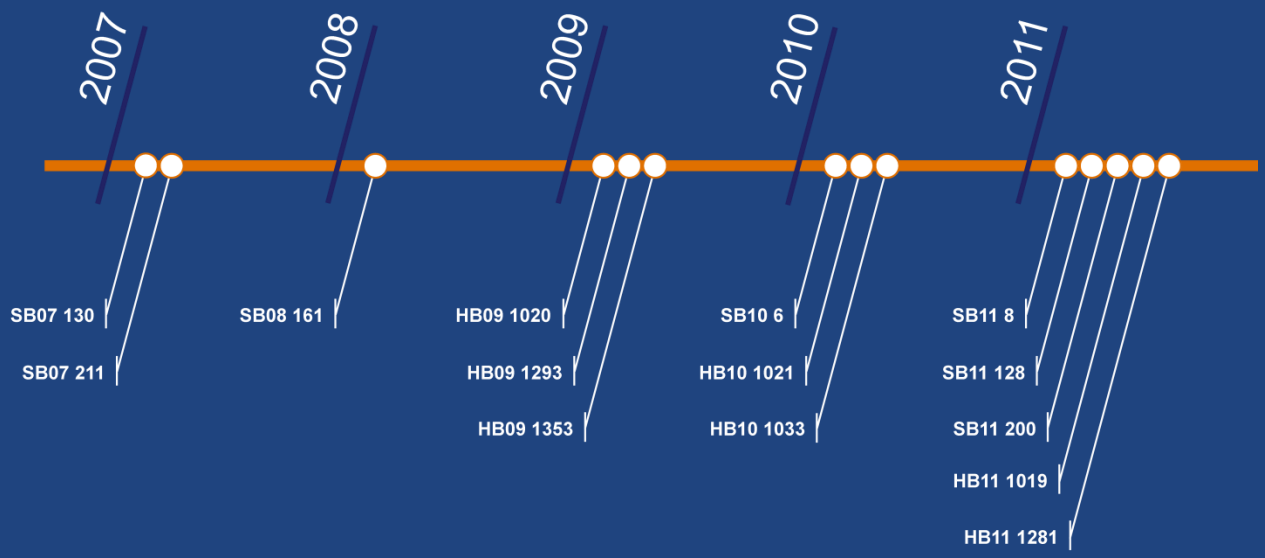
**SB10 006: <u>Identification Documents Reduce Poverty</u>** (Boyd, Summers)

- Allows individuals to obtain a birth certificate or death record for free if referred from a county department of social services or human services.

**SB11 008: <u>Aligning Children's Medicaid Eligibility</u>** (Boyd, Gerou)

- Allows for the alignment of CHP+ and Medicaid eligibility, regardless of a child's age. This would establish Medicaid eligibility for all children under the age of 18 to 133% of the Federal Poverty Level.
- Implementation has been planned for January 1, 2013.

## Timeline of Kids' Coverage and Access Legislation



## INCREASING ACCESS

**SB07 130: Medical Home for Colorado Children** (Boyd, M. Carroll)

- Declares that a "medical home" is important for children. A medical home is a concept, rather than physical location, that ensures a child has coordinated and comprehensive access to medical care, mental health care, and oral health care.
- Directs the Colorado Department of Health Care Policy and Financing (HCPF) to implement standards and systems to increase the number of children in Medicaid and CHP+ programs with a medical home. This process began in July 2008 and shortly thereafter, the medical homes were established and are still serving children on Medicaid and CHP+.

**HB10 1033: Screening Brief Intervention and Referral to Treatment** (Massey, Boyd, Schwartz)

- Adds to the list of optional services provided to Medicaid recipients, screening, brief intervention, and referral to treatment for alcohol and other substance abuse services.
- Became effective August 2010.

**HB 11 1019: Exempt School-Based Clinics Copay** (Kagan, Boyd)

- Allows school-based health clinics to waive patients' copayments and still bill private insurance for the visit. Previously, a clinic could not bill private insurance for the visit if the copayment or deductible were waived.
- Became effective upon signature.

**HB 11 1281: Health Care Professional Loan Forgiveness** (Joshi, Boyd)

- Dedicates some state dollars to the Colorado Health Service Corps, the state's health care professional student loan repayment program. This would allow for more effective administration of the program with incoming federal dollars.
- Provides loan repayment for certain eligible nursing faculty or health care professional faculty members.
- These provisions became effective June 2011, and will help alleviate the provider shortage.

