State of Colorado
Office of Client and Community Relations
Colorado Department of Health Care Policy and Financing

Outreach Assessment and Gap Analysis for
Medicaid and CHP+ Expansion

Report

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EXECUTIVE SUMMARY

Background

Colorado's recent and upcoming public health insurance expansions provide an opportunity to ensure that eligible Coloradans are enrolled in health care; and that the state's outreach and enrollment infrastructure is prepared to accommodate full implementation of federal health care reform in 2014. In light of significant expansion in eligibility for public health insurance over the next five years,[1] the Department of Health Care Policy and Financing (the Department) has requested an extensive analysis of current, past, and potential new outreach activities to ensure the engagement of new populations in the public programs for which they are eligible. While Colorado's Children's Health Insurance Program (marketed and hereafter referred to as Child Health Plan Plus or CHP+) program provides considerable insight as to outreach to children and families under 200% FPL, it provides little direction as how to engage other expansion populations.

The Department contracted with JSI Research and Training Institute (JSI) to conduct an outreach assessment and gap analysis that will inform the development of outreach strategies for expansion populations. The analysis performs the following tasks:

- Identifies national best practices pertaining to outreach and enrollment for Medicaid and the Children's Health Insurance Program (CHIP);
- Outlines the scope, function and efficacy of previous outreach and enrollment efforts;
- Identifies common barriers to outreach and enrollment efforts, with a specific focus on Colorado's experience; and
- Makes strategic recommendations to support outreach to and enrollment of the expansion populations.

Approach

JSI's project approach consisted of:

- An extensive literature review to identify nationally recognized best practices and known barriers related to expansion populations, as well as promising new outreach methods;
- Review of Colorado-specific strategies and efforts including review of materials made available from the Department, various Department and stakeholder websites to inform both the gap analysis as well as the key informant interview process;
- Key informant interviews with Department and stakeholder representatives to understand their perspectives and experiences; and
- Using the literature review as a framework, analysis of the findings to identify gaps in populations served, barriers to effective outreach, and challenges faced by the outreach infrastructure.

[1] The Expansions are: May 1st 2010 from 205 to 250% FPL for children and pregnant women, and from 60 to 100% FPL parents; planned 2011 Medicaid buy-in for people with disabilities up to 450% FPL; planned spring 2012 Medicaid expansion for adults without dependent children to incomes up to 100% of FPL; planned spring 2012 implementation of guaranteed continuous 12-month enrollment for children on Medicaid.

Key Findings

Colorado has a well established outreach and enrollment infrastructure that includes Department administration and oversight of the Medicaid and CHP+ programs and CHP+ administration, enrollment services provided by county departments of human/social services, and an extensive network of application assistance sites that are able to provide varying levels of assistance to eligible families in the enrollment process. Colorado has piloted initiatives to maximize enrollment of children, pregnant women, and families. Many of these efforts can be leveraged to conduct outreach and enrollment to activities for Adults without Dependent Children and to inform outreach efforts for the Buy-In for Individuals with Disabilities.

However, Colorado's current outreach efforts have uneven reach across geographic and demographic groups. Further, current Medicaid and CHP+ processes and requirements create barriers to effective outreach and enrollment services. These gaps and barriers, along with the challenges faced by enrollment programs, must be addressed in order to maximize the impact of efforts to reach the expansion populations.

Gaps in Populations Reached

The major gaps in populations served by current and recent outreach and enrollment include:

- **Rural populations.** While there are some resources available to assist with outreach and enrollment in all counties, the type and adequacy of those resources vary greatly. Rural areas outside of major media markets have not been reached by prior mass media campaigns and many rural counties either lack application assistance sites or have limited access to those sites.
- **Adults without Dependent Children**. As most prior marketing messages and outreach strategies were designed to reach children, pregnant women and families, there have been no marketing messages developed to target adults without dependent children (AwDC). While some outreach sites, especially safety-net medical providers, serve AwDC and could expand their outreach strategies to include this population, there is either limited capacity or limited interest among other assistance sites.
- **Individuals with disabilities.** As with AwDC, prior marketing messages and outreach strategies have not been designed with this population in mind. Existing programs are not structured as buy-in programs, and have much lower poverty level limits (100% for parents and AwDC and 250% for children, compared to 450% for the buy-in program). Thus, the population eligible under the buy-in will be significantly different than those around which the current outreach infrastructure is built. The current outreach infrastructure is not sufficient, and does not explicitly involve or collaborate with entities that have experience working with people with disabilities.
- **Diverse communities.** While some campaigns and marketing efforts have targeted specific communities of color, there is no statewide strategy or metrics regarding the provision of linguistically or culturally specific outreach and enrollment in the areas where they are most needed.
- **Non-English speakers.** While a number of outreach, enrollment, and marketing resources are available in Spanish several key resources, such as the Department client web pages, are not. Further, there are no state-developed materials in other languages outside of Spanish and English, and access to assistance in other languages is limited.

Barriers to Outreach and Enrollment

Key informant interviews and an extensive Colorado based literature review helped to identify several barriers associated with outreach and enrollment. Identified were barriers related to the manner in which public programming is perceived, as well as specific procedural hurdles related to documentation, application assistance, and technical issues. Key issues related to the following:

- **Outreach:** Two types of media and outreach barriers were identified: those related to the experience and perceptions of eligible or potentially eligible persons; and those related to the way current systems and efforts are organized or delivered. Among the former were the perceptions of and stigma related to public programs. Barriers related to systems included the lack of sub-county or population-specific data to guide the development of outreach strategies and limited tracking systems to assess their effectiveness.
- **Enrollment.** Enrollment barriers include the limited availability of application assistance overall (varying greatly throughout the state), language barriers to accessing assistance, and the time and expense of obtaining required documentation**.** Colorado's current enrollment and eligibility systems also create barriers, despite ongoing efforts to modernize and streamline eligibility and enrollment. The barriers identified include the length of the application, documentation requirements, and hand-offs of applications across site types. Additional barriers exist related to the use of the Colorado Benefits Management System (CBMS) to determine eligibility. These include longer processing times due to the limited capacity of the system and county staff using it, as well as the generation of notices which clients find unclear or confusing.

