



Health Care Coverage and Access for Children in Low-Income Families: Stakeholder Perspectives from Colorado

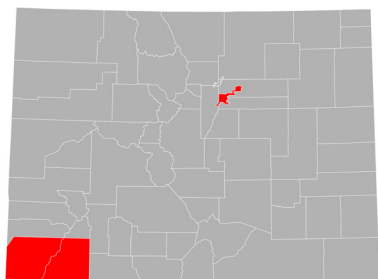
Research Brief 2

January 2016

State Statistics

- With a population of 5.36 million, Colorado is the 22nd most populous state in the country.
- 24 percent of Colorado residents are under age 18.
- The population of Colorado is 84 percent white, 4 percent black, 3 percent Asian, and 9 percent other; 21 percent of Coloradans are Latino or Hispanic.
- The governor is a Democrat and the legislature is divided, with a Republican majority in the senate and a Democratic majority in the house.

Sources: Colorado General Assembly (2015); U.S. Census Bureau (2014a).



Map of Colorado, with Denver County (middle) and La Plata and Montezuma counties (lower left) shaded red.

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Policy Research

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Executive Summary

An important question to ask about any health care system is how well it serves children in low-income families. In Colorado, as in many states, there are reasons to ask that question with optimism and concern. On one hand, the proportion of eligible Colorado children enrolled in Medicaid or the Children's Health Insurance Program (CHIP) increased from 70 percent in 2008 to 84 percent in 2013. The passage of the Affordable Care Act (ACA) in 2010, the reauthorization of CHIP in 2015, and earlier Colorado policies to expand Medicaid and CHIP help protect these gains. But uncertainty exists: although Colorado expanded Medicaid and established a state-run health insurance Marketplace, Medicaid's rapid growth in the state may become politically contentious, and the Marketplace faces a challenging transition from a start-up to a sustainable entity. Moreover, CHIP is funded only through 2017 and reauthorized until 2019; there are concerns about how Colorado would cover children if CHIP were eliminated.

Purpose. This issue brief was prepared as part of a small-scale qualitative study funded by the Colorado Health Foundation to convey recent policy developments, remaining unmet needs, and emerging issues in children's health care coverage and delivery, from the perspective of knowledgeable stakeholders. Issue briefs on children's health in California and Texas and a cross-state analysis will be available in early 2016.

Methods. The brief draws information from telephone interviews with 27 respondents in summer 2015. Respondents represented the Colorado Department of Health Care Policy & Financing, health care providers, health care organizations and professional associations, CHP+ (Colorado's CHIP program) managed care plans, community-based organizations, and advocacy organizations. To capture some of the variation in insurance access and care delivery across the state, the interviews focused on three areas: (1) the state as a whole; (2) Denver County, the urban county that includes Denver and is home to the greatest number of children who are enrolled in Medicaid or CHP+; and (3) La Plata and Montezuma counties, largely rural neighboring counties in southwest Colorado.

Key findings. When asked about health insurance coverage, interview respondents described several positive developments in insurance eligibility expansion, outreach, and enrollment simplification, nearly all of which stemmed from ACA mandates or recent state policy developments. Respondents also described children who still face barriers to coverage, including eligible children in families with mixed immigration status. When asked about access to care, respondents emphasized Colorado's strong network of primary care providers. However, they expressed concerns that children in low-income families may not be receiving all recommended preventive services and face barriers in accessing specialty care. Looking ahead, respondents identified several areas of interest or concern, including potential political backlash associated with rapid and substantial Medicaid expansion, prospects for continued funding and reauthorization of CHIPRA, and how children will fit into plans for Colorado's State Innovation Model (SIM) Award, payment reform, and Phase II of the state's Medicaid Accountable Care Collaborative (ACC).

References to legislative activities are provided for context. No Colorado Health Foundation funds were used in any legislative activities.

Implications for advocates, decision makers, and funders. Respondents suggested several possible agenda items for children’s health stakeholders: (1) developing targeted outreach and enrollment assistance for hard-to-reach children, (2) promoting access to and use of preventive services, (3) promoting Medicaid participation among specialists or otherwise increasing children’s access to specialty care, (4) ensuring continued policymaker support of the newly expanded Medicaid program and a reauthorized CHP+ program, and (5) ensuring the inclusion of children’s health stakeholders in payment and Medicaid reform planning and implementation.