## FEDERAL POLICY CHANGES

In 2009, the Children's Health Insurance Plan was reauthorized (CHIPRA). This guaranteed a source of federal funds for the CHP+ program in Colorado through 2013. In addition, the law created the opportunity to receive federal matching dollars for coverage of lawfully residing immigrant children and pregnant women (which was furthered by Colorado's HB09 1353 which put mechanisms in place to take advantage of this provision) and enable the children of state employees to participate in CHP+.[10]

Other provisions in the CHIPRA law created grant funding opportunities to support outreach and enrollment of eligible children and authorized bonus payments to states that improve enrollment, access and efficiency. Colorado has received two bonus payments through this provision, $13.7 million in December 2010 and $26.1 million in December 2011. Of the 23 state awards in 2011, Colorado's bonus of $26.1 million was the third largest - behind only Maryland and Virginia.[11]

The Patient Protection and Affordable Care Act of 2010 includes many provisions that impact children's health insurance coverage and access to care. In 2014, the Colorado Health Benefit Exchange will create a new health insurance marketplace for individual plans and small employer coverage. It is estimated that nearly 16,500 uninsured children in 2009 who live in families with incomes between $55,000 and $80,000 (250%-400% FPL) could find coverage through the Exchange.[6] Many more children may eventually purchase their health insurance through the Exchange, however, it will be through the child-only and family plans or through their parents' employer who may use the Exchange to purchase their employer-sponsored coverage.

The creation of state-based health insurance exchanges will create a new path to coverage for many children in Colorado; it will increase the affordability of private health insurance coverage through federal tax credit subsidies for their families and allow them to shop and enroll in a private health plan. The Exchange will use a single application through which families can apply online, by mail or by phone, and families who shop at the Colorado Health Benefit Exchange who are found to have children eligible for Medicaid or CHP+ will be connected to those programs for enrollment.

Other provisions in the Patient Protection and Affordable Care Act important to kids' coverage goals aim to simplify Medicaid and CHP+ enrollment through streamlined application procedures and data matching opportunities reducing the paperwork burden for families as well as county and state staff.[12]

## REGULATORY AND PROGRAM CHANGES

In 2009, the Colorado Department of Health Care Policy and Financing received funding from the federal Health Resources and Services Administration, State Health Access Program (SHAP). This funding served as the foundation for Colorado's program, the Colorado Comprehensive Health Access Modernization Program (CO-CHAMP). The CO-CHAMP program includes making investments in infrastructure and technology and new strategies around outreach and enrollment, benefit design, and cost-sharing. The original grant totaled over $42 million over five years with requirements to apply annually to receive funds. However, before the third year of funding began, the federal funding for the SHAP program was eliminated in April 2011. As a result, Colorado will not receive funding for years three through five. The Department of Health Care Policy and Financing has requested and been granted a one year "No Cost Extension" which will enable Colorado to use unspent funds from the first two years of the grant with an official end date of August 31, 2012.

Despite the loss of this federal funding, Colorado had made significant progress toward modernizing the public programs in the state. In October 2009, the state launched an electronic tool called Colorado Program Eligibility and Application Kit (PEAK) which allows Coloradans to check their eligibility for benefits, and since May 2011, apply and manage benefits online.

Additionally, effective August 29, 2011, the Colorado Department of Health Care Policy and Financing put in place three new administrative policies that will streamline the eligibility determination and enrollment processes for Medicaid and the Child Health Plan Plus (CHP+) program.

- **Income Verification** – Reduces the need for outdated paperwork requirements in favor of a new electronic Income Eligibility Verification System (IEVS) that allows Medicaid and CHP+ officials to verify income using data already collected from employers by the Colorado Department of Labor and Employment. This change, which applies to most Coloradans seeking Medicaid or CHP+ coverage, was made possible by state legislation passed in 2008 (Senate Bill 08-161).
- **Citizenship & Identity Verification** – Streamlines eligibility determinations by verifying applicants' U.S. identity and citizenship electronically via a direct connection with the U.S. Social Security Administration. This improves on prior requirements that applicants provide birth certificates or other paper documentation of U.S. citizenship and identity. This change was made possible by the federal Children's Health Insurance Program Reauthorization Act of 2009.
- **Automatic Reenrollment** – Eligible Coloradans who have had no change in their income or number of household members will be able to automatically re-enroll in Medicaid and CHP+ without having to return a renewal form.[13]