Challenges

A number of challenges exist for any potential intervention to address the current barriers or gaps pertaining to outreach and enrollment that will effectively reach the expansion populations. These challenges include:

- **Development of effective messages and strategies to reach eligible populations.** Outreach and enrollment partners struggle to identify what these messages are and how to convey to eligible persons that the program is "for them," especially in regards to populations they have not previously served.
- **Limited information about successful outreach and enrollment strategies generally, and for specific income and racial and ethnic groups**. Data on what strategies work well in Colorado are just emerging, and there are limited opportunities for outreach and enrollment partners to learn from each other regarding best practices.
- **Ensuring that Colorado's outreach and enrollment partners are effective and sustainable.** Colorado has built an outreach and enrollment strategy that relies heavily on community-based resources. These local partners require ongoing, strategic support and engagement to be effective including regular communication and training from the Department, assistance in overcoming barriers, and opportunities to share best practices and provide the Department with input on strategies for reaching expansion populations. Most outreach and enrollment efforts rely on grant funding (either from foundations or the state) to sustain at least some of their core activities, making them vulnerable to fluctuations in funding priorities.
- **Using data to ensure adequate availability of outreach and enrollment services.** Availability of outreach and enrollment assistance varies greatly across the state and does

not necessarily correspond to eligible but not enrolled populations. There is a lack of information on which specific geographic or population groups are being effectively reached or which type of outreach venue or process might be most effective in reaching specific demographic groups.

Recommendations

In order to maximize the impact of outreach and enrollment to the expansion populations, it is critical that Colorado:

- **Move forward with planned enrollment simplification and modernization efforts.** Complex program rules and requirements make it difficult to develop clear and simple marketing messages, and require extensive application assistance that could otherwise be focused on more extensive outreach or re-enrollment activities. Streamlined and modernized enrollment and re-enrollment make it easier to engage families and assist them in applying.
- **Develop targeted, clear and consistent messaging to support outreach to the expansion populations**. Expansion populations may not respond to existing messages emphasizing child health. The Department should ensure that the over-arching message it uses for Medicaid and CHP+ reinforces the value of the programs and the importance of health, employs social marketing research and techniques to develop and test messages for the expansion population and specific demographic groups, and provides clear and timely informational materials for community partners to use in their own marketing and outreach.
- **Ensure availability of Application Assistance Sites for the newly eligible populations.** While the number of application assistance sites has increased substantially, that growth has not been targeted to geographic regions with the highest eligible but not enrolled expansion populations, nor has it strategically included organizations with the most capacity to reach the expansion populations.
- **Continue to provide systemic support to Community Application Assistance Sites.** With the shift to the Healthy Community Partners, in which Family Health Coordinators are charged with providing more of a direct case management and education role to both enrolled and eligible but not enrolled families, it is important that all application assistance sites, including Healthy Communities Sites, receive consistent and clear information and training, and are able to share best practices.
- **Design an outreach strategy specific to people with disabilities with incomes below 450% FPL.** Because the income parameters for this population are so much higher than those for other populations, and because the structure of the program as a buy-in program will be distinct from current programs, it requires a distinct outreach strategy, albeit one coordinated with CHP+ and Medicaid.
- **Increase the ability of the state and individual Application Assistance Sites to identify and adopt effective practices.** The outreach and enrollment infrastructure Colorado employs to enroll expansion populations over the next several years should become the platform upon which federal health care reform expansion, effective in 2014, is implemented. Given limited state resources and the high stakes involved, an investment should be made to establish mechanisms for measuring and identifying successful sites.
- **Support the use of a case management approach to outreach and enrollment.** This approach includes the critical component of educating eligible individuals about the

benefits of health insurance and how to access those benefits. The Department is already supporting this approach in the Healthy Communities program and should seek ways to support and encourage this model, particularly among application assistance sites that are, or have very direct links to, medical providers.

Summary

Colorado has a well established outreach and enrollment infrastructure that includes Department administration and oversight of the Medicaid and CHP+ programs and CHP+ administration, enrollment services provided by county departments of human/social services, and an extensive network of application assistance sites. The application assistance sites range from those that offer information and application assistance site only to Presumptive Eligibility Sites that can assist families with obtaining presumptive coverage and critical services and Medical Assistance sites that are able to complete the enrollment process for eligible families. Colorado has piloted exciting initiatives to maximize enrollment of children, pregnant women, and families. Many of these efforts can be leveraged to conduct outreach and enrollment activities for Adults without Dependent Children, and to inform outreach efforts for the Buy-in for Individuals with Disabilities.

INTRODUCTION

In the coming years, Colorado has the opportunity to enroll many of its 800,000 uninsured children and adults into Medicaid and the State Child Health Insurance Program (CHIP). Governor Ritter's administration developed and implemented key building blocks for health care reform, based on the recommendations of the Blue Ribbon Commission for Health Care Reform established in 2006.[2] One of these building blocks is the Colorado Health Care Affordability Act (H.B. 09-1293), signed into law by Governor Ritter on April 21st, 2009, which is expected to expand coverage to more than 100,000 uninsured Coloradans, phasing in several expansion populations over the next several years. These state expansions, along with anticipation of full implementation of Federal health care reform under the Patient Protection and Affordable Care Act (PPACA), which will expand Medicaid eligibility to all persons under 133 percent of the Federal Poverty Level (FPL) in 2014, will require a robust and effective outreach and enrollment strategy to ensure eligible persons are enrolled.