I. Access to Health Insurance Coverage

In what ways has it become easier for low-income families in Colorado to obtain health insurance for their children in the past few years?

Awareness of coverage options for Medicaid and CHP+ has increased. Respondents said that media coverage of the ACA (both positive and negative) raised awareness among families and led many to explore their options for coverage. Often, adults who called enrollment assisters or insurance brokers to explore coverage options for their children were pleasantly surprised to hear that they also were now eligible for coverage. Respondents also reported witnessing a “welcome mat effect,” in which newly eligible adults enrolling in Medicaid become aware of their children’s eligibility for the same programs. One respondent referred to a shift among low-income families to thinking about health coverage as a “family activity,” as opposed to the piecemeal approach that many families previously experienced.

Families benefited from stronger statewide outreach and enrollment assistance. Noting recent increases in the resources available for outreach and enrollment, respondents described several ways these activities have been strengthened.

Statewide funding and activities. Colorado used ACA planning and establishment grants to award \$17 million to the Connect for Health Assistance Network, which includes more than 50 Assistance Sites located within hospitals and clinics; public health, community, and faith-based organizations; and trade associations. In addition, Colorado’s federally qualified health centers (FQHCs) received over \$3 million in ACA application assistance resources (Hill et al. 2014). The Colorado Health Foundation has supported various aspects of outreach and enrollment including the provision of training support for assisters across the state. The Department of Health Care Policy & Financing recently expanded Healthy Communities, which now combines components of the Early Periodic Screening Diagnostic and Treatment (EPSDT) outreach and administrative case management program and CHP+ outreach into one program, through which family health coordinators assist families with enrollment, preventive care education, finding providers, and eligibility redetermination (Colorado Department of Health Policy & Financing 2015a). Formerly, Healthy Communities focused on outreach related to specific Medicaid benefits and was not combined with CHP+ outreach.

Local activities. Respondents in Denver and the Southwest described several recent efforts to increase outreach to immigrant families, each described as strong and promising approaches. Denver, La Plata, and Montezuma counties benefit from the efforts of a diverse group of outreach workers, many of whom are bilingual and are members of immigrant communities themselves. Working in providers’ offices, family resource centers, and school-based health clinics, these outreach workers educate families on available health coverage options and help them apply.

Respondents reported that school-based health clinics throughout the state are excellent venues for outreach. Nurses and others working in school-based health clinics help identify uninsured children and adolescents accessing care and connect their

families to enrollment specialists. Some school-based health centers have enrollment specialists on site periodically or regularly to assist families with enrollment.

In Denver, respondents said Head Start programs are a good place to reach families who are eligible for Medicaid and CHP+. Denver Health, a large health care system in the city that serves a large proportion of Medicaid and CHP+ enrollees, partners with Head Start programs in the city to place mobile outreach units at Head Start centers. Mobile units provide information to families about coverage options and help them apply for coverage.

“Having access [to mobile outreach units] within your community, right next to your Head Start, is invaluable.”

– Denver County respondent

Families benefit from a streamlined application process and new technologies to aid with enrollment, redetermination, and reporting life changes. The ACA created a single, streamlined application to apply for all subsidized medical coverage, including Medicaid, CHP+, and the Marketplace. Colorado’s adoption of the new, single application led many health insurance brokers who previously worked exclusively on private insurance enrollment to also begin enrolling applicants in Medicaid and CHP+.

Colorado recently rolled out the PEAK website, an online service for families to apply for health and other public assistance programs (Colorado Department of Health Care Policy & Financing 2013). Families can use a computer or smartphone to submit an application, track eligibility and redeterminations, submit documents, report updates on life changes, make payments, and print insurance cards. PEAK allows more families to enroll from their homes instead of visiting a public health or county office. Over 2,000 individuals have downloaded the PEAK application to their smartphones. Members of a small remaining segment of the population lack access to a computer or smartphone and do not benefit from PEAK. In addition, respondents indicated that small typos in PEAK online applications can result in processing problems. However, the overarching perceptions of the website’s ability to simplify enrollment and redetermination were positive.