Another significant program change is the pilot program, the Accountable Care Collaborative. This Medicaid initiative aims to contain costs and improve health outcomes of individuals enrolled in Medicaid. There are three components to the program – Regional Care Collaborative Organizations (RCCOs) which serve to coordinate the Accountable Care Collaborative implementation in seven regions across the state. Primary Care Medical Providers work with the RCCOs to provide a medical home for individuals covered by Medicaid by managing their health needs. The final component of the program is the Statewide Data and Analytics Organization which is collecting and managing the data and Medicaid claims information to inform care delivery and evaluation of the Accountable Care Collaborative. Individuals covered by Medicaid began enrolling in the Accountable Care Collaborative in May 2011.[14]

## CROSSING THE FINISH LINE FOR ALL KIDS

*We can overcome the inherent obstacles to reaching our lofty, but achievable goal of ensuring coverage and access to health care for all Colorado children.*

It's not too much to ask that all of Colorado's kids have access to the health care they need, when they need it. To build on the strong momentum of the past few years and ensure coverage and access for all kids in all communities across Colorado, All Kids Covered has identified five key strategies to continue this progress on behalf of Colorado's children.

### LEADERSHIP AND ACCOUNTABILITY

Crossing the finish line in Colorado will require strong leadership and a commitment to accountability. Colorado's elected officials, state and local agency staff, funders and advocates have been strong partners in the effort to provide coverage and access to all children in our state. Through this collaborative model and under the vision established by Amendment 35, the Blue Ribbon Commission for Health Reform, the Building Blocks agenda, Child Health Insurance Plan Reauthorization Act and the Patient Protection and Affordable Care Act, we have made tremendous progress in recent years. To continue this movement and reach our shared goal of covering all kids, we must all commit to protecting the progress that has been made, come to an agreement about the next steps towards our goal and hold ourselves accountable for continued success using shared metrics for evaluation. With a clear roadmap noting where we have been and charting the course for where we are going, we can continue our cross-sector, non-partisan work together. We can break down the jurisdictional boundaries and overcome the inherent obstacles to reaching our lofty, but achievable goal. We can ensure coverage and access to health care for all Colorado children.

### COVERAGE AND ACCESS FOR ALL CHILDREN

While Colorado has made tremendous progress in reducing the number of uninsured children in our state, we know more can and must be done to reach our goal of ensuring all kids have coverage and access to needed care. There are three key areas of opportunity moving forward. First, a significant number of uninsured children – research estimates well over half of all uninsured children – are eligible, but not enrolled in either Medicaid or CHP+. Over 90% of low-income parents say they would enroll their uninsured child if he or she was eligible, but around half do not know that their child is eligible, do not know how to apply, or find the application processes difficult.[15] We can address these identified challenges by making our public coverage programs more accessible, effective and efficient. Second, as we build the Colorado Health Benefit Exchange and prepare to launch it in 2014, we must ensure that the needs of families, not just adults, are considered. Child-specific considerations for the exchange include: (1) ensuring high quality customer service and support for low-income families that move back and forth between subsidized products in the Exchange and our public coverage programs; (2)

ensuring good customer service for families with children served by CHP+ and parents with subsidized exchange coverage; and (3) ensuring the Exchange offers a choice of products that are designed to provide appropriate benefits for children. Finally, recognizing that even in the best case scenario, some percentage of children will remain uninsured, we must ensure Colorado has a healthy and sustainable safety net provider network that will provide high quality and affordable care to the uninsured. To do this, we must support the Colorado Indigent Care Program (CICP) and other provider reimbursement and grant programs that fund safety net providers.