The Colorado expansions made possible under H.B. 09-1293 are:

- May 1st, 2010
  - ***CHP+ expansion for children and pregnant women*** from 205 to 250% FPL – expands coverage for 24,000 children and pregnant women
  - ***Medicaid expansion for parents or guardians*** from 60 up to 100% of FPL – expands coverage for 43,500 low-income parents
- Summer 2011
  - ***Medicaid buy-in program for individuals with disabilities*** with family income up to 450% of FPL – expands coverage for 9,000 individuals with disabilities
- Spring 2012
  - ***Medicaid expansion for adults without dependent children*** with incomes up to 100% of FPL – expands coverage for 82,000 low-income adults without dependent children
  - ***Guaranteed continuous 12-month enrollment*** for children on Medicaid

Colorado operates separate insurance programs; Medicaid and Child Health Insurance Program (CHIP). Colorado's CHIP program, the Children's Basic Health Plan (marketed and hereafter referred to as Child Health Plan Plus or CHP+), replaced an existing state financed program, separate from Medicaid, and called the Colorado Child Health Plan. Implementation of a separate program allowed Colorado to retain flexibility in state funding which would not have been possible under a Medicaid expansion due to the entitlement nature of the Medicaid program and the requirement for state matching dollars. As a result, CHP+ has an administrative structure distinct from Medicaid, has a separate funding allocation, and submits separate reports to the state legislature. While the CHP+ program has received state dollars to support marketing activities, no such funding has been available to the Medicaid program.

[2] "Final Report to the Colorado General Assembly." *Blue Ribbon Commission for Health Care Reform* (2008). Web. 24 Aug. 2010.

As of 2008, there are an estimated 176,000 uninsured children (ages 0-18) in Colorado. While a substantial portion of those, almost 16,000 children, are estimated to be ineligible due to citizenship requirements, as many as 115,000 are eligible for, but not enrolled, in either Medicaid or CHP+.[3] Further, an estimated 172,266 adults (including both parents of eligible children and childless adults) under 100% FPL are uninsured. Of that population, over 25,500 parents were eligible for Medicaid before May 1st, 2010 but were not enrolled.[4]

The department contracted with JSI to conduct an outreach assessment and gap analysis that will inform the development of outreach strategies for expansion populations. The objectives of the assessment and analysis are to:

- Identify national best practices pertaining to outreach and enrollment for Medicaid and CHP+;
- Understand the scope, function and efficacy of previous outreach and enrollment efforts;
- Identify common barriers to outreach and enrollment efforts, with a specific focus on Colorado's experience;
- Make strategic recommendations as how to apply best practices in light of Colorado's current efforts.

This effort is part of the Colorado Comprehensive Health Access Modernization Program, or CO-CHAMP, funded under the Health Resources and Services Administration (HRSA)'s State Health Access Program (SHAP). The SHAP supports state efforts to significantly increase health care coverage as part of a plan for comprehensive health care reform. Colorado's SHAP proposal includes a variety of projects that will lead to greater access to health care, increase positive health outcomes and reduce cost-shifting, including the Maximizing Outreach, Retention and Enrollment (MORE) Project. Under MORE the Department will conduct outreach and marketing campaigns to inform the expansion populations of the availability of public health insurance programs and how to access health care services in appropriate settings. Activities in year one include this outreach needs assessment and gap analysis, 2010 Stakeholder Conferences, 2011 Regional Conferences, the development of an outreach strategic plan, focus groups with two of the expansion population groups and the distribution of grants to local community-based organizations for targeted outreach.

[3] Colorado Health Institute. Center for the Study of the Safety Net. *Colorado Children's Health Insurance Status: 2010 Update.* Issue brief. 2010. Print

[4] Colorado Health Institute. Center for the Study of the Safety Net. *Health Insurance Coverage among Low-Income Adults in Colorado.* Issue brief. 2010. Print

APPROACH

JSI project staff used the following approaches to complete the outreach assessment and gap analysis:

- An extensive literature review to identify nationally recognized best practices and known barriers related to expansion populations, as well as promising new outreach methods;
- Review of Colorado-specific strategies and efforts including review of materials made available from the Department, various Department and stakeholder websites (including the Department's website, the CHP+ website, and those of Covering Kids and Families, the Colorado Health Foundation, The Colorado Trust and other key stakeholders) to inform both the gap analysis as well as the key informant interview process;
- Key informant interviews with Department and stakeholder representatives to identify existing or perceived gaps and barriers related to outreach and enrollment;
- Presentation of initial analyses and pertinent findings to the Department, and incorporation of Department feedback in the continued analysis and development of report outline.

The literature review first identified national best practices relating to outreach and enrollment methodologies utilized by other states to enroll eligible populations. The review focused on the most common barriers related to outreach and enrollment from both a stakeholder and client perspective, and successful strategies for addressing them. The review identified state examples relating to the use of media, targeting of specific audiences with clear messaging, simplified enrollment practices, and innovative approaches for overcoming barriers, among others.

This literature review revealed several key themes related to outreach, enrollment and access, as well as the barriers associated with each step. It also provided a framework for understanding each process to better inform the final analysis. For the purposes of this study, JSI developed the following working definitions associated with the various processes involved with raising public awareness of and assisting eligible persons in applying for public health insurance:

> **Marketing:** the process by which interest is created in a good or service, in this case public health insurance via Medicaid or CHP+. For the purposes of this project, marketing refers to the use of mass media (i.e. television advertisements, public service announcements, radio advertisements, magazines and other print ads or articles) generated and dispersed to create awareness and interest.
> **Outreach:** efforts made by individuals, organizations or State agencies to link specific audiences with public health insurance and assist them in using the benefits once enrolled. This involves use of education, facilitation and targeted campaigns to find, reach, and assist eligible applicants with the enrollment process and with health care systems.
> **Enrollment:** refers to the process through which an eligible person or population is granted eligibility for public health insurance. Enrollment procedures vary greatly from state to state and, if complex or onerous, may create challenges for outreach efforts. Because outreach and enrollment are inexorably linked, simplified, efficient enrollment systems facilitate both the outreach worker's ability to guide an applicant through the process and the applicant's own interest in applying.