Colorado has also simplified the enrollment process by implementing administrative income verification in 2010 and real-time eligibility in 2013. Prior to administrative income verification, applicants had to submit paystubs with their applications. Respondents agreed that the automated system reduced barriers that were keeping families from completing their applications. In addition, because of real-time eligibility, approximately 80 percent of Medicaid applicants receive a determination in 45 minutes, instead of up to 45 days (Colorado Governor’s Office of Information Technology 2015). Recently, the state legislature also approved a shift from monthly to annualized income for Medicaid and CHP+ eligibility determinations. While not yet implemented, this change is likely to mitigate churn between programs throughout the year for enrollees whose incomes vary month to month, such as seasonal workers.

Continuous eligibility in Medicaid, adopted in 2014, means children may be more likely to retain coverage and benefit from continuity of care. Several respondents praised the state’s 2014 adoption of 12-month continuous eligibility for children in Medicaid, which allows them to remain eligible regardless of changes in income. Children in CHP+ already had 12-month continuous eligibility. Some respondents predicted that continuous eligibility in Medicaid and CHP+ will improve continuity of care; others added that continuity would be further strengthened if Colorado implemented 12-month continuous eligibility for parents in Medicaid as well. Respondents added that continued advocacy and monitoring of this policy change will be necessary to ensure effective implementation.

Children’s Well-Being

- 15 percent of children in Colorado live in poverty.
- 35 percent of children (475,900) in Colorado are enrolled in Medicaid/CHP+.
- Medicaid/CHIP participation among eligible Colorado children increased from 70 percent in 2008 to 84 percent in 2013.
- Colorado’s Medicaid program covers children up to 142 percent of the federal poverty level (FPL). Its combination CHIP program covers children between 143 and 260 percent FPL.

Sources: CMS (n.d., 2015); Henry J. Kaiser Family Foundation (2015); Kenney et al. (2012); U.S. Census Bureau (2014b).

Health Care

- 6 percent of children and 14 percent of working-age adults in Colorado lacked health insurance in 2014.
- Colorado expanded its Medicaid program as envisioned by the ACA. It operates a state-based insurance Marketplace.
- Colorado implemented a Medicaid Accountable Care Collaborative (ACC) in 2011, with the goals of controlling costs and increasing quality.

Sources: CMS (n.d.); U.S. Census Bureau (2014c).

What key factors are driving these changes?

Many federal and state policies shaped these positive changes in coverage. Below is an overview of some of the recent policy changes that have expanded eligibility for health coverage in Colorado (see Table 1).

Federal changes

ACA. Respondents attributed the decline in children’s uninsured rates in large part to the positive effects of ACA Medicaid expansion. The ACA also made federal matching funds and grants available for outreach and enrollment and modernization of states’ eligibility and enrollment systems. Finally, the law eliminated stair-step eligibility, which split sources of coverage for children in the same family. However, Colorado implemented stair-step elimination prior to the ACA; in 2013, Colorado began transitioning all children enrolled in CHP+ with family incomes under 133 percent of the federal poverty level into Medicaid (Prater and Alker 2013).

Table 1. Federal and state policies expanding eligibility for health coverage in Colorado

		Policy	Description
Federal policies	ACA	Medicaid expansion	Expanded Medicaid coverage to adults with household incomes up to 138% FPL.
		Marketplace coverage	Expanded health coverage to adults with household incomes up to 400% FPL.
	CHIP Reauthorization	Extended federal CHIP funding through 2017.	
State policies		Elimination of stair-step eligibility	Aligned coverage so that all children with household incomes under 133% FPL are eligible for Medicaid. Children previously eligible for CHIP transitioned to Medicaid.
		12-month continuous eligibility	Provided 12 months of continuous eligibility for children in Medicaid.
		Elimination of CHP+ waiting period	Eliminated the three-month waiting period that a child must be uninsured before enrolling in CHIP.
		Elimination of five-year waiting period	Eliminated the five-year waiting period for lawfully present immigrant children and pregnant women to enroll in public health coverage.
		Medicaid buy-in	Allows children with disabilities in households with incomes under 300% FPL to buy into Medicaid or CHP+ coverage.
	Hospital provider fee	Allowed for expansion of Medicaid coverage to parents from 60 to 100% FPL and to pregnant women in CHP+ from 205 to 250% FPL.	

Sources: CMS (n.d.); Family Voices Colorado (2012); Prater and Alker (2013); Colorado Department of Health Care Policy & Financing (n.d.).

FPL = federal poverty level.

“In the last two years, the biggest win would be the Medicaid expansion in Colorado...we’re excited about that progress.”

