CONNECTING KIDS TO COVERAGE:

Continuing the Progress

2010 CHIPRA ANNUAL REPORT

"Indeed, we have a moral obligation to move forward—to close this gap in health coverage among children."

– HHS Secretary Kathleen Sebelius, *Health Affairs*, September 3, 2010

EXECUTIVE SUMMARY

Two years ago, on February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act (CHIPRA) into law. CHIPRA offers states new financial resources and options to improve health coverage for children through Medicaid and the Children's Health Insurance Program (CHIP). The new law, combined with the financial support provided to state Medicaid programs through the American Recovery and Reinvestment Act of 2009 (ARRA), enabled states to improve their coverage rules and procedures and to insure more eligible children in Medicaid and CHIP, despite ongoing economic challenges.

CHIPRA offered a wide range of policy and programmatic "tools" to enable states to move their coverage efforts forward. In addition to providing an unprecedented amount of federal funding dedicated to outreach and enrollment efforts, the law authorized several new policy options—like Express Lane Eligibility, coverage of pregnant women in CHIP, and removing the 5 year waiting period for lawfully residing immigrant children and pregnant women to enroll in Medicaid and CHIP. All of these tools have proven significant to states' ability to find and enroll uninsured children and keep them enrolled for as long as they are eligible.

This year's enrollment growth stemmed partly from the effects of the continued economic downturn combined with the aggressive steps states and an array of stakeholders have taken to ensure eligible children get the health coverage they need. Secretary Sebelius stressed the importance of such efforts on the first anniversary of CHIPRA when she issued the *Connecting Kids to Coverage* Challenge, calling upon leaders at all levels of government and the private sector to find and enroll the nearly five million uninsured children eligible for Medicaid and CHIP and keep them covered for as long as they qualify. She emphasized that CHIPRA provides the support needed for this work to be successful, by providing the tools to modernize and build consumer-friendly, data-driven enrollment systems, and by supporting outreach and enrollment efforts at the state and community levels.

Connecting Kids to Coverage has generated a significant amount of support, with over 40 national, state and local organizations as well as two Governors officially signing on. Ohio Governor Ted Strickland was the first to accept the Challenge in March 2010 and Governor Ted Kulongoski of Oregon joined the Challenge in August 2010. Since the Secretary formally announced *Connecting Kids to Coverage* in September 2010, more than 150 organizations have registered their support on the **www.challenge.gov** website.

This report reviews the progress achieved during Federal fiscal year (FY) 2010 and highlights the steps being taken at the state, federal, and community levels to bring the nation closer to the widely shared goal of ensuring that all children in America have quality, affordable health coverage.

- **More than 2 million children gained Medicaid or CHIP coverage during federal fiscal year 2010 (October 1, 2009 – September 30, 2010). In total, Medicaid and CHIP served more than 42 million children last year.** This steady increase in enrollment is evidence of the important role that Medicaid and CHIP play for children, especially during economic downturns. The uninsurance rate for children continues to decline at a time when the rate for adults is climbing. The increase in children's enrollment demonstrates that Medicaid and CHIP are serving the purpose for which they were created—providing high quality health coverage for lower-income families.

- **13 states implemented eligibility expansions in 2010 and many others simplified their enrollment and renewal procedures.**[1] Forty-six states and the District of Columbia now cover children with incomes up to 200% of the Federal Poverty Level (FPL) in Medicaid and CHIP, with 24 of those states and the District of Columbia covering children with incomes up to 250 percent of the FPL. Twenty-two states now offer coverage to lawfully residing immigrant children and/or pregnant women, enabling states to receive federal funding for this coverage. (Fifteen states previously provided this coverage with state-only funds, so this option has resulted in new coverage for children and/or pregnant women in 7 states.)
- **CHIPRA Performance Bonuses have encouraged states to adopt and augment simplification measures in Medicaid and CHIP.** Fifteen states qualified for a total of $206 million in Performance Bonuses for FY 2010. This is a significant increase over 2009 when 10 states received bonuses totaling $75 million. The bonuses provide additional federal financial support each year to states that successfully boost enrollment above target levels among previously eligible but uninsured children in Medicaid. To qualify, a state not only has to enroll more children, but must also have implemented program features that are designed to promote enrollment of eligible children. The bonuses were designed to help offset the cost of covering the additional children that are enrolled as a result of these efforts.
- **States are increasing their use of technology to facilitate children's enrollment and retention.** Nearly two-thirds of states (32) have an on-line application that can be submitted electronically; 29 states allow electronic signatures on those applications.[2] Six states have received approval to enroll children through the "Express Lane Eligibility" (ELE) option created by CHIPRA. Thirty-three states are utilizing the CHIPRA data matching process provided by the Social Security Administration to confirm U.S. citizenship for children.
- **Outreach and enrollment grants have advanced coverage and led to public-private partnerships throughout the country to enroll more children.** Sixty-eight grantees across 41 states are working diligently to facilitate children's enrollment in health coverage (See Grantee Spotlights). A second round of $40 million in outreach and enrollment grants will be awarded in the summer of 2011.

- **Improving quality of care continues to be a priority for the federal government and the states—as well as the new Medicaid and CHIP Payment and Access Commission (MACPAC)—which began its work in 2010.** HHS awarded $100 million in quality improvement funding in the form of 10 grants that will span across 18 states to help them implement and evaluate provider performance measures and utilize health information technologies. HHS also finalized the core set of 24 child health quality measures that states may report and is preparing to provide technical assistance on implementing these measures. Finally, MACPAC was formally established and has held four public meetings with its Commissioners, with its first report scheduled for release in March 2011.

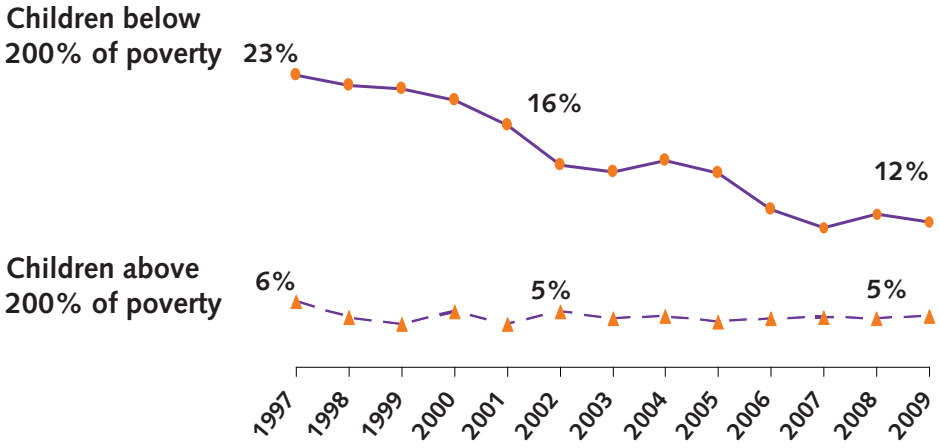
The accomplishments continue to grow, but our collective work is not complete. The U.S. Census Bureau reported that while Medicaid and CHIP are playing the critical role of providing health coverage for children, and states have continued to make steady progress, we continue to face the challenge of reaching the nearly 5 million uninsured children in the United states that are eligible for Medicaid or CHIP but are not enrolled.