Re-enrollment/renewal: refers to the process by which an enrolled individual is determined eligible for continued services within the program at the end of their current enrollment span.
Eligibility: refers to a person's ability to access public programs based upon specific demographics related to eligibility criteria. Demographics involved with the eligibility determination process include income level, citizenship status, state residency, family structure and age.

With national best practices and barrier serving as a framework, key informants were interviewed to gain additional insight into Colorado-specific barriers and outreach strategies. Interviews were first held with Department personnel responsible for community outreach and enrollment functions to gain an understanding of the overall outreach and enrollment strategy to date. Interviews were then held with representatives of application assistance sites including Certified Application Assistance Sites, Presumptive Eligibility sites, Medical Assistance sites and Healthy Community grantees in various regions of Colorado, as well as statewide coalitions involved in informing outreach or enrollment efforts. A complete listing of key informants is provided in Appendix A.

JSI project staff developed an interview guide informed by the literature review and refined with feedback from the Department. The guide sought the perspective of key informants on five major areas of Colorado's outreach and enrollment efforts:

- Identification of current and past Medicaid and CHP+ outreach and enrollment;
- Success of historic and current outreach efforts in increasing enrollment of eligible persons;
- Current barriers related to CHP+ and Medicaid outreach and enrollment efforts;
- Outreach and enrollment approaches that are likely to be effective with specific expansion populations,
- Identification of documented, successful outreach/enrollment methodologies that have been utilized at one location or in a widespread fashion in Colorado.

Information from the literature review and key informant interviews was analyzed to identify common themes. Where possible, the effectiveness of specific outreach strategies employed was also documented. Ultimately, each best practice and barrier was related to a specific step in the enrollment process from initial outreach attempts to the application and documentation process to enrollment, either successful or unsuccessful. The analysis also identified which eligibility or demographic groups were most impacted by specific best practices and barriers. Demographics considered were age, race/ethnicity, language, income and geography. The analysis sought to identify populations not currently being reached by existing outreach methodologies, as well as expansion populations for which specific, new and innovative techniques will have to be developed for successful outreach and enrollment.

FINDINGS

NATIONAL BEST PRACTICES

Best practices for outreach and enrollment in public health insurance were identified through extensive literature review, and categorized and analyzed for their applicability to Colorado. The resources most heavily utilized to identify national barriers and best practice methodologies were publications from the Kaiser Family Foundation, The Robert Wood Johnson Foundation's Covering Kids and Families, Families USA, and The National Academy for State Health Policy, although other resources were identified and utilized as needed. Colorado-specific information was obtained both from the Department and key informants, along with materials publicly available from Colorado stakeholder groups such as Covering Kids and Families, All Kids Covered, the Colorado Health Institute and several Colorado health foundations.

States and communities have implemented new, innovative and often simple techniques to peak public interest, target specific populations and provide streamlined enrollment processes for public health insurance. The identified best practices include:

Marketing

- *Use of clear, simplified messages*: Providing clear and easily understood messages can simplify what may seem to be an increasingly complicated process. Simple messages promoting Medicaid as "pure and simple" will become increasingly pertinent as Medicaid becomes available to a wider audience. Messages such as "Free or low-cost insurance available for uninsured children," "one less worry," "All kids are covered," "You are wanted," "New Medicaid Program," or "the rules have changed," can help new audiences understand the program is changing and they may be eligible.[5,6]

- *Targeted marketing*: States have increasingly moved away from broad based messaging and towards targeted marketing campaigns directed at specific demographics such as income levels, race or ethnicity, and language. Indiana, for example, found that partnering with Vernon Williams, a minority marketing expert, increased minority participation in the Healthy Indiana Plan from seven to thirteen percent.[7]

- *Increase publicity on the value and importance of health insurance*: Newly eligible populations may not actively seek health insurance for a variety of reasons. Some may not feel the need to obtain health insurance, especially if it is perceived to be unaffordable. Increasing publicity on the value of health insurance shows significant promise in reaching populations otherwise hesitant to prioritize insurance, such as a younger population with fewer immediate health needs.[8]

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[5] Kaiser Family Foundation: Kaiser Commission on Medicaid and the Uninsured. *Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experience.* Issue brief. 2010. Print.
[6] Williams, Susan R., and Margo L. Rosenbach. "Evolution of State Outreach Efforts Under SCHIP." *Health Care Financing Review* 28.4 (2007): 95-107. *Centers for Medicare & Medicaid Services*. Web. 7 Sept. 2010. http://www.cms.gov/HealthCareFinancingReview/.../07Summerpg95.pdf.
[7] Indiana Check Up Plan. Indiana Check Up Plan Task Force Report November 1, 2009. Rep. no. FSSA88. 2009.
[8] Goldstein, Aviva. "Childless Adults: Barriers to Enrollment in Public Health Insurance." *National Center for Law and Economic Justice* (2010): 1-29. Web. Sept. 2010.

- *Engage community leaders*: Engaging community leaders who can effectively champion specific outreach messages, such as covering all children, could provide a potentially potent tool in reaching new communities. Research has shown that utilizing key leaders within the community to act as spokespersons for outreach messaging is a vital aspect of increasing enrollment by providing a trusted voice to inform the public.[9]

- *New Outreach Venues*: As new populations become eligible for public programs, new outreach venues must be considered to promote effective outreach. Adults without Dependent Children (AwDC), for example, may not be reached via traditional methodologies, such as public school partnerships. Conducting outreach in unemployment offices, assisted housing programs, job training programs, community colleges, and homeless or domestic violence shelters could provide new opportunities to populations not typically involved with public programs.[10]

- *Use of social media*: Social Media is a relatively new, potentially potent tool for reaching newly eligible populations. Its effectiveness in assisting with outreach and enrollment in health insurance has not, however, been proven. Further discussion of the use of new media is included in the Challenges section of this report.