## SYSTEMS AND PRACTICES FOR MAXIMIZING ENROLLMENT AND RETENTION

An efficient and reliable technical infrastructure and related business processes are essential to supporting successful public coverage programs and the new Colorado Health Benefit Exchange. Without them, customer service, program integrity and basic operations all suffer. While Colorado has made some modest progress in the area of technological and business systems improvements in recent months, with the launch of the PEAK online application and implementation of electronic income and citizenship verification, the technology and related business systems that serve as the backbone of public insurance coverage have significant flaws. Since its creation, the Colorado Benefits Management System (CBMS) has been plagued by performance problems that have been well catalogued by federal and state audits and lawsuits. The state's Medicaid Management Information Systems (MMIS) have also contributed to coverage problems, but with less public attention. The reasons for these system challenges are many and, unfortunately, the solutions are not simple. Recent progress to develop a plan to modernize the information technology infrastructure of public programs and the availability of new resources to support this work are hopeful developments. The promised results of these investments cannot be accomplished without leadership, transparency, accountability and broad stakeholder participation.

## MESSAGING AND COMMUNICATIONS

Health insurance is like any other product or good – consumers need clear, consistent and easy-to-understand information to make smart choices about their coverage options. However, we know that consumers often are better informed about many of the products they buy than the health insurance they choose. A recent survey of low-income parents revealed that the top barriers to enrollment in public programs include the perception of a difficult enrollment process, uncertainty regarding income eligibility requirements and where to apply, and concerns about quality and access.[16] States that have achieved the highest levels of coverage for kids often have simplified and consolidated their public coverage programs under a single name or brand eliminating confusion about eligibility and have found innovative and effective avenues for communication with families. They have also ensured clear and consistent communication with health plans and providers who often serve as trusted messengers to families. There is significant opportunity for Colorado to help families understand the importance of health insurance and their health insurance options as new options become available in the near future.

## REGIONAL ADAPTATION

The state of Colorado includes communities ranging from major urban centers to frontier communities separated by hundreds of miles and demanding terrain. A one-sized-fits-all approach to coverage and care won't work for the children who live throughout our diverse state. As such, local communities must come together to determine what works for them and how, under a unified framework, they can ensure expanded coverage and access for kids. There are many examples of effective regional approaches to coverage and care – from the collaborative coverage and access efforts in Mesa County, which has a highest percent of insured residents on the Western Slope[3], to the successful and strong network of locally supported safety net clinics across Colorado, we have shown that we can make meaningful progress at the local level. Public policy must continue to foster that local innovation and support strategies that integrate local knowledge, cultural sensitivity and community commitment.

# STRATEGIES FOR SUCCESS: LESSONS FROM COLORADO AND OTHER STATES

*The clearly stated goal of expanding health coverage for kids helped to drive legislative action, community effort and concerted investments by state and national foundations to achieve it.*

## LEADERSHIP AND ACCOUNTABILITY

The Colorado Blue Ribbon Commission for Health Care Reform was created in 2006 to study and establish models for expanding coverage, especially for the uninsured and underinsured, and to decrease state health care costs. Shortly following the release of the commission's final report, Governor Bill Ritter announced a "Building Blocks for Health Care Reform" plan that incorporated the commission's recommendations into a $25 million investment that focused on the highest priority areas—one of which was expanding children's health coverage.

This clearly asserted goal of expanding health coverage for kids helped to drive both legislative action and concerted investments by state and national foundations to achieve it. In addition to the passage of several bills that increased coverage and access and improved the quality of the programs, grant funding was supplied to state departments, safety net clinics, enrollment programs, workforce recruiters, advocacy organizations and more, in order to address the problem on all fronts.

Other states with strong leadership and a commitment to the cause have also seen great success in their work. The New England states of Massachusetts, Vermont, Connecticut, New Hampshire, Maine, and Rhode Island have significantly lower rates of uninsured children than any other region in the United States.[17] The **New England Alliance of Children's Health** attributes this success to strong partnerships with health care decision makers, regional collaboration among dedicated advocates and use of personal stories with descriptive data, cultivation of champions in state government, and continued focus on coverage including outreach, education and training, and assistance.[18]

Under the leadership of Ruth Kennedy, Deputy Director of Eligibility at the Department of Health and Hospitals, the state of Louisiana has implemented a process improvement program to streamline Medicaid and Children's Health Insurance Program administration and ultimately to provide benefits to children who were eligible but not yet enrolled.[19] Teams built across agencies and involvement from the entire system working toward a common goal has been key to their success: coverage for more Louisiana children.