INTRODUCTION

On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This legislation marked a new era in children's coverage by providing states with significant new funding, new programmatic options, and a range of new incentives for covering children. One of the clear goals of the legislation is to support states in developing efficient and effective strategies to identify, enroll, and retain health coverage for uninsured children who are eligible for Medicaid or CHIP but are not enrolled.

The passage of the American Recovery and Reinvestment Act (ARRA) followed soon after the signing of CHIPRA in early 2009 and has served as a stabilizing force for states by providing additional federal payments for Medicaid coverage during the economic downturn. This additional support has played a significant role in strengthening Medicaid coverage in general, and for children, in particular.

PERCENTAGE OF CHILDREN WITHOUT HEALTH INSURANCE, BY POVERTY LEVEL, 1998–2009



Source: U.S. Census Bureau September 2009.

U.S. Census Bureau data show that although more than 7 million children are uninsured, the uninsurance rate among children continued to decline from 2008 to 2009. This trend is significantly better for children than for adults, whose insurance coverage rate actually declined between 2008 and 2009.[3] On average, 82 percent of eligible children participate in Medicaid and CHIP, a further indication that these programs are fulfilling the role for which they are intended.[4]

Building on efforts that began in 2009, HHS continued to work closely with states, other federal departments and agencies, and a broad array of private and public leaders and organizations interested in children's coverage to implement CHIPRA. This report highlights federal and state activities over the course of the two years since CHIPRA was enacted and notes some of the plans for continued and enhanced activities in 2011.

CHIPRA IN 2010: CONTINUING THE PROGRESS

Eligibility and Enrollment Improvements

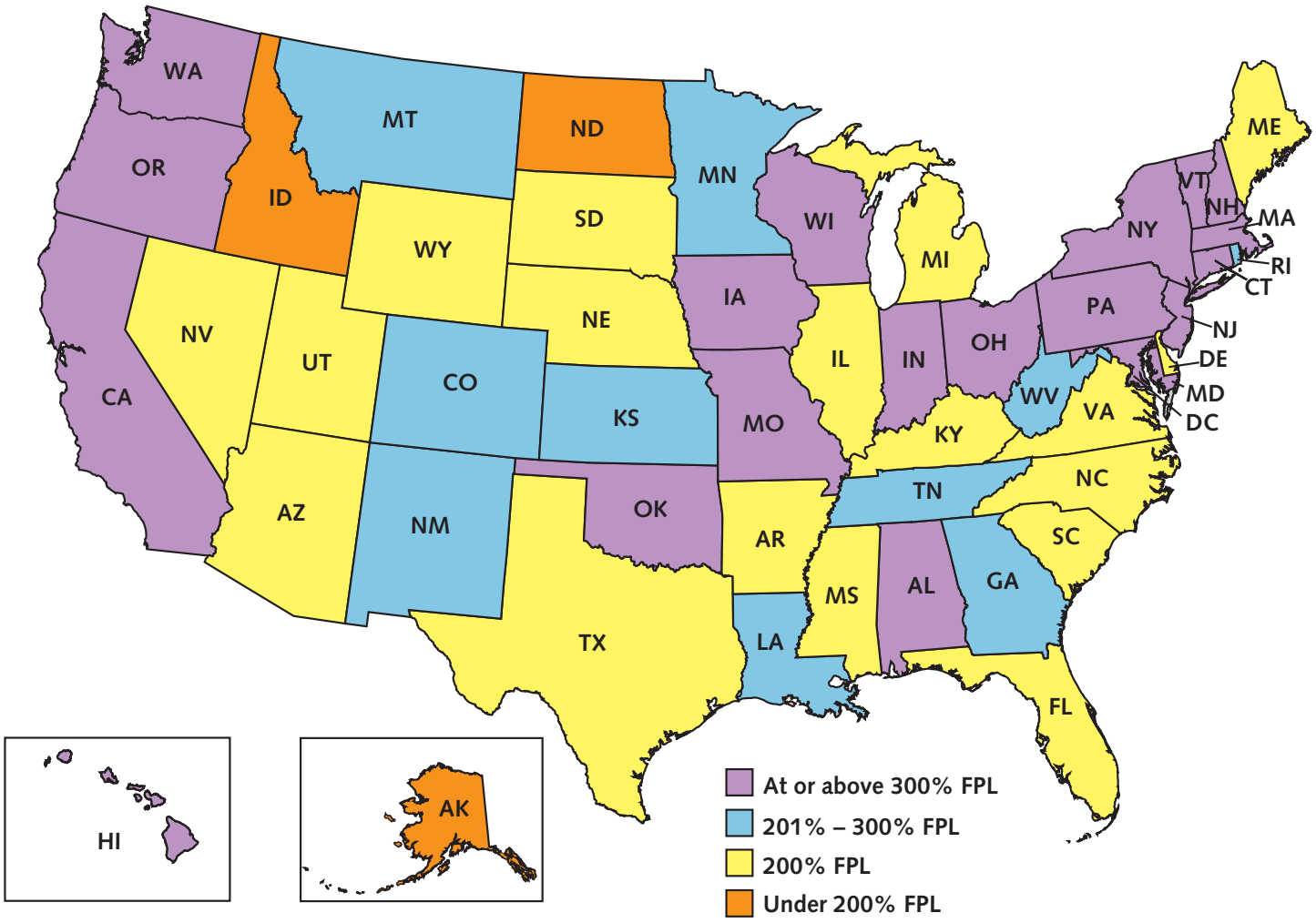
2010 was another busy year for both the federal government and states in terms of children's coverage. The Centers for Medicare & Medicaid Services (CMS) continued to provide policy guidance in the form of letters and question-and-answer documents for state health officials (state Medicaid and CHIP directors as well as public health officials) to assist states in implementing the provisions of CHIPRA. Many of the CHIPRA provisions relate to improving eligibility and enrollment practices and utilizing the new financing opportunities like the increased federal match for translation and interpretation services, among other key policy issues. CMS has released nearly two dozen policy letters and other guidance to states since CHIPRA was enacted.[5]

State progress continued at a surprising pace in 2010, particularly considering the economic downturn. According to an annual survey released in January 2011 by the Kaiser Family Foundation (prepared by the Georgetown Center for Children and Families), nearly all states maintained or made improvements to their Medicaid and CHIP eligibility and enrollment procedures. According to the study, 13 states expanded eligibility and 14 states made improvements in enrollment and renewal procedures in Medicaid and/or CHIP.[6] Arizona was the only state that restricted eligibility in 2010 by putting an enrollment cap in place in its CHIP program.