Community-Based Outreach

- *Provide a direct link from application assistance to enrollment*: Among the most pertinent barriers to access is the gap between receiving application assistance and enrollment. Enrollment facilitators do invaluable work by collecting documents, explaining eligibility guidelines, and assisting families and individuals in understanding public programs. Their frequent inability, however, to enroll persons into programs for which they are eligible represents a major hindrance to accessing care.

- *Use a case management approach to enrollment.* This approach supports both families and the assistance sites. It includes consistent training, technical assistance, and compensation for those facilitating enrollment, and provides the applicant with access to one person who can see them through the entire enrollment process. Case management models are widely used to assist families in accessing health services and can be extended to include the enrollment process as well.[11]

- *One-on-one contact*: Direct, one-on-one contact with families has been found to be among the most effective tools in providing information, correcting misconceptions and assisting with applications. Locally led efforts are particularly useful in providing

[9] Wachino, Victoria, and Alice M. Weiss. Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children. Rep. Robert Wood Johnson Foundation, 2009. Print.

[10] Kaiser Family Foundation: Kaiser Commission on Medicaid and the Uninsured. *Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experience*. Issue brief. 2010. Print.

[11] Colorado Covering Kids and Families. *A Case Management Approach to Medicaid and CHP+ Enrollment: Recommendations for Colorado's Investment in Medicaid and CHP+ Outreach*. Rep. Colorado Covering Kids and Families, 2008. Print.

customized, direct assistance to clients and have allowed States to tailor their outreach efforts to specific populations.[12]

- *Promoting cultural competence*: It stands to reason that the very first step in conducting outreach activities is to know your audience. Incorporating targeted methodologies to reach diverse communities is an integral step to reducing the barriers and disparities so often associated with race, ethnicity and English proficiency. Collecting data on race and ethnicity of the target population is the very first step to enhancing such strategies and developing innovative and advanced culturally competent techniques.[13] California's experience has revealed other key steps to promoting cultural competence in public programs.
    - **Designating Cultural Competence staff:** Developing specific positions dedicated to promoting and incorporating cultural competence in service delivery.
    - **Workforce Diversity:** Establishing corporate level strategies or formal diversity programming to recruit and retain multi-racial and multi-ethnic staff.
    - **Health Promotion:** Modifying health education and disease management materials to be more culturally appropriate and relevant, across multiple cultures and languages.
    - **Education and Training:** Training and educating staff surrounding the definition and importance of cultural competence is integral to promoting an organizational shift to promote cultural competency. New staff orientation is one venue to promote such training. Written materials and manuals offer additional opportunities.[14]

- *Reducing language barriers*: Outreach and enrollment to persons with limited English proficiency, lower education levels, or reduced literacy rates presents unique challenges. To address such issues, materials should be written below a 9th grade level and avoid legal terminology which can often exacerbate a confusing application process. Providing program materials printed in multiple languages, as informed by a comprehensive data gathering process to properly understand an audience's demographics, can create new opportunities to reach vulnerable populations.[15]

- *Targeted community partnerships*: Community partnerships provide the opportunity to engage families on a local level in a setting in which they are comfortable and familiar. Outreach through Community Based Organizations (CBOs) offers the opportunity to utilize grassroots approaches to meet individuals and families where they are.[16] CBOs can frequently provide culturally appropriate services, as well as direct access to hard to

[12] Williams, Susan R., and Margo L. Rosenbach. "Evolution of State Outreach Efforts Under SCHIP." *Health Care Financing Review* 28.4 (2007): 95-107. *Centers for Medicare & Medicaid Services*. Web. 7 Sept. 2010. http://www.cms.gov/HealthCareFinancingReview/.../07Summerpg95.pdf.
[13] Bocchino, Carmella. "Appendix G Racial and Ethnic Data Collection by Health Plans." *The National Academies Press*. 2004. Web. Aug. 2010. http://www.nap.edu/openbook.php?record_id=10979&page=272
[14] Brach, Cindy, Kathryn Paez, and Irene Fraser. 2006. "Cultural Competence California Style." Agency for Healthcare Research and Quality Working Paper No. 06001. Feb. 2006. Web. 30 Aug. 2010.
[15] Kaiser Family Foundation: Kaiser Commission on Medicaid and the Uninsured. *Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experience*. Issue brief. 2010. Print.
[16] Chung, Phillip, Tia A. Cavender, and Debbi S. Main. "Trusted Hands: The Role Of Community-Based Organizations In Enrolling Children In Public Health Insurance Programs." *The Colorado Trust* (2010). Web.

reach populations, such as immigrant families, families in rural areas, or families with language or cultural differences.

Partnerships with schools have been found to be particularly effective in reaching potential enrollees, as have Hospitals and Community Health Clinics (CHCs). In Michigan, hospital emergency room staff provides information and referrals to CHIP when a patient arrives without coverage. In South Dakota, health providers work with vocational schools, colleges and universities to distribute informational brochures.

Further, partnering with private employers, unions and business associations provide additional avenues through which to reach potentially eligible populations. McDonalds, K-mart and Wal-Mart, for example, have advertised the CHIP toll-free number on bags and tray liners. New Jersey has even partnered with agencies to include information in presentations to businesses expecting closings or layoffs.[17]

- *Expand enrollment sites*: Expanding the number and availability of enrollment application assistance sites can greatly enhance programmatic ability to reach vulnerable populations.[18] As direct, one-on-one contact is vital to targeted, customized outreach efforts, access to enrollment assistance sites has been found to be vital in enrolling new applicants. California, for example, experienced significantly stunted enrollment growth when they reduced the number of available Certified Application Assistant Sites (CAAS).[19] Further, offering a range of assistance sites with flexible schedules could provide meaningful assistance to working families.