– State-level respondent

CHIP reauthorization. Across the state, respondents lauded federal reauthorization of CHIP. As of August 2015, nearly 49,000 Coloradans were receiving coverage through CHP+ (Colorado Department of Health Care Policy & Financing 2015b). Several respondents indicated that, without CHP+, many children would become uninsured because some families perceive that Marketplace coverage is unaffordable. In addition, the “family glitch,” which prevents some low-to moderate-income families from receiving financial assistance to purchase health coverage through the Marketplace, could become increasingly problematic if CHP+ were to be eliminated. The “family glitch” refers to the fact that under the ACA, employees seeking coverage through the Marketplace are not eligible for subsidies if they have access to affordable employer-sponsored coverage. However, affordability is based on the cost of individual-only coverage, not higher-cost family plans. In the absence of Colorado’s CHP+ covering children with household incomes up to 260 percent of the federal poverty level, the glitch would affect more families.

State changes

Recent state policies have also likely increased enrollment in Medicaid or CHP+, including: (1) elimination of stair-step eligibility (described above); (2) introduction of 12-month continuous eligibility for Medicaid, (3) elimination of the three-month waiting period for CHP+, (4) funding to implement Colorado’s 2009 elimination of a five-year waiting period that prevented lawfully present immigrant children and pregnant women from enrolling in public health coverage programs, (5) implementation of a Medicaid and CHP+ buy-in program for low-income children with disabilities, and (6) the passage of Hospital Provider Fee legislation in 2009, which authorizes the Department of Health Care Policy and Financing to collect a fee from hospital providers to increase Medicaid and Colorado Indigent Care Program payments to hospitals and expand health care coverage in Medicaid and CHP+ programs.

In what ways has it remained difficult for low-income families to obtain coverage for their children? What factors are at work?

Although Colorado has achieved considerable recent success with enrolling eligible children into Medicaid and CHP+, a small population of hard-to-reach but eligible children remain uninsured. Below is information about coverage issues that affect some groups of children.

Eligible children of undocumented immigrants. By federal law, none of Colorado’s undocumented immigrants are eligible for health insurance coverage through Medicaid, CHP+, or the Marketplace, and across the state, respondents identified coverage for undocumented immigrants as a pressing need. In addition, many Colorado families have mixed immigration status and include children who are citizens and are eligible for coverage. Respondents said that undocumented parents are often afraid that enrolling their eligible children in coverage could lead to deportation. When immigrant families do enroll eligible children in health coverage, they often need additional assistance, including interpretation services and materials written in languages other than English.

Other eligible but not enrolled children. Respondents stated that some families living in poverty are difficult to enroll in health coverage. These families may be facing homelessness, domestic violence, job loss, and other challenging circumstances that make enrolling in health coverage a secondary concern. In the Southwest region of the state, some respondents identified a continued lack of awareness about available

health coverage in some communities; low-income families either do not know that they are eligible, or assume that coverage will be unaffordable. Also in the Southwest region, some respondents indicated that there is a stigma associated with Medicaid and CHP+ enrollment, particularly among ranching and farming families; they may choose not to enroll because they do not want to receive public assistance.

Families that enrolled a child in CHP+ may not have been notified of their assigned health maintenance organization HMO, because of technical systems errors. Colorado passively enrolls CHP+ beneficiaries into an HMO based on zip code. Enrollees should then receive a notice in the mail with the name of their assigned HMO and an indication that they have 60 days to change their HMO if other options are available in their area. According to health plan representatives, these letters have not been sent to all families over the past two years due to technical glitches. Health plan respondents also reported that statements with enrollment fees were sometimes not mailed to enrollees, and as a result, coverage may have been terminated without enrollees knowing they owed a fee. Respondents added that the state was actively working to resolve these technical issues after significant advocacy to bring this to the attention of the Department.

County-based eligibility systems mean families may face challenges enrolling or renewing coverage if they move. In Colorado, each county has its own process for enrolling people in Medicaid and CHP+, and several respondents indicated there is a lack of standardization in the way the 64 counties process applications and communicate with constituents. When families move to a new county, they may face challenges in transferring their coverage and understanding the different ways their new case worker conducts business.

II. Access to Health Care Services

In what ways has it become easier for low-income families in Colorado to get health care services for their children in the past few years?