Enrollment Gains. Children's enrollment in Medicaid and CHIP increased by more than 2 million during federal Fiscal Year (FY) 2010. Together, these critical programs served more than 42 million children over the course of the year (See Appendix A). This time frame also coincided with the period during which enhanced federal Medicaid matching payments to states were made through ARRA. This enrollment increase reflects the greater need for affordable coverage options during the economic downturn. Whereas Medicaid and CHIP enrollment increases correspond with a continued decline in the uninsurance rate for children, the rate of uninsurance among adults increased between 2008 – 2009.[7] This demonstrates the value of the strong programs that states have built over the past 13 years and the new efficiencies and improvements that states have incorporated into their programs.

CHILDREN'S HEALTH INSURANCE PROGRAM

Upper Income Limits as of January 1, 2011



Raising the bar on eligibility. States have clearly committed themselves to the importance of children's coverage and the opportunities provided through the enhanced federal matching rates in CHIP. Forty-six states and the District of Columbia now cover children with incomes up to 200 percent of the Federal Poverty Level (FPL) ($44,700 for a family of four in 2011) in Medicaid and CHIP; with 24 of those states and the District of Columbia covering children with incomes up to 250 percent of the FPL ($55,875 for a family of four in 2011). Twenty-two states now offer coverage to lawfully residing immigrant children and/or pregnant women, enabling states to receive federal funding for this coverage. (15 states previously provided this coverage with state-only funds, so this option has resulted in new coverage for children and/or pregnant women in 7 states.)

Shifting the paradigm toward simplified, family-friendly enrollment and renewal processes. As states and community organizations have gained experience over the 13 years since the Children's Health Insurance Program was created and states began investing in improvements to their Medicaid programs for children, a number of program characteristics that were widely used in the pre-welfare reform era are now virtually obsolete.[8] For example:

- 48 states and the District of Columbia have eliminated the requirement for a face-to-face interview before being enrolled in coverage;
- 49 states and the District have removed the face-to-face interview requirement at renewal; and
- 47 states and the District of Columbia no longer consider a family's assets when determining eligibility for children in Medicaid and CHIP.

As strategies for streamlining enrollment and renewal processes have been proven effective and, in some cases have achieved cost-savings over the years, increasing numbers of states are learning from each other and adopting these best practices. For example:

- 48 states and the District of Columbia have a 12 month eligibility period for Medicaid and CHIP; and 23 states offer 12 months of continuous eligibility—keeping children enrolled for a full year regardless of changes in circumstances;
- 36 of 38 states that operate a separate CHIP program have a single joint application that can be used to apply for and renew both Medicaid and CHIP coverage;
- 32 states now have an on-line application and in 29 states applications can be submitted electronically; and
- 33 states and the District of Columbia are utilizing the data matching process provided by the Social Security Administration to confirm U.S. citizenship for children in Medicaid.

FY 2010 Performance Bonuses. CHIPRA established a new series of Performance Bonuses to provide additional federal funding for qualifying states that have taken specific steps to simplify Medicaid and CHIP enrollment and renewal procedures and have also increased Medicaid enrollment of children above a baseline level. The amount of the award correlates with the percentage increase in enrollment above the baseline—the more children states enroll, the higher the bonus—and states that achieve more than a 10 percent increase in enrollment receive an even larger ("Tier 2") bonus.

CMS awarded $206 million in FY 2010 CHIPRA Performance Bonuses to 15 states across the country. The number of children enrolled in Medicaid in the 15 states receiving Bonuses increased by 875,000 children above the baseline level established for FY 2010. (See Appendix) The enrollment increases in the qualifying states ranged from 6% to 36%, and 10 of the 15 states had enrollment increases of 10% or more, qualifying them for a larger, "Tier 2," award. Alabama received the largest bonus of any state for the second year in a row. This year, Alabama achieved a 36% increase in enrollment over the statutorily-set baseline and earned a $54.9 million award. All states that received a Performance Bonus in 2009 qualified again for 2010; 5 of the states receiving bonuses this year are newly qualifying states. (CMS awarded over $75 million in Performance Bonuses to 10 states in FY 2009.) The increase in Performance Bonuses for 2010 demonstrates states' ongoing commitment to covering children and improving their programs despite fiscal challenges.

FY 2010 PERFORMANCE BONUS AWARDS	
Alabama	$54,965,407
Alaska	$ 4,408,789
Colorado	$13,671,043
Illinois	$14,962,171
Iowa	$ 6,760,901
Kansas	$ 2,578,099
Louisiana	$ 3,555,853
Maryland	$10,549,086
Michigan	$ 9,268,552
New Jersey	$ 8,788,959
New Mexico	$ 8,553,431
Ohio	$12,376,346
Oregon	$15,055,255
Washington	$17,607,725
Wisconsin	$23,076,127
TOTAL:	$206,157,744

Performance Bonus Highlights

States received the bonuses by enrolling more currently eligible children, rather than for expanding eligibility levels. Cutting red tape and streamlining procedures enables families to more easily enroll their children in health coverage and keep them covered for as long as they are eligible. The simplification measures that help states qualify for the bonuses remain a part of the programs, and therefore have a long-term positive impact on access to coverage and continuity of care into the future. States have simplified their programs in various ways:

- **Iowa** adopted the presumptive eligibility option and, in March 2010, began implementing the program on a small scale by training 16 state-employed outreach workers to carry out eligibility determinations. In October 2010, the Department of Public Health led a joint training with the Department of Education to qualify school nurses to make determinations, as well. By the end of the year, about 300 children had been enrolled using presumptive eligibility. The state expects this number to increase substantially when it ramps up the program over the next year, in part, by allowing certified workers to use an on-line process.

- **New Mexico** Medicaid pre-populates renewal forms with the most recent income information that has been reported by the child's family. Upon receiving the renewal form in the mail, families have several options for confirming that the information is correct: they can sign the form and mail or fax it back, call a hotline, or email their confirmation. Since the inception of the simplified renewal process in October 2007, most families have used mail or telephone (including an automated voice response system), and about 20 percent have taken advantage of the fax and email options. Information from the Supplemental Nutrition Assistance Program (SNAP) or cash assistance files also can be used to renew the child's Medicaid coverage. According to state officials, prior to the use of the pre-populated renewal form, renewal rates ranged from 40% to 60%—today, about 80% of children are getting their coverage renewed.
- **Wisconsin** families have had the option to apply for children's health coverage using the state's on-line application, ACCESS, since June 2006. Currently, about 45% of applicants choose to apply online. In January 2010, the state simplified its online renewal process so that families that apply on-line can now go into their personal ACCESS account and answer a few simple questions about changes in employment or home address. If no changes have occurred, the family can sign electronically and coverage can be renewed. If changes have occurred, the family can provide the new information so that a renewal decision can be made. Wisconsin is working on additional systems enhancements that will further simplify the renewal process. For example, information from available databases will automatically update the family's case summary prior to renewal so that families will be able to review the most recent data the state has about their situation.
- Cutting red tape also reduces the administrative burden on states. Over the last decade, **Louisiana** has continuously improved its renewal processes and the state now boasts that the shift to a streamlined system is saving $19 million annually and is keeping the vast majority of eligible children from losing coverage. In August 2010, of the 45,809 children who were up for renewal, just 327—less than 1%—were not renewed for procedural reasons, such as not returning paperwork.[9]