- *Promote a culture of coverage*: Moving away from a culture of "gate-keeping" and towards a culture of enrollment encouragement could have dramatic, systemic effects on internal outreach practices. This type of culture shift will become increasingly pertinent on a national scale as Medicaid is expanded in 2014 and families and individuals have new avenues through which to access insurance, both public and private. Promoting an internal culture of coverage, by reorienting Medicaid management practices, public system structure, and caseworker training materials could align programmatic administration with the new culture of coverage.[20]

[17] Williams, Susan R., and Margo L. Rosenbach. "Evolution of State Outreach Efforts Under SCHIP." *Health Care Financing Review* 28.4 (2007): 95-107. *Centers for Medicare & Medicaid Services*. Web. 7 Sept. 2010. http://www.cms.gov/HealthCareFinancingReview/.../07Summerpg95.pdf.

[18] Hess, Catherine, and Maureen Hensley-Quinn. "Building on Success to Effectively Integrate Current Children's Coverage with National Coverage with National Health Reform: Ideas Form State CHIP Programs." *State Health Policy* (2009): 1-8. *National Academy for State Health Policy*. Web. 23 Aug. 2010.

[19] Wooldridge, Judith. *Making Health Care a Reality for Low-Income Children and Families.* Issue brief. Robert Wood Johnson Foundation, 2007. Print.

[20] Kaiser Family Foundation: Kaiser Commission on Medicaid and the Uninsured. *Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid's Reach under Health Care Reform.* Issue brief. 2010. Print.

Colorado has made significant steps to incorporate a number of these nationally recognized best practices. For example, Governor Ritter and Lt. Governor Barbara O'Brien have appeared in multiple public service announcements advocating the CHP+ program, providing a cohesive voice of central leadership. Colorado has also ensured that direct, one-on-one assistance is provided to many potential applicants through a variety of application assistance sites and focused project pilots. Further, the Medicaid and CHP+ joint application is available in Spanish, significantly enhancing reach to Spanish speaking populations.

Additional progress is still needed to further simplify and modernize Colorado's eligibility systems, to minimize the number of handoffs between outreach and enrollment, and to ensure that outreach and enrollment strategies will reach expansion populations. Appendix B summarizes the national best practices and Colorado's progress on adopting them. The next section takes a closer look at Colorado's approach to outreach and enrollment.

COLORADO OUTREACH AND ENROLLMENT ASSESSMENT

As previously discussed, outreach for public health insurance programs includes a continuum of activities ranging from making eligible populations aware of their eligibility to providing assistance in application completion and enrollment processes and facilitating retention and re-enrollment. One of the facilitators of the outreach and enrollment processes is the development of a streamlined program which lends itself to direct and simple outreach messages, supported by simple and streamlined enrollment processes.

Described in this section is Colorado's outreach and enrollment efforts as they relate to identified best practices and the ability. Because eligibility and modernization can dramatically support outreach and enrollment efforts, this section also includes a discussion of Colorado's efforts to simplify eligibility in CHP+ and Medicaid.

Marketing

State-led marketing for public insurance programs in Colorado have historically focused on populations eligible for CHP+: children and pregnant women with incomes over the Medicaid income limit but below the CHP+ income threshold. It is important to note, however, that CHP+ media and outreach efforts can also assist in identifying and enrolling persons in Medicaid due to the fact that:

- All CHP+ applicants must be screened for Medicaid eligibility;
- CHP+ and Medicaid programs utilize a joint application;
- Most community outreach venues assist families in learning about and/or applying for both Medicaid and CHP+.

The level of CHP+ marketing activities has depended upon the availability of state general fund dollars and has varied over the years. Between 2006 and 2010 the Department contracted with MAXIMUS to conduct targeted media campaigns with funds authorized by the state legislature. As of July 2009 those marketing services have ceased due to reductions in state funding, and the Department has shifted to a community-level outreach approach. Past advertising messages have focused on the value and peace of mind that CHP+ can provide to families. In addition to this message, the media messages have included a "call to action" and provided the CHP+ toll free number and website so that families can obtain further information or an application. The objectives of CHP+ campaigns have been to promote awareness of the program and increase program enrollment, targeting families and single mothers with children under the age of 18. Marketing campaigns and materials have been in both English and Spanish and have targeted most major media markets in the state.

Marketing activities by the Department and its direct contractor have included:

- Newspaper and television articles generated as a result of press releases or legislative activity related to the program;
- Print media advertisements in state and local publications;
- Television advertisements;
- Radio advertisements;
- Billboard advertisements; and

- Maintenance of a CHP+ website with informational materials.

In addition to purchasing media venues, materials have also been developed that lend themselves to airing as public service announcements, with no associated costs.[21,22]

The overall theme of Colorado's campaign has been "Keeping Colorado Kids Healthy" with annual campaigns including the themes:[23]

- Keeping Colorado Kids Healthy, from their pearly whites to their piggily wigglies; and
- Keeping Colorado Kids Healthy throughout the seasons.

Also, 15 and 30 second television ads ("When I grow up") featuring Governor Bill Ritter were run during the Democratic National Convention and Summer Olympics.

In addition to these media exposures, the CHP+ program has maintained a website and print materials that provide information about the program along with tools for community partners to utilize. The materials include colorful program brochures and posters targeted at families, desktop reference materials for outreach partners, and links to program applications and television and radio ads. CHP+ materials have also been modified to reflect the inclusion of expansion populations newly eligible as of May 2010.