Low-income families in many parts of the state have several options when seeking primary care for their children enrolled in Medicaid or CHP+. Colorado families benefit from there being a range of primary care providers who serve children enrolled in Medicaid or CHP+, including private pediatric and family medicine practices, FQHCs, and school-based health centers. For example, Denver is home to a strong network of safety net providers, including Denver Health, Rocky Mountain Youth Clinics, and school-based health centers throughout the city. In La Plata County, respondents reported that two private pediatric practices form a hub of pediatric care and serve a high percentage of Medicaid patients (and to a lesser degree, CHP+ patients) from La Plata and nearby counties. Montezuma County has a more limited supply of children's health providers, with only two pediatricians who recently began working in a local health center. One respondent noted that, ideally, Montezuma County would have at least four pediatricians to serve children enrolled in Medicaid and CHP+, but even having just two has improved local families' access to primary care. Previously, many Montezuma County families had to travel to La Plata County for primary care, which was a hardship for some due to lack of transportation and the long distance (50 miles or more) to travel.

“Colorado statutorily defined a medical home for children in 2007, so we were one of the national leaders in creating medical home standards for kids.”

– State-level respondent

Several respondents noted that access to primary care in Colorado for children in low-income families is generally adequate at this time, but many providers are near or at capacity. Provider and community health networks in both Denver and the South-

west region are exploring ways to increase capacity to serve more children. For example, according to one respondent, many FQHCs and other practices have adopted team-based care, in which multidisciplinary teams work together to provide comprehensive care to patients. Through workflow redesign, these teams can shift paperwork and other duties away from providers to other team members, allowing providers to work “at the top of their licensure” and spend more time with patients.

Some families have better access to basic oral and behavioral health care, thanks to providers’ recent efforts to integrate these services with primary care. Children’s health care providers in Colorado are working to improve oral health care access by integrating oral health staff in FQHCs and school-based health centers. In addition, the Cavity Free at Three initiative trains primary care providers to perform oral health screening and apply fluoride varnishes. Some county health departments also provide limited, on-site dental and hygienist access for low-income families.

Providers across the state have also been active in initiatives to integrate behavioral health consultants in primary care settings, including private practices, FQHCs, and school-based health centers. Behavioral health consultants often are licensed clinical social workers or psychologists who perform screenings and may be equipped to provide short-term counseling services and/or refer patients to outside services, such as community mental health centers or child psychiatrists. Despite these positive trends in integration, significant challenges related to oral and behavioral health services for children with Medicaid or CHP+ remain, as discussed below.

What key factors are driving these changes?

Colorado’s decision to extend higher Medicaid reimbursements for primary care providers has incentivized more providers to accept Medicaid patients. Under the ACA, the federal government temporarily increased Medicaid reimbursement levels to match Medicare reimbursements for some primary care practices as an incentive for more providers to treat Medicaid patients. The Colorado legislature voted to extend this parity policy until the end of the 2016 fiscal year and expanded its reach from physicians only (the limit of the federal law) to include nurse practitioner services. Respondents described this decision as a “game changer” in terms of incentivizing more private practices to accept Medicaid patients and improving the financial status of safety net providers. They cited early data suggesting this change may have had positive effects on Medicaid enrollees’ access to care, but added that continued funding will depend on the legislature extending the policy past 2016. The governor’s proposed 2016-17 budget would not extend this policy.

Colorado’s earlier legislative efforts to define and require medical homes for children with Medicaid and CHP+ laid the groundwork for more recent efforts to improve access to care for these children. In 2007, Colorado statutorily defined medical homes for children and required that children with Medicaid and CHP+ be connected to a medical home. Respondents emphasized that this legislation acknowledged that children in low-income families deserve and benefit from comprehensive, patient-centered care. The law also attached additional payment for private practices and others who became certified medical homes for children. By familiarizing children’s health care providers with medical home concepts nearly a decade ago, Colorado was well-poised to implement these types of activities and to improve the integration of primary and behavioral health care. In addition, the enhanced Primary Medical Care Provider Program, part of Colorado’s Medicaid Accountable Care Collaborative, rewards providers who meet five of nine medical home criteria, including integration of physical and behavioral health services.

The Colorado Children’s Healthcare Access Program (CCHAP) influenced providers to accept Medicaid and CHP+ patients and safety net providers to transform their practices. CCHAP

Denver County Context

- *Denver County has just over 650 thousand residents, and 31 percent of its population is Latino or Hispanic.*
- *22 percent of children in Denver County live in poverty.*
- *6 percent of children in Denver County lacked health insurance in 2014.*

Sources: U.S. Census Bureau (2014a, 2014b, 2014c).