Promising Strategies

Efforts to modernize and streamline enrollment and renewal procedures and boost children's enrollment are also actively underway in states that have not yet qualified for a performance bonus:

- Under its CHIPRA outreach grant, the **Oklahoma** Health Care Authority (OHCA) has launched "SoonerEnroll" which enlists outreach partners across the state to assist families with online enrollment. The state has noted significant increases in enrollment since the online system launched in September 2010. Oklahoma has also taken steps to improve retention. The state began making calls to families scheduled to renew their coverage and offered them the opportunity to renew by phone. The process takes five minutes and coverage is renewed immediately, meaning children needing health services experience no unnecessary gaps. In two months, more than 1,800 children and adults renewed their coverage using the telephone process.

- Despite its budget constraints, **Kentucky** has continued to train and encourage community partners to assist families in completing the state's KCHIP application. In addition to enlisting faith-based organizations and child care centers, the state has trained retired teachers and paraprofessionals making home visits to teach parenting skills. State officials also responded when it became apparent that 700 children were losing coverage each month because their premiums were not paid. Recognizing that families are experiencing difficult economic times, Kentucky suspended the $20 per month premium. The state estimates that the suspension of the premium resulted in an increase of 2,257 children in KCHIP during the two months that followed.

Setting the Stage for Further Coverage Improvements

HHS has initiated a multi-pronged strategy designed to ensure further improvements and to reach those children who are eligible for Medicaid or CHIP but unenrolled. In September 2010, the Secretary hosted an event that highlighted a report prepared by the Urban Institute and published in the journal *Health Affairs* that analyzed participation rates among children eligible for Medicaid and CHIP. The study found that, nationally, 82 percent of eligible children were participating in these programs. The state-specific participation rates ranged from 55 percent in Nevada to 95 percent in Massachusetts and the District of Columbia.[10] These data, combined with the Census Bureau findings that two-thirds of the 7.3 million uninsured children in the nation are currently eligible for coverage under Medicaid and CHIP program rules but are not enrolled, underscored the importance of the Secretary's *Connecting Kids to Coverage Challenge*. The Challenge is the main component of the CHIPRA-funded national outreach campaign.

GRANTEE SPOTLIGHT

Michigan Primary Care Association Uses Tech-Savvy Approach to Outreach and Enrollment

The Michigan Primary Care Association (MPCA) is using a variety of technological tools to expand the outreach and enrollment capacity of its 13 Americorp members who are working as "community navigators" throughout the state. Through its partnership with Michigan Association of United Ways, MPCA is connected to 2-1-1, the human services resource and referral system. When a 2-1-1 caller asks for health coverage, the call is transferred directly to a community navigator. Navigators, equipped with lap top computers, can use Michigan's on-line application to help families faster and more accurately, give on-the-spot feedback about eligibility, and link newly enrolled children to a medical home.

Google Maps and Voice technologies have enhanced the services MPCA offers. Google Maps is used to plot the locations of health clinics throughout the state, helping refer families to a nearby source of care. Google Voice allows MPCA to advertise one phone number that rings on both the land-line and cell phone of the navigator closest to the caller. This saves the expense of running an 800-number and ensures access to navigators when they are traveling—which is most of the time. Finally, an on-line case management system has enabled the navigators to go paperless, but maintain access to case files 24/7. A secure database with all case information allows enrollment to proceed and follow-ups to be scheduled. The system is HIPPA compliant and costs only about $100 per month per user. In its first year, MPCA's "community navigator" project has enrolled over 600 eligible children in Medicaid and CHIP. For more information, contact Phillip Bergquist, Michigan Primary Care Association, pbergquist@mpca.net

The other elements of the broader CHIPRA outreach and enrollment campaign involve use of the $100 million in federal funding provided by CHIPRA together with an additional $40 million provided by the Affordable Care Act to be dedicated to promoting outreach and enrollment strategies focused on children. CHIPRA allocated $80 million for grants to community-based organizations, states, schools, faith-based organizations and health care providers, and $10 million for grants to health care providers and Indian Tribes that serve the Native American community to find and enroll eligible children. The Affordable Care Act divided up the additional $40 million proportionately, providing an additional $4 million for the national campaign, $4 million for tribal providers, and the remaining $32 million to be devoted to grants. These funds are collectively available through FY 2015.

Outreach Grants—Closing the Gaps. As noted above, CHIPRA made a total of $80 million in outreach grant funds available between FY 2009 and FY 2013. CMS awarded the first $40 million in grant awards to 68 grantees across 42 states and the District of Columbia in September 2009. In February 2011, HHS is making available the remaining $40 million in grant funds authorized by CHIPRA. This "Cycle II" funding opportunity is directed to projects that focus on closing the gaps in coverage among some of the nation's most vulnerable populations of children. The Urban Institute study released in October 2010 found that nationally, there is an 82 percent participation rate among eligible children in Medicaid and CHIP. Another study found that, in addition to geographic disparities, certain populations of children, such as adolescents and Latinos, are more likely to be uninsured.[11] This may be due to a variety of barriers, including but not limited to language, literacy, and other cultural factors.

As such, the CHIPRA "Cycle II" grant solicitation requests that applicants select one Focus Area for the proposed grant project that will target efforts around a specific strategy or population.

- Using Technology to Facilitate Enrollment and Renewal
- Focusing on Retention: Keeping Eligible Children Covered for as Long as They Qualify
- Engaging Schools in Outreach, Enrollment and Renewal Activities
- Reaching Out to Particular Groups of Children that are More Likely to Experiences Gaps in Coverage
- Ensuring Eligible Teens Are Enrolled and Stay Covered

The grant applications are due to be submitted on April 18, 2011 and awards will be announced in late July 2011.

Tribal Outreach Grants. In April 2010, CMS awarded nearly $10 million in grant funds to 41 Tribal health providers, Indian Health Service providers, and other health providers in urban areas across 19 states. These grants are available for tribal outreach and enrollment efforts for a five year period.