Community partners have used the media messages and materials generated at the state level within their local communities. In addition, several substantial media initiatives to increase CHP+ enrollment have been carried out by community partners and funded by state or national foundations. Two prominent examples include:

- A Spanish-language television series entitled *Encrucijada, Sin Salud no Hay Nada* (Crossroads: Without Health, There Is Nothing). A project team, including CHP+ marketing staff, created a series of twelve locally developed half hour episodes that educate Spanish speaking Hispanics on the Front Range about how to enroll their children in CHP+ and Medicaid, how to access health care, and how to prevent chronic disease. The effort was funded by The Colorado Health Foundation and supported by Entravision Communications, with considerable involvement from Entravision's Creative Service Director. The subject matter for the series was determined by a group of project advisors including community and community partner representatives. Airing of the series was coordinated with the availability of a Spanish-language information line.
- Denver Community Voices, with support from the W. K. Kellogg Foundation developed a culturally specific campaign to encourage enrollment of Native American families in public health insurance. Development of the campaign included testing media messages within the Denver Native American communities, and developing print materials with images and messages specific to the community.

[21] MAXIMUS. CHP+ Marketing and Outreach Services: FY 08-09 Third Quarter Report, January - March 2009. Rep. 2009. Print.

[22] MAXIMUS. *CHP+ Marketing and Outreach Monthly Report: April 2009.* Rep. 2009. Print. Submitted to the Colorado Department of Health Care Policy and Financing.

[23] Child Health Plan Plus: The Medical Services Board. *Children's Basic Health Plan: Annual Report - State Fiscal Year 2002-2009*. Rep. 2009. Print.

While no mass media campaigns have run since June 2009, outreach materials and links to television and print ads are available on the CHP+ and department websites for use by local communities. The Department continues to use press releases related to program expansions or changes to garner media support. As a result of this change the Department is shifting its focus to a community-level outreach approach.

Outreach

As previously stated, outreach and application assistance are inexorably linked. Media and community outreach campaigns are used to increase the number of eligible applications submitted by families. Families are able to download applications and submit them via mail to either the CHP+ administrator or their local county department of human/social services. In-person application assistance sites play a critical role in educating families about their eligibility for CHP+/Medicaid and assisting families in completing the application and understanding how to utilize their benefits. Application assistance sites located within or affiliated with provider sites, such as community health centers, Colorado Indigent Care Program Providers, and hospitals are critical for assisting families who may have an immediate need for health insurance due to a medical issue. These sites have an added interest and commitment to assisting families because they are better able to receive reimbursement for services provided.

Application Assistance

The CHP+ and Medicaid programs are developed and supervised by the Department of Health Care Policy and Financing. Since they are separate programs, however, they are administered separately. For CHP+, the department contracts with a statewide eligibility and enrollment contractor who accepts applications via mail, screens CHP+ applications submitted by mail (either by clients or by assistance sites) for eligibility, and makes final eligibility determinations. County departments of human/social services also accept CHP+ applications. Because Colorado is a state-supervised, county-administered system for traditional social services, including Medicaid, the primary entities responsible for taking Medicaid applications and determining whether or not an applicant is eligible is the county department of human/social services.

- Departments of social/human services in each county accept mail-in applications, provide in-person application assistance, determine eligibility through CBMS, and provide ongoing maintenance to Medicaid cases.
- The CHP+ administrator accepts applications submitted via mail. As part of its determination process the administrator also screens applicants for Medicaid eligibility and enrolls them as appropriate.

Neither the CHP+ administrative contractor nor county departments of human/social services are designed to focus on community outreach. Rather, the Department has developed a network of assistance sites within communities that conduct outreach to eligible families and provide varying degrees of assistance with completion of applications, as well as additional state-level mechanisms. The department provides certification, training and oversight for the three site types, which offer varying levels of assistance to potentially eligible families.

- **Certified Application Assistance Sites (CAAS)**. CAAS sites are typically non-profit organizations working with families and children that offer application assistance as a way to meet the needs of their clients. CAAS sites may or may not offer medical

services. To be a CAAS, sites must apply to the Department, adhere to Department rules and regulations, assist families in completing the Colorado Application for Medical Assistance (including verifying and certifying citizenship and identity documentation) and offer voter registration assistance. CAAS sites do not have a role in eligibility determination, and are required to submit completed applications to their local county within five business days. The number of CAAS sites has increased dramatically in recent years, from 129 in late 2009 to over 175 in 2010, with sites certified in 42 counties. CAAS sites were trained through a series of regional outreach conferences and individual trainings.

- **Presumptive Eligibility (PE) Sites.** In addition to assisting families in completing an application for Medicaid/CHP+, PE sites are able to grant temporary health care coverage to children 18 and under and/or pregnant women while their eligibility is being determined. In Colorado PE sites may be designated for children only, pregnant women only, or both. PE sites must be a Medicaid and/or CHP+ provider and able to provide pregnancy testing or assure referral to prenatal care and/or children's routine medical care, depending on the type of PE site they are. PE sites are required to maintain a 90% accuracy rate in their eligibility determinations and be capable of assisting non-English speaking clients. They also must have an internet connection capable of connecting with the Colorado Benefits Management System (CBMS), the rules-based program that is used to determine eligibility, although their ability to look-up information within CBMS varies. Currently there are 126 PE sites in 41 counties, including 11 for pregnant women, 24 for children and 91 that serve both children and pregnant women.
- **Medical Assistance (MA) Sites**. These sites accept (via mail and in person) and process applications for Medical Assistance Programs and have access to CBMS. They are the only application assistance sites able to make final eligibility determinations and transfer the case to the appropriate county for ongoing case maintenance. MA sites must furnish their own staff and hardware to access CBMS and must comply with the same application processing timeline (45 days) as counties. MA sites must conduct internal quality improvement reviews on a monthly basis and participate in the state's Medicaid Eligibility Quality Control process as requested. Because of the more intensive resource requirements and responsibilities for MA sites, the number of MA sites is limited. Currently Denver Health and Hospitals, Peak Vista Community Health Center in Colorado Springs, and three school-based enrollment pilot sites (in Pueblo, Jefferson County and Aurora) serve as MA sites, as does the CHP+ administrator.
- **PEAK.** The PEAK system will, in its second phase of deployment, allow families to complete applications on-line. The applications will then be electronically transferred to either the local county department of human/social services or the CHP+ eligibility and enrollment vendor for eligibility. The Office of Information Technology is developing a PEAK tool-kit which will educate community partners on how to assist clients with completion of the on-line application.
- **Facilitated Enrollment of Expansion Populations.** The Department developed an expedited and streamlined process for identification and enrollment of parents of Medicaid children made eligible with the May 2010 expansion of Medicaid from 60% to 100% of FPL. Colorado Indigent Care Program (CICP) providers used completed CICP applications to identify households between 60% and 100% of FPL with children enrolled in family Medicaid, and worked with families to complete the standard Medicaid