## COVERAGE AND ACCESS FOR ALL CHILDREN

Colorado has a number of initiatives actively and creatively addressing the need for coverage and access for all children. The **Maximizing Outreach, Retention and Enrollment (MORE)** grant program was established to design, develop, and implement outreach for enrollment into Medicaid and CHP+ expansion populations identified in the Colorado Health Care Affordability Act. Since October 2010, over $1.5 million dollars has been awarded by the Department of Health Care Policy and Financing to community organizations through the MORE grant program. These grants provide funding for enrollment activities and application assistance that respects the community's cultural and economic needs. The grants also have supported the establishment of new collaborative relationships with community partners to expand educational opportunities. The MORE grant program has provided essential outreach and education throughout Colorado. [20]

The **Colorado Medical Home Initiative** includes representatives from agencies, hospitals, organizations, families, and policymakers. Together, they promote solutions to develop a quality-based system of health care for children in Colorado.

The **Colorado Children's Health Care Access Program (CCHAP)** is also actively working to address barriers that have prevented private pediatric and family practices from accepting Medicaid children and providing them with a medical home. CCHAP helps pediatric practices meet the state's medical home certification requirements and receive the enhanced Medicaid reimbursements made possible with a medical home designation. CCHAP also provides these practices with an array of support services, including care coordination, a resource hotline, and billing assistance. A recent evaluation shows children covered by Medicaid and with a medical home in a private pediatric practice supported by CCHAP, visit the emergency department less often, have more preventive care visits, and are less expensive for the state Medicaid program than children in non-CCHAP affiliated practices.

While Colorado has primarily addressed this issue through targeted initiatives, other states have made an even stronger declaration of coverage and access for all children. All children age 18 and under living in Illinois, regardless of immigration status or income, are eligible for **All Kids** so long as insurance requirements are met (primarily based on family income and whether the child has been insured in the last twelve months).[21]

In 2007, Washington passed its Cover All Kids Law, which affirmed their commitment to offer coverage options and ensure access to care for all children. Eligibility for their **Apple Health for Kids** program is based on residence and income only and offers comprehensive benefits to all eligible applicants.[22]

## HIGH FUNCTIONING SYSTEMS AND PRACTICES FOR MAXIMIZING ENROLLMENT AND RETENTION

Colorado recently implemented changes to its eligibility verification process as an important step in improving the functioning of its public insurance programs. These changes are in line with a

national trend of reducing paperwork and simplifying processes. New electronic interfaces reduce the need for paperwork and simplify the verification of income, citizenship, and identity.

**Maximizing Enrollment for Kids** is a national initiative that identified the increased utilization of electronic capabilities as a central criterion to success in increasing enrollment and retention. Sponsored by the Robert Wood Johnson Foundation, it has made targeted investments to help states adopt these best practices to realize their coverage goals. Methods employed by high-achieving states include self-declaration of income, third-party databases to identify uninsured children and verify enrollment data, electronic signatures, and electronic case records.

Also proven as an essential best practice is a strong "no wrong door" policy to improve coordination when separate agencies administer the Medicaid and CHP+ programs, as is the case in Colorado. Such a policy helps ensure that families can apply through any possible avenue—office visits, mail, online, or community organizations—and have assurance their children will be enrolled in the program for which they are eligible.

Other best practices identified by the Maximizing Enrollment for Kids program include joint applications for Medicaid and CHP+, online applications, and presumptive eligibility, all of which have all been implemented in Colorado. Presumptive eligibility allows qualified sites to grant temporary public coverage based on the family's declaration of income so a child can receive medical care while the application is processed.

Colorado has also looked to Louisiana as a model, since they provide a strong example of best practice systems and practices for benefits enrollment. Louisiana maximizes the use of technology and electronic data exchange in their administration of the public coverage programs. In a recent evaluation, less than 1% of renewal applications were denied for procedural reasons and 95% of Medicaid and 90% of CHIP renewals were completed without the family submitting additional paperwork. [23]

Several other states, including Colorado, make pre-populated renewal forms available to families to ease the burden. Such forms make the process simpler and more time-efficient, reducing the risk of families missing their renewal deadlines. Families will be automatically re-enrolled in Medicaid and CHP+ if there are no changes and only need to update information that has changed since the last review.

Some states take the renewal process even further by eliminating much of the need for families' direct involvement. In ex parte renewal, needed renewal information is populated automatically and the staff responsible for determining eligibility can access external information systems, such as a state's tax system or employer payroll records filed with the state, to verify income. The child can be reviewed without further family involvement based on this information. Louisiana renews one-third of renewals through this process. In Colorado, information reported for other public assistance programs from the prior three months is used to automatically renew people on Medicaid.