CONNECTING KIDS TO COVERAGE: STEPPING UP TO THE CHALLENGE		
American Academy of Pediatrics	National Covering Kids and Families Network	United Way of Santa Cruz Co. (CA)
Center on Budget and Policy Priorities	New England Alliance for Children's Health-Community Catalyst	United Way of Silicon Valley (CA)
Children NOW (California)	Northwest Georgia Healthcare Partnership	United Way of Ventura Co. (CA)
Children's Defense Fund (and CDF affiliates in CA, LA, MN, MS, NY, OH, and TX)	PICO	United way of Connecticut
City of Tampa, Florida	Philadelphia Eagles Youth Partnership	United Way of Greater Cincinnati (OH, KY)
Families USA	The Robert wood Johnson Foundation	United Way of Greater Toledo (OH)
First Focus	SingleStop USA	United Way of Greater Williamsburg (VA)
March of Dimes	Tarrant County CHIP Coalition (Fort Worth, TX)	United Way of Kentucky
Michigan Primary Care Association	United Way Worldwide and their affiliates:	United Way of Madison County (IN)
MomsRising	Aloha United Way	United Way of the Plains
National Academy for State Health Policy	United Ways of California:	United Ways of Tennessee
National Association of Children's Hospitals and Related Institutions	United Way of Corono-Norco (CA)	Voices for America's Children
National Association of School Nurses	United Way of Kern Co. (CA)	
National Council of La Raza		

Connecting Kids to Coverage. In September 2010, the Secretary refocused attention on the *Connecting Kids to Coverage* challenge she issued on the first anniversary of CHIPRA, in which she called upon leaders in government, community and faith-based organizations, health care providers, schools, and others to identify and enroll all children who are eligible for Medicaid and CHIP within the next five years. As a result of the excitement that the Challenge has generated, more than 40 organizations have formally "stepped up" and more than 150 organizations and individuals have registered their support at **www.challenge.gov/hhs54**, a government-wide website that is tracking progress on a wide range of challenges. (See text box)

The Coaches Campaign: Get Covered, Get in the Game. During the summer of 2010, CMS launched the *Get Covered, Get in the Game* Campaign to enlist coaches of school and community youth sports teams in seven pilot states (Colorado, Florida, Maryland, New York, Ohio, Oregon, and Wisconsin) to help meet the *Connecting Kids to Coverage* Challenge. To participate in sports programs, children are usually required to have a physical exam, which can be difficult to get without health insurance. Families of uninsured children are often reluctant to let their uninsured children play, for fear they won't be able to pay the bills if the child gets hurt. *Get Covered, Get in the Game* gives schools and communities the tools they need to link youth athletes and all eligible children and teens to Medicaid and CHIP. CMS provided customized outreach materials and signage for school sports events, and helped pilot states organize events, build partnerships with youth sports organizations and generate media coverage.[12]

InsureKidsNow.gov. The *InsureKidsNow* Web site (**www.insurekidsnow.gov**) has been updated and further enhanced to include additional information for consumers interested in learning about the Medicaid and CHIP programs and providers in their states. The Web site includes direct links to individual state CHIP and/or Medicaid sites where families can access the program application or even apply on-line. It also includes links to information about how to find health care and dental providers. InsureKidsNow now serves the dual purpose of providing policy and program information for professionals and states interested in federal activities around children's coverage broadly and CHIPRA implementation specifically. This site will continue to be augmented and regularly updated and will serve as a resource for research and policy analysis conducted by government and other organizations about the effectiveness of these programs.

Thriving Public-Private Partnerships. More than a decade of successful philanthropic initiatives like the Covering Kids and Families initiative that started in the late 1990s, the Maximizing Enrollment for Kids project, the Finish Line project and the initiatives sponsored by United Way Worldwide demonstrate how much can be achieved when communities are united behind a common goal.

The Max Enroll project began in 2008 and is supported by the Robert Wood Johnson Foundation. The program provides targeted funding to eight states to help them improve their Medicaid and CHIP systems, policies, and procedures and assisting them with implementation strategies to cover more eligible children.[13] The Finish Line project is an initiative of the David and Lucile Packard Foundation that has, since 2006, worked in and across states to build efforts toward achieving the goal of providing health coverage to all children. The initiative supports policy efforts in select states to advance coverage for children; and supports the broader movement to cover all children through its support for policy advocacy organizations.[14]

A key example of the success of these efforts can be taken from the CHIPRA Performance Bonuses —11 of the 15 states that are involved in Max Enroll and/or the Finish Line project received a Performance Bonus in FY 2010.

United Way Worldwide was one of the first national organizations to step up to the *Connecting Kids to Coverage* Challenge in the fall of 2010, dovetailing its efforts to promote health and wellness among children. Several longstanding United Way initiatives present rich opportunities for finding and enrolling eligible children. For example, United Way's successful 2-1-1 human services helpline is a great way to link callers to health coverage for their children and even to help them enroll over the phone. Many United Ways sponsor Volunteer Income Tax Assistance (VITA) sites, an IRS program that provides low-income working families free help preparing their tax returns. Getting information and assistance enrolling in Medicaid and CHIP will benefit many of the families at the VITA sites who have children likely to qualify. United Way Worldwide is actively encouraging its local affiliates to step up to the Challenge in their own communities and, since September 2010, state and local United Ways in California, Kentucky, Ohio, Tennessee, Texas and Washington have committed to Connecting Kids to Coverage.

GRANTEE SPOTLIGHT

Durango Student is off and Running with Health Coverage

Whenever a family is concerned about how to pay for a child's health care, finding out if Medicaid or CHIP can help is a key first step. And thanks to a CHIPRA outreach grant awarded to the Colorado Association for School-Based Health Care (CASBHC), a Durango child got coverage and care right away.

One afternoon, 13-year-old Jackie (not her real name) showed up at her school's health center, eager to get the required sports physical so she could run track. As the nurse was going through Jackie's medical history, the first red flag went up. Jackie could not be cleared to play without further evaluation because her mother's heart problems put her at risk. The second red flag was raised when Jackie's Mom said she was uninsured. How would she get the tests, let alone specialty care if she needed it? Because Colorado has a presumptive eligibility process, the school's outreach worker was able to enroll Jackie in coverage on the spot. Just two days later, Jackie had been to a cardiologist who, after further exams, gave Jackie the green light for track. Now Jackie's off and running—with track meets ahead of her and the protection of health insurance behind her!

Jackie is just one of more than 1,000 children who were enrolled in Medicaid or CHIP, or were able to renew their coverage, in the first year of the CASBHC program. School clinics in five pilot sites participate, using data from the National School Lunch Program and school-level data on insurance status to identify children who might qualify for coverage. For more information about Colorado's efforts, contact Stacey Moody, Colorado Association for School-Based Health Care, moody@casbhc.org.