La Plata and Montezuma County Context

- La Plata and Montezuma counties had a combined population of approximately 78 thousand in 2013. About 12 percent of residents in each county are Latino or Hispanic.
- 12 percent of children in La Plata County lived in poverty in 2013, compared to 31 percent of children in Montezuma.
- 11 percent of La Plata County children and 18 percent of Montezuma County children lacked health insurance in 2013.

Sources: U.S. Census Bureau (2013a, 2013b, 2013c).

is a private, nonprofit organization founded in 2006 whose mission is to advance health equity and improve health outcomes by assisting medical homes statewide to provide comprehensive, cost-effective, coordinated, quality health care for Colorado children. Several respondents said CCHAP's recent efforts to educate providers about Medicaid and CHP+ reimbursement amounts and processes encouraged more providers to accept patients covered by Medicaid and CHP+. CCHAP also helps safety net providers with practice transformation activities aimed at preparing for payment reforms, improving care coordination and integration, and becoming recognized medical homes.

In what ways has it remained difficult for low-income families to get health care services for their children? What factors are at work?

Lack of transportation and other barriers mean many children with Medicaid and CHP+ are not receiving all recommended preventive services. Several respondents observed that children with Medicaid and CHP+ are likely to be connected to a primary care provider, but they are more likely to see that provider when they are sick or injured, rather than for preventive services. Although one respondent reported that some providers contend well-child care often occurs during acute visits but is not coded as such, several respondents emphasized that it is still important for stakeholders to work together to ensure families are seeking preventive care for their children as recommended.

“[The Medicaid rate increase] has been a huge incentive for other private practices to accept more Medicaid patients. After we work on... expanding coverage, we need to always make sure that then reimbursement allows for providers to give access to care for those populations.”

– Denver County respondent

Several barriers related to socioeconomic factors may contribute to lower-than-optimal rates of children enrolled in Medicaid and CHP+ accessing preventive care. In particular, respondents identified issues with transportation, parents' time away from work, and fears of potential costs to the family (such as co-pays) as challenges. One Denver respondent noted that school nurses working in the city's school-based health centers were making a concerted effort to reach out to families and encourage them to seek recommended preventive services for their children. A few respondents mentioned the Medicaid transportation option available to families without other means of transportation, but identified several challenges associated with that option. For example, sometimes only the parent and the child with an appointment are allowed to ride, which is problematic for parents caring for several young children. In addition, the service must be booked in advance, and it is often difficult to reserve a spot. In La Plata and Montezuma counties, where distances between patients and providers can be substantial and public transportation options are few, these challenges are even more pronounced. Finally, a respondent noted that transportation is reimbursed at a lower level in Colorado than other states.

Accessing specialty care is particularly difficult for children with Medicaid and CHP+. Respondents indicated that most of Colorado's pediatric specialists are located in the Denver Metro area, work in hospitals rather than in smaller practices, and often have long wait times for appointments. In Denver, a respondent noted that wait times for specialist appointments for children with Medicaid or CHP+ can be up to a year, unless advocates “put on our hard hats and beg providers to get kids in if they need to see the doctor right away.” In La Plata and Montezuma counties, access to specialty care for children with Medicaid and CHP+ is particularly challenging due to the lack of pediatric specialists in that part of the state. Respondents said that children with acute illness that cannot be treated locally are flown from Cortez or Durango to Denver or

Grand Junction to see a specialist, but that follow-up care is very challenging, due to the distance between the specialists and the child's primary care provider and family.

"We've done a great job getting people insured. Now is that coverage buying them access to primary care physicians, specialists, others?"

– State-level respondent

Colorado lacks an adequate supply of child psychiatrists serving low-income children. In both Denver and the Southwest, screening and short-term behavioral health services for children have been increasing, as has integration of short-term behavioral health services in primary care and school-based health clinics (see above). However, connecting low-income children to longer-term psychiatric care is very challenging due to the limited supply of child psychiatrists serving these children. Respondents across the state reported a dire need for these services. In Denver, respondents emphasized difficulties in connecting children with Medicaid or CHP+ to psychiatrists for ongoing care, particularly when English is not the child's first language. In La Plata and Montezuma counties, one respondent identified child psychiatry access as "a huge unmet need." One local provider described positive experiences with her clinic's use of telepsychiatry—connecting child and adolescent patients with a Denver-based psychiatrist using video conference technology.