## MESSAGING AND COMMUNICATIONS

As Colorado's children's health insurance programs have grown and changed, it has been important that significant outreach was done to communicate its effects. Many stakeholder meetings have been held to explain new policies, fee structures, and benefits modifications, and feedback was requested throughout. Transparency of the process was important for gaining stakeholder buy-in and support, which allowed for smoother implementation and fewer battles between constituent groups.

A particularly creative medium for communicating public program information to a target audience was also a Colorado innovation—**Encrucijada** was a Spanish-language telenovela designed to explain health insurance options to viewers within the plot lines of the story. It resulted in more than 2,000 calls to a health hotline over the course of the show's seven-month season. One-third of callers requested information about CHP+, and about one-fifth called to learn about low-cost health insurance options. Others sought help for depression, domestic violence, and diabetes.[24]

One model Colorado could look to for a successful branding effort is the **Wisconsin BadgerCare Plus for Children and Families**. Wisconsin uses a single program name as an umbrella for various coverage options, and it is aggressively marketed as one program with a single application and coordinated outreach. However, behind the scenes, CHIP, Medicaid, Healthy Start program dollars, and other funds are matched to each enrollee. The singular messaging targeting all children has been identified as a key factor behind the program's success. Today more than 90% of children in Wisconsin are insured. [25]

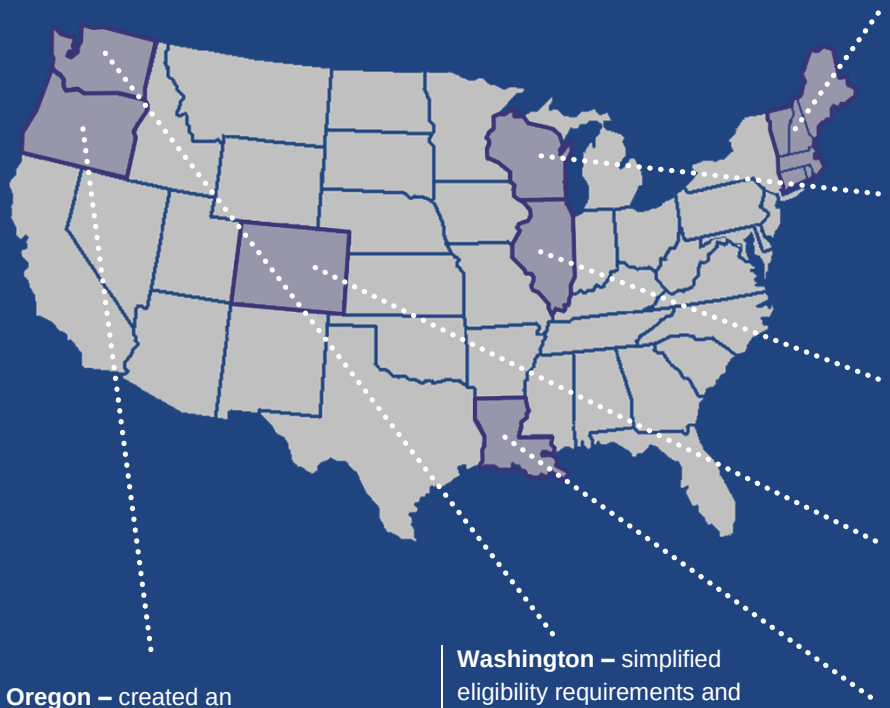
The program's success has attracted not only attention but also funding. BadgerCare Plus received a $23 million federal performance bonus in 2010 in recognition of its significant simplification efforts in application and renewal processes.

A recent program evaluation conducted by the University of Wisconsin Health Policy Institute identified several key best practices including the careful program planning and thoughtful implementation over the course of two years, including strong community outreach, media attention, and enrollment assistance mini-grants.

Many of these benefits are perceived to derive from the positive public perception and decreased stigma. Participants often speak of the "insurance program" and no longer articulate the program as public assistance.