Assuring Access to Quality Care for Children

Core Quality Measures. Relying on a collaboration between the Agency for Health Care Research and Quality (AHRQ), CMS, and a National Advisory Committee made up of experts in quality and performance measurement, HHS developed a proposed core set of 24 child health quality measures that states, health insurance issuers, and managed care entities may adopt to monitor and assess access to care and health outcomes among children served by Medicaid and CHIP. As a follow-up to identifying the initial core set of children's health care quality measures, CHIPRA required the establishment of a Pediatric Quality Measures Program (PQMP) of grants and contracts. Results of the PQMP are to be used to develop future enhanced and improved core sets of measures and provide for development of new measures as needed. To meet these requirements, AHRQ has issued a funding announcement for a Coordinating and Technical Assistance Center and also for a CHIPRA Pediatric Healthcare Quality Measures Program Centers of Excellence funding opportunity. The proposed priorities for the PQMP have been made available for public comment in the Federal Register.[15]

Quality Demonstrations. CHIPRA provided $100 million in federal funding for a series of demonstration projects designed to establish and evaluate a national quality system for children's health care. In February 2010, the Secretary awarded 10 grants to improve health care quality and delivery systems for children enrolled in Medicaid and CHIP. The awardees represent both single-state projects and multi-state collaborations. Grantees working in multi-state partnerships will share award funds with those partners—to be distributed among 18 states in total.[16] The grants, which are available over a five year period, will help states implement and evaluate provider performance measures and utilize health information technologies such as pediatric electronic health records and other quality improvement initiatives.

While this first year is largely the planning phase of the grants, states are undertaking promising interventions related to behavioral health, care coordination, and oral health services for children. Maryland (with Georgia and Wyoming), North Carolina, and Pennsylvania plan to enhance children's access to behavioral health services by testing different approaches to paying for and coordinating physical and behavioral health services. Maine (with Vermont), Illinois (Florida's partner), and Massachusetts have created opportunities to improve care coordination for children by using electronic health records and offering incentives to ensure referral information is shared among providers. Other grantees including Florida and Oregon are building better connections between their medical homes and dental care services provided to their pediatric patients. This coming year holds even more promise as grantees begin moving from planning into implementation of clinical interventions, collecting the CHIPRA initial core measures, and testing pediatric health record format.

Improving Access to Dental Care. Improving access to dental care for children is a high priority for HHS, for the Medicaid and CHIP programs and an area of emphasis in CHIPRA. The legislation made dental services a mandatory benefit for separate CHIP programs and required states to provide a listing of all participating Medicaid and CHIP dental providers through the *InsureKidsNow* website. The purpose of this requirement was to give families the opportunity to more easily identify participating dental providers in their community. In addition, the Center for Medicaid, CHIP and Survey & Certification within CMS has begun a major initiative to work with states to improve access to preventive dental care. In April 2010, CMS announced two specific goals for improvement in this area:

- To increase the rate of children ages 1–20 enrolled in Medicaid or CHIP who receive any preventive dental service by 10 percentage points over a five-year period; and
- To increase the rate of children ages 6–9 enrolled in Medicaid or CHIP who receive a dental sealant on a permanent molar tooth by 10 percentage points over a five-year period.

CMS held national stakeholders meetings with states in October and November 2010 and with provider, policy and advocacy organizations in January 2011 and has shared a draft Dental Strategy with a wide range of stakeholders for informal comment before finalizing the plan which will be posted on the *InsureKidsNow* website as well as the CMS website.

GRANTEE SPOTLIGHT

Massachusetts: Enrollment Help "On Call" for a Day

In September 2010, Health Care for All, a Massachusetts health care advocacy organization and CHIPRA grantee conducted its first one-day Phone-A-Thon, part of the group's campaign, "Got Coverage? Health Coverage for Children and Teens." From 9 am to 9 pm, 15 staff and volunteers responded to calls requesting health coverage information and helped to enroll children over the phone. In one day over 400 calls were answered and 300 children were enrolled in health coverage. (The HelpLine typically enrolls 150 to 200 children in the course of three months.)

In preparation for the Phone-A-Thon, Health Care for All conducted intensive, targeted outreach for three weeks before the event. Postcards and posters were distributed to nearly 400 organizations, with a focus on Spanish- and Portuguese-speaking communities, which are most likely to include higher numbers of eligible, uninsured children. The group made presentations at individual churches and with faith-based networks and appeared on more than 30 Spanish, and Portuguese, language radio shows. A commercial featuring the Phone-A-Thon was developed and aired on two Brazilian TV channels, as well as on Univision and Channel 7, which covered the Phone-A-Thon on the news. Massachusetts now boasts a 1% uninsured rate for children, the lowest in the country. Yet groups like Health Care for All continue to execute innovative new strategies to find and enroll children who still may be missing out on health coverage. For more information, contact Dayanne Leal, Health Care for All, leal@hcfama.org.

CONCLUSION: FORGING AHEAD, BUILDING ON SUCCESS

During the two years since CHIPRA was enacted, millions of uninsured children have gained coverage in Medicaid and CHIP and, as a direct result, the portion of children in America are going without health insurance continues to decline despite job losses and the difficult economic circumstances facing families. While participation rates in Medicaid and CHIP—averaging 82% nationally[17]—are higher than the levels achieved in most other means-tested programs, boosting participation remains the key step in closing the coverage gap for children.

Further improvements in outreach, enrollment, and retention are needed if states and communities are to be successful in ultimately covering the nearly 5 million uninsured children who are already eligible for Medicaid or CHIP coverage. State efforts to improve these programs and corresponding data shows that it is possible to ensure that eligible children are enrolled, but these efforts will not be sustainable unless all stakeholders continue to come together, pool resources, and share best practices over the next three years as we make the transition to 2014 and the seamless system of health coverage that lies ahead. These partnerships will be the key to our success in creating a culture of coverage where all Americans, adults and children alike, are enrolled and receive the health care they need.

APPENDICES

1. FY 2010 Children's Enrollment in Medicaid and CHIP by State
2. Children's Health Coverage: 2011 Upper Income Limits
3. FY 2010 CHIPRA Performance Bonus Awards Chart

REFERENCES:

[1] M. Heberlein, T.Brooks, J. Guyer, S. Artiga, and J. Stephens, "Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP, 2010–2011," Kaiser Commission on Medicaid and the Uninsured and Georgetown University Center for Children and Families, January 2011, 8. Available at http://www.kff.org/medicaid/8130.cfm

[2] M. Heberlein, T.Brooks, J. Guyer, S. Artiga, and J. Stephens, "Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP, 2010–2011," Kaiser Commission on Medicaid and the Uninsured and Georgetown University Center for Children and Families, January 2011, 8. Available at http://www.kff.org/medicaid/8130.cfm

[3] Urban Institute analysis of 2008 and 2009 American Community Survey data. Between 2008 and 2009, uninsured rates improved for children relative to adults 12 of the 16 states that were sampled—Alabama, California, Colorado, Florida, Georgia, Illinois, Kentucky, Maryland, Michigan, New Jersey, New York, and Virginia.