Significant barriers to accessing oral health services remain. Despite recent efforts to integrate some oral health services in primary care settings, several respondents noted that oral health awareness and understanding is low among families enrolled in Medicaid and CHP+. Families perceive oral health care as being unaffordable and not covered, despite efforts by health plans and others to advertise the oral health benefits available through Medicaid and CHP+. The fact that CHP+ provides these benefits to children, but not pregnant women, may contribute to the confusion. Uncertainty around which family members are covered may prevent some families from accessing oral health services for their children. In addition, one respondent said that allowing primary care providers to administer a limited amount of oral health services in their offices, while beneficial in many ways, may have the unintended consequence of leading families to believe that additional care from a dentist is not necessary.

In the Southwest, an extremely limited number of dentists accept Medicaid and CHP+ patients, particularly in the most remote, rural areas. Some respondents described families driving up to 50 miles to New Mexico for oral health services for their children. Local health departments and FQHCs reported working to secure grants to fund more time from dentists and hygienists who already provide services in these settings a few times a week, and whose schedules are always fully booked.

"Access...is a huge issue down here because we are spread out, and the providers that are in the area often do not take the CHIP or the Medicaid. We have a dentist over in Farmington, New Mexico, which is a little town about 45 miles away. "

– La Plata County respondent

Many low-income families with children who have special health care needs have difficulty accessing early intervention services, ongoing specialty care, and transitional care when children reach adulthood, especially in rural areas. Respondents indicated there are disparities across the state in helping infants and children with special health care needs early in life. Particularly in the more rural parts of the state, it is difficult for families to connect to early intervention services due to a lack of resources available to assist families. Southwest respondents also indicated that families with children who have

mental or physical disabilities struggle to find local specialists who accept Medicaid or CHP+ for ongoing care. County health departments and local hospitals occasionally (for example, on a quarterly basis) bring in specialists from Denver or other areas of the state to see patients, which helps ease the burden on low-income families seeking these services. In addition, children with special health care needs throughout the state face challenges in transitioning to adulthood. When these children grow into adults with chronic conditions, finding providers and day programs to care for them is a particular challenge, according to respondents.

III. Emerging Issues and Opportunities

What issues will children's health stakeholders in Colorado keep their eyes on during the next year or two, and why?

Several respondents indicated that Colorado's rapid growth in Medicaid enrollment has raised concerns among some state lawmakers who believe Medicaid expansion represents inappropriate growth in government programs. Colorado faces unique state constitutional budget constraints, which shape the political debates about funding for public services. Specifically, the state's Taxpayer Bill of Rights (TABOR) amendment limits the annual growth in state revenues or spending to the sum of the inflation rate and the percentage change in the state's population. Under the TABOR, the legislature may not expand the budget for public health coverage unless it finds savings elsewhere. As a result, health care is pitted against K-12 and higher education, transportation, and other human services.

If Congress fails to fund CHIP past 2017, respondents are unsure how Colorado will cover its CHP+ enrollees. The ACA mandates that all states cover CHP+ eligible children through 2019 at the eligibility level in place on March 23, 2010. However, Colorado has not decided how it will cover CHP+-enrolled children if CHIP funding is not extended. The state Department of Health Care Policy & Financing is already hosting meetings with children's health stakeholders to identify the state's goals and strategies for child health coverage should CHIP funding be eliminated, but no decisions have been made as of this writing.

Respondents are uncertain how children will be incorporated into the state's \$68 million SIM Award from the Centers for Medicare & Medicaid Services. Colorado's SIM focuses on integration of physical and behavioral health care. Respondents indicated that children's health stakeholders have been active in SIM workgroups and that the state has indicated a certain percent of practices receiving technical assistance under the SIM must be pediatric practices. However, some respondents worried that children's particular behavioral health needs may get "lost in the shuffle" of the larger delivery system issues the SIM aims to address.

Respondents worry that Colorado's extension of parity in Medicaid and Medicare reimbursements for primary care providers will end in 2016. Respondents viewed Colorado's extension of ACA reimbursement parity as a boon to primary care providers serving low-income families as well as an incentive for additional primary providers to serve this population. If the policy does not survive past 2016, as the governor's proposed budget suggests, low-income families may face new challenges in accessing primary care services.