Illinois has been a leader in providing universal health coverage to children in 2006 with its **All Kids** program. The program is comparable to Wisconsin's BadgerCare Plus in that a single program, All Kids, serves as the face of multiple funding streams. All Kids has a single application, but on the backend the enrollees are matched with appropriate funding sources. Key findings in an evaluation case study by the Robert Wood Johnson Foundation revealed that Illinois' CHIP and Medicaid enrollment increases were among the highest in the nation.

## Strategies for Success



**New England –** lowest rate of uninsured children in the US, due to strong partnerships, regional collaboration, and cultivation of champions in state government

**Wisconsin –** combined all children's programs into a single program with one application, coordinated outreach, and singular messaging.

**Illinois –** provided universal health coverage for children, regardless of citizenship status, and simplified eligibility verification

**Colorado –** identified and served children through schools, cultural hubs, and combined service and enrollment sites

**Louisiana –** streamlined Medicaid/CHIP administration through teams built across agencies and by maximizing technology

**Oregon –** created an extensive network of school-based health centers

**Washington –** simplified eligibility requirements and offered mobile services to suit local needs

Interviewees agreed that key factors for the rise included public relations investments with targeted outreach and simplification of income verification requirements. [26]

### REGIONAL ADAPTATION

Across Colorado, various locally-focused strategies have been developed to address health care needs for children. Creative programs have found ways to improve access, such as bringing services to the children to remove obstacles for families. School-based health clinics, mobile health care, and after-hours phone triage provide valuable opportunities for health care access to many in need of care.

**School-based health centers** have been effective in reaching underserved children of school age. These health clinics are on school premises and provide preventative care while also responding to illnesses and other immediate needs. Such clinics are able to utilize lulls in classroom activity to provide immunizations or other wellness checks. School-based health care also eliminates the sometimes difficult issue of scheduling time with parents, because the parent does not have to be present. School health center team members include physicians, physician assistants, nurse practitioners, social workers, mental health therapists, and health educators.

Currently, there are 47 school-based health centers in Colorado. School-based health centers are hosted by 19 of Colorado's 178 school districts. They are located in communities where

access to care is limited for a large number of children, because of low incomes, lack of health insurance, or geographic isolation. Most school-based health centers assist eligible families with the Medicaid/CHP+ applications.

According to recent data, school-based clinics in Colorado provided health care to children who represent an array of coverage: 31% were uninsured, 51% were enrolled in Medicaid or CHP+, 11% were covered by other insurance, and 7% did not report their insurance status.[27]

Studies show school-based health care positively impacts students in many areas, including: reduced absenteeism, increased access to preventive and mental health care, increased care coordination and referral completion, reduced costs for Medicaid programs, reduced emergency and urgent care visits, and increased health knowledge among students.

As an example, the school-based health centers offered by **Denver Health**, a local hospital, provide primary care, health education and mental health care for students at 13 City of Denver elementary, middle, and high schools. These clinics expand access, provide preventive treatment, and help children stay in school while offering a convenient way for parents to ensure their children get quality physical and mental health attention. More than 8,000 students receive services through these clinics each year.

**Rocky Mountain Youth Clinics** operates three traditional pediatric clinics as well as three mobile units (one medical, one dental, and one combo unit) serving school and community needs. They provide health care services including assistance with enrollment into Medicaid and CHP+, health education, immunizations, mental health counseling, minor acute care, prescription assistance, preventive checkups, referrals to specialists, sick visits, social services, and other related services. These services are provided regardless of a patient's insurance status or a family's ability to pay.

Many health care service sites are also enrollment assistance sites, addressing two key needs simultaneously—coverage and service. Additional efficiencies should be explored to ensure that all community needs are met. Co-located services provide an opportunity to reduce administrative cost, enhance community benefit, and improve quality of life.

Outside of Colorado, there are excellent examples in the Northwest of adapting programs to suit local needs.[28] Oregon has a school-based health center network of over 22 counties, which serves 50,000 kids at 55 centers. They have 7 sites in development, and were able to restore funding of $500,000 last legislative session to continue these programs for kids. Most of the clinics serve all the children within the clinic's school district, and some offer expanded after-school hours.

The state of Washington provides similar services through mobile clinics. The **SmileMobile**, a collaborative, privately-funded project, is a three-chair traveling dental clinic. Since 1995, it has treated more than 25,000 children, or an average of 60 per week. Its services range from regular examinations and preventive care to fillings and minor oral surgery, all of which are provided on a sliding fee scale to patients.[29]

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