[4] J Genevieve M. Kenney, Victoria Lynch, Allison Cook and Samantha Phong. Who And Where Are The Children Yet To Enroll in Medicaid And The Children's Health insurance Program? Health Affairs, 29, no. 10 (2010): 1920-1929. Available at http://www.urban.org/health_policy/url.cfm?ID=1001449). For state-specific participation rates for 2008 see http://insurekidsnow.gov/facts/index.html

[5] For a complete listing of CMS policy guidance on CHIPRA see http://www.insurekidsnow.gov/professionals/federal/index.html

[6] M. Heberlein, T.Brooks, J. Guyer, S. Artiga, and J. Stephens, "Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP, 2010–2011," Kaiser Commission on Medicaid and the Uninsured and Georgetown University Center for Children and Families, January 2011, 8. Available at http://www.kff.org/medicaid/8130.cfm

[7] Urban Institute analysis of 2008 and 2009 American Community Survey data. Between 2008 and 2009, uninsured rates improved for children relative to adults 12 of the 16 states that were sampled—Alabama, California, Colorado, Florida, Georgia, Illinois, Kentucky, Maryland, Michigan, New Jersey, New York, and Virginia.

[8] The following examples are based on the Kaiser Family Foundation's annual survey for 2010. M. Heberlein, T.Brooks, J. Guyer, S. Artiga, and J. Stephens, "Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP, 2010–2011," Kaiser Commission on Medicaid and the Uninsured and Georgetown University Center for Children and Families, January 2011, available at http://www.kff.org/medicaid/8130.cfm

[9] Ruth Kennedy, Deputy Medicaid Director, Louisiana Department of Health and Hospitals, presentation to CMS during a visit to the Louisiana Medicaid office, New Orleans, LA, October 2010.

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[11] Kaiser Commission on the Uninsured and the Urban Institute in December 2009, available at http://www.urban.org/uploadedpdf/411981_Progress_Enrolling_Children_11_10.pdf

[12] Get Covered, Get in the Game outreach materials can be found at http://www.insurekidsnow.gov/professionals/campaigns/getcovered/index.html

[13] The National Academy for State Health Policy directs the Max Enroll project. The eight Max Enroll states are Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin. For more information about Max Enroll see http://www.maxenroll.org/

[14] The Georgetown University Center for Children and Families (CCF) provides technical assistance and guidance to the Finish Line project. The organizations receiving Finish Line funding are: Arkansas Advocates for Children and Families, California 100% Campaign (Children Now, Children's Defense Fund-CA and The Children's Partnership), Colorado Children's Campaign, the Iowa Child and Family Policy Center, Voices for Ohio's Children, Rhode Island KIDS COUNT, Children's Defense Fund of Texas, Washington Children's Alliance. For more information see http://ccf.georgetown.edu/index/finish-line

[15] A *Federal Register* notice seeking public input on priorities for the PQMP has been posted at http://edocket.access.gpo.gov/2010/2010-30262.htm

[16] The complete list of states receiving grant funds is available at http://www.hhs.gov/news/press/2010pres/02/20100222a.html. A summary of the grants can be accessed at http://www.insurekidsnow.gov/professionals/CHIPRA/grants_summary.html.

[17] Genevieve M. Kenney, Victoria Lynch, Allison Cook and Samantha Phong, "Who And Where Are The Children Yet To Enroll In Medicaid And The Children's Health Insurance Program?" Health Affairs, October 2010, available at http://content.healthaffairs.org/content/29/10/1920.abstract. See http://www.insurekidsnow.gov/facts/index.html for state-by-state information.

APPENDIX 1:
FY 2010 Number of Children Ever Enrolled in Medicaid and CHIP

STATE AND PROGRAM TYPE	NUMBER OF CHILDREN EVER ENROLLED BY PROGRAM TYPE						PERCENT GROWTH OVER 2009
	CHIP		Medicaid		CHIP and Medicaid		
	FY 2009	FY 2010	FY 2009	FY 2010	FY 2009	FY 2010	
Alabama (S)	110,158	137,545	519,672	846,766	629,830	984,311	56.3
Alaska (M)	11,655	12,473	75,040	78,034	86,695	90,507	4.4
Arizona (S)	66,275	39,589	888,175	951,092	954,450	990,681	3.8
Arkansas (C)	101,312	100,770	408,574	404,307	509,886	505,077	-0.9
California (C)	1,748,135	1,731,605	4,333,458	4,457,183	6,081,593	6,188,788	1.8
Colorado (S)	102,395	106,643	418,966	452,636	521,361	559,279	7.3
Connecticut (S)	21,874	21,033	264,551	282,100	286,425	303,133	5.8
Delaware (C)	12,599	12,852	83,521	83,857	96,120	96,709	0.6
District of Columbia (M)	9,260	8,100	81,576	89,402	90,836	97,502	7.3
Florida (C)	417,414	403,349	1,751,232	1,915,980	2,168,646	2,319,329	6.9
Georgia (S)	254,365	248,268	1,047,790	1,098,937	1,302,155	1,347,205	3.5
Hawaii (M)	24,691	27,256	99,235	114,736	123,926	141,992	14.6
Idaho (C)	44,319	42,208	149,682	169,216	194,001	211,424	9.0
Illinois (C)	376,618	329,104	1,951,325	2,080,461	2,327,943	2,409,565	3.5
Indiana (C)	142,665	141,497	660,617	670,047	803,282	811,544	1.0
Iowa (C)	52,608	63,985	273,031	293,103	325,639	357,088	9.7
Kansas (S)	48,090	56,384	204,258	201,038	252,348	257,422	2.0
Kentucky (C)	73,143	79,380	455,384	490,486	528,527	569,866	7.8
Louisiana (C)	170,082	157,012	636,440	662,861	806,522	819,873	1.7
Maine (C)	31,349	32,994	139,380	142,931	170,729	175,925	3.0
Maryland (M)	124,622	118,944	401,412	437,840	526,034	556,784	5.8
Massachusetts (C)	143,044	142,279	483,167	488,191	626,211	630,470	0.7
Michigan (C)	72,035	69,796	1,158,502	1,188,936	1,230,537	1,258,732	2.3
Minnesota (C)	5,470	5,164	482,792	482,352	488,262	487,516	-0.2
Mississippi (S)	86,839	95,556	589,784	618,332	676,623	713,888	5.5
Missouri (C)	103,709	86,261	568,309	548,085	672,018	634,346	-5.6
Montana+ (C)	25,749	25,231	56,612	70,175	82,361	95,406	15.8
Nebraska (M)	48,139	47,922	162,738	164,435	210,877	212,357	0.7
Nevada (S)	33,981	31,554	176,845	212,426	210,826	243,980	15.7
New Hampshire (C)	13,197	10,630	89,019	94,531	102,216	105,161	2.9
New Jersey (C)	167,009	187,211	577,553	617,895	744,562	805,106	8.1
New Mexico (M)	11,169	9,654	356,332	372,989	367,501	382,643	4.1
New York (S)	532,635	539,614	2,001,995	2,080,412	2,534,630	2,620,026	3.4
North Carolina (C)	259,652	253,892	1,035,284	1,243,785	1,294,936	1,497,677	15.7
North Dakota (C)	6,983	7,192	39,256	43,568	46,239	50,760	9.8
Ohio (M)	265,680	253,711	1,100,316	1,150,356	1,365,996	1,404,067	2.8
Oklahoma (C)	123,681	122,874	415,414	477,181	539,095	600,055	11.3
Oregon (S)	51,835	64,727	253,823	289,123	305,658	353,850	15.8
Pennsylvania (S)	264,847	273,221	1,196,395	1,228,017	1,461,242	1,501,238	2.7
Rhode Island (C)	19,596	23,253	106,906	108,321	126,502	131,574	4.0
South Carolina (C)	85,046	73,438	508,374	485,322	593,420	558,760	-5.8
South Dakota (C)	15,249	15,872	45,296	46,994	60,545	62,866	3.8
Tennessee (C)	83,333	81,341	759,080	781,567	842,413	862,908	2.4
Texas (S)	869,867	928,483	2,916,283	3,279,846	3,786,150	4,208,329	11.2
Utah (S)	59,806	62,071	219,464	237,125	279,270	299,196	7.1
Vermont (S)	7,092	7,026	72,180	72,891	79,272	79,917	0.8
Virginia (C)	167,589	173,515	562,093	603,166	729,682	776,681	6.4
Washington (S)	27,415	35,894	730,194	705,950	757,609	741,844	-2.1
West Virginia (S)	38,200	37,539	240,813	247,953	279,013	285,492	2.3
Wisconsin (C)	153,917	161,469	489,706	520,003	643,623	681,472	5.9
Wyoming (S)	8,871	8,342	54,409	58,277	63,280	66,619	5.3
TOTALS:	**7,695,264**	**7,705,723**	**32,292,253**	**34,441,217**	**39,987,517**	**42,146,940**	**5.4**