As Colorado continues to explore health care payment reform and Medicaid redesign, respondents emphasized the importance of considering how children's health care needs differ from those of adults. In particular, respondents stressed the importance of promoting prevention: well child visits, early screening and intervention, preventive counseling, and immunizations. These types of services may not immediately demonstrate

cost savings, but they are crucial to child health and well-being. Respondents indicated this must be taken into account when discussing payment reform, which tends to focus on generating more immediate savings, such as by reducing costs associated with adult chronic conditions. In addition, the proposal for Phase II of the state's Medicaid ACC (which would begin after July 1, 2017) would make ACC enrollment mandatory and automatic for Medicaid enrollees (Colorado Department of Health Care Policy & Financing, 2015c). Respondents noted that this shift essentially redesigns Colorado's current Medicaid delivery system, in which ACC enrollment is voluntary—though most Medicaid enrollees participate. Given Medicaid's extensive coverage of children in Colorado, proposed changes to the ACC must be carefully considered with an eye towards these changes' impacts on children.

What opportunities might advocates, decision makers, and funders choose to consider?

To further improve insurance coverage and access to high quality comprehensive services for children in low-income families, respondents recommended attention to and investments in the following areas:

- **Finding and enrolling hard-to-reach children.** While Colorado has made significant strides towards enrolling eligible children in Medicaid and CHP+, small groups of uninsured children remain. Challenges include identifying eligible but unenrolled children and assisting families with enrollment, particularly in immigrant communities. Continued recruitment and training of enrollment assisters who are members of the same communities as immigrant families could help mitigate families' concerns, as could ongoing efforts to streamline enrollment and make enrollment assistance more convenient.
- **Promoting prevention.** Respondents praised primary care providers' efforts to care for children covered by Medicaid and CHP+, but agreed that children from low-income families may not be receiving adequate preventive and specialty services. Most children with Medicaid and CHP+ are connected to a medical home, but respondents indicated they are more likely to access care for acute illness or injury, rather than for well-child preventive care. This issue could be addressed through family engagement and education to increase health literacy, increased provider awareness of the problem, and reducing families' socioeconomic barriers to accessing preventive care.
- **Increasing access to specialists.** Access to specialty care remains difficult throughout the state, due to an inadequate supply of specialty providers who accept Medicaid and CHP+, and to socioeconomic constraints on low-income families. Strategies respondents identified to address this problem include: (1) offering educational loan repayment programs or other incentives to encourage providers to serve Medicaid and CHP+ patients and/or to live in underserved areas, (2) promoting telemedicine to allow more specialists located in urban areas to consult with primary care providers in underserved areas, and (3) providing additional resources to families to help with transportation and navigation of the health care system.
- **Ensuring the continuation of Medicaid expansion and CHP+.** State legislators' reactions to rapid growth in the Medicaid program will affect continued expansion, particularly when federal funding for newly eligible adults phases down to 90 percent by 2020. In addition, the outcome of the 2017 CHIP funding decision will determine whether the state must pursue alternatives to covering children with CHP+. In the absence of bipartisan political support for these programs, development of contingency plans for low-income families' potential loss of coverage would become important.

IV. Conclusion

Using data from interviews with children's health stakeholders, this issue brief has characterized the recent experiences of low-income families in Colorado as they seek health care coverage and services for their children. Medicaid expansion and other policy reforms have markedly improved low-income families' access to coverage, though small pockets of eligible but unenrolled children remain, particularly in mixed-status immigrant families. Access to primary care and basic behavioral and oral health services has also improved, but securing specialty care and more comprehensive behavioral and oral health services remains difficult for children in low-income families throughout the state. Stakeholders believe vigilance in pursuing the enrollment of hard-to-reach children, promoting preventive care, increasing access to specialists, including child health advocates in discussions of state health reforms and initiatives, and securing political support for Medicaid and CHIP will be key factors shaping long-term improvements in children's access to health care coverage and services.

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Acknowledgements

This brief was prepared with funding from The Colorado Health Foundation (The Foundation). Through its work in Health Coverage and Health Care, The Foundation strives to ensure that Coloradans have access to stable, affordable, and adequate health coverage and that they achieve health with support from a network of primary health care and community services.

Listed below are The Foundation grantees and other children's stakeholders who made this brief possible by participating in interviews and sharing their perspectives.

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