(S) – Separate child health programs (M) – Medicaid expansion programs (C) – Combination programs (NR) – Not Reported

Data Source: SCHIP Statistical Enrollment Data System (SEDS) forms CMS-21E, CMS-64.21E, and CMS-21waiver (1/10/11)
Montana changed to (C) 10/1/09

APPENDIX 2: Children's Health Coverage: 2011 Upper Income Limits

STATE	% FPL	ANNUAL INCOME LIMITS
Alabama	300%	$67,050
Alaska	175%	$48,897
Arizona	200%	$44,700
Arkansas	200%	$44,700
California	300%	$67,050
Colorado	250%	$55,875
Connecticut	300%	$67,050
Delaware	200%	$44,700
District of Columbia	300%	$67,050
Florida	200%	$44,700
Georgia	235%	$52,523
Hawaii*	300%	$77,130
Idaho	185%	$41,347
Illinois	200%	$44,700
Indiana	300%	$67,050
Iowa	300%	$67,050
Kansas	241%	$53,864
Kentucky	200%	$44,700
Louisiana	250%	$55,875
Maine	200%	$44,700
Maryland	300%	$67,050
Massachusetts	300%	$67,050
Michigan	200%	$44,700
Minnesota	275%	$61,462
Mississippi	200%	$44,700
Missouri	300%	$67,050
Montana	250%	$55,875
Nebraska	200%	$44,700
Nevada	200%	$44,700
New Hampshire	300%	$67,050
New Jersey	350%	$78,225
New Mexico	235%	$52,523
North Dakota	160%	$35,760
Ohio	300%	$67,050
Oklahoma	300%	$67,050
Oregon	300%	$67,050
Pennsylvania	300%	$67,050
Rhode Island	250%	$55,875
South Carolina	200%	$44,700
South Dakota	200%	$44,700
Tennessee	250%	$55,875
Texas	200%	$44,700
Utah	200%	$44,700
Vermont	300%	$67,050
Virginia	200%	$44,700
Washington	300%	$67,050
West Virginia	250%	$55,875
Wisconsin	300%	$67,050
Wyoming	200%	$44,700

All figures based on the 2011 Federal Poverty Level (FPL) for a family of four ($22,350).

Note: Alaska's FPL for a family of 4 is $27,940 and Hawaii's FPL for a family of 4 is $25,710.

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APPENDIX 3: FY 2010 CHIPRA Performance Bonus Awards Chart

State	Program Features								Enrollment Target*			FY 2009 Bonus Payment Amount (if applicable)	FY 2010 Bonus Payment Amount
	Continuous Eligibility	Liberalization of Asset Requirements	Elimination of In-Person Interview	Same App and Renewal Form	Auto/ Admin. Renewal	PE	Express Lane	Premium Assistance Subsidies	Additional enrollment above 2010 baseline (#)	% increase in enrollment over 2010 baseline	Tier 2 enrollment reached?		
AL	X	X	X	X	X				132,999	36%	Yes	$39,752,546	$54,965,407
AK	X	X	X	X	X				7,553	12%	Yes	$707,253	$4,408,789
CO		X	X	X		X		X	37,359	14%	Yes	n/a	$13,671,043
IL	X	X	X	X	X	X			106,047	8%	No	$9,460,312	$14,962,171
IA	X	X	X	X		X			27,729	14%	Yes	n/a	$6,760,901
KS	X	X	X	X		X			14,809	9%	No	$1,220,479	$2,578,099
LA	X	X	X	X	X				36,857	6%	No	$1,548,387	$3,555,853
MD		X	X	X	X		X		43,152	10%	Yes	n/a	$10,549,086
MI	X	X	X	X		X			93,113	10%	Yes	$4,721,855	$9,268,552
NJ		X	X	X	X	X	X		44,387	9%	No	$3,131,195	$8,788,959
NM	X	X	X	X	X	X			37,094	13%	Yes	$5,365,601	$8,533,431
OH	X	X	X	X		X			92,503	9%	No	n/a	$12,376,346
OR	X	X	X	X	X				40,373	20%	Yes	$1,603,336	$15,055,255
WA	X	X	X	X				X	74,815	14%	Yes	$7,861,411	$17,607,725
WI		X	X	X	X			X	85,557	23%	Yes	n/a	$23,076,127
											Total Bonus Payments for FY 2010		**$206,157,744**

States shaded blue had at least 5 of 8 program features in place for FY 2009.

****The enrollment target is a baseline level of Medicaid child enrollment that is calculated based on a formula that accounts for population growth and for increases in enrollment during an economic recession. States that exceed their enrollment target have increased enrollment above what would have been expected without expanded outreach efforts.***

States that exceed their enrollment target by more than 10% qualify for a "Tier 2" performance bonus payment, in which additional enrollment is rewarded at a higher rate.

For more information about connecting eligible children to health coverage, visit **www.insurekidsnow.gov**