Redetermination/Reconsideration package to update their existing family Medicaid case and add the eligible parent. Integrated Document Solutions (IDS), a division of the Department of Personnel and Administration, acted as an MA site and made eligibility determinations for these applications.

While application assistance is a critical component of outreach activities, CAAS, PE and MA sites are not required by HCPF to conduct community outreach in order to be certified. The degree of outreach provided varies depending on the interest and capabilities of the certified sites.

Community Outreach

Application assistance sites provide effective avenues for reaching families and individuals that are accessing other social or medical services. However, community outreach activities are essential for reaching families who qualify for public insurance and do not access such services[24] and/or do not perceive that they are eligible for coverage. Communities across Colorado have engaged in a number of community outreach strategies to increase enrollment.

State-led efforts

- **Program Eligibility Application Kit (PEAK)**. The PEAK website provides a convenient mechanism for families with internet access to determine whether they might be eligible for CHP+ or Medicaid (as well as nutrition programs), and can also be used by enrollees to verify the status of their benefits. It provides an overview of available programs and a web-based system through which families can enter their information and understand which programs they may be eligible for. A tool kit is being designed to educate community partners on how to assist clients with the on-line application. In the next phase of development families will be able to complete and submit an application through PEAK.
- **Regional Outreach Coordinators**. From 2006-2009 the CHP+ marketing and outreach contractor implemented a Regional Outreach Coordinator (ROC) model. Outreach coordinators were assigned to designated regions across the state and were responsible for supporting community partners in their outreach and enrollment efforts. These coordinators provided consistent information and resources across all of the state's regions. The ROCs provided training on the CHP+ program, including eligibility for the program and resources for enrollment. Both community members and community partners (such as medical providers, recreation centers, school districts, faith based organizations, counties, Head Start programs, and childcare centers) were trained. ROCs were also available to participate in community events, local and statewide coalitions, and task forces. The ROCs were discontinued in 2009 due to a reduction in funding available to support the activities.
- **Healthy Communities**. The Healthy Communities program, implemented July 1, 2010, is a new model that will allow the Department to combine outreach for CHP+ and Medicaid and support community outreach activities statewide. This model utilizes the

[24] Uzoigwe, Chioma, and Sheila Hoag. *Improving Public Coverage for Children: Lessons From CKF in Colorado.* Issue brief. Robert Wood Johnson Foundation, 2008. Print.

existing county-level outreach infrastructure of Medicaid's Early Preventive Screening Treatment and Diagnosis (EPSDT) to reach out to children and families eligible for Medicaid and assist them in accessing services. EPSDT has historically focused on ensuring the Medicaid enrollees are able to navigate the health care system and access the care for which they are eligible. Under the Healthy Communities model, Family Health Coordinators guide families through all the activities that are necessary for obtaining coverage and accessing public health insurance. Their role includes working with eligible or potentially eligible children (under age 21) and pregnant women to:

  - Generate awareness of the existence of the Medicaid and CHP+ programs;
  - Offer information on how and where to apply for Medicaid and CHP+, the availability of face-to-face application assistance, and re-enrollment;
  - Educate families on the value of preventive health care services and how to access their benefits at the appropriate settings;
  - Link clients to Medicaid and CHP+ providers that will serve as the client's Medical Home;
  - Provide clients with information and referrals to other community programs and resources.

- **Community Enrollment Fairs**. In 2009, the Department funded 23 community service providers to conduct enrollment fairs and outreach activities to children eligible but not enrolled in CHP+ through the KidzBlitz program of All Kids Covered. The fairs offered application assistance, document review, pro-bono legal advice, presumptive eligibility and, for families not eligible for public programs, referrals to low cost health services. The KidzBlitz model is centered on community and encourages relationship building with state and county officials, community and faith-based organizations, and policymakers working. Forty-eight enrollment fairs were held in the spring of 2009 during which 652 children were determined presumptively eligible for Medicaid or CHP+. A Tool Kit was developed to assist organizations in replicating the model.
- **Maximizing Outreach Retention and Enrollment (MORE) Grants**. The Department received funding through its HRSA State Health Access Program (SHAP) grant to provide community grants to inform expansion populations of the availability of public health insurance programs and to assist newly eligible populations with the application process and accessing health care services. The first 14 grants were issued in September 2010, half for between $15,000 and $25,000 and half for between $32,000 and $96,000. Grants were awarded for new outreach and enrollment activities and designed by the applicants to meet the particular needs of their communities. Grantees are required to be CAAS sites or to document a partnership with an application assistance site (CAAS, MA, PE or County) to facilitate certification of documents required for enrollment under the federal Deficit Reduction Act of 2005.
- **School-Based Medical Assistance Site Pilot**. This pilot was authorized by the Colorado General Assembly in 2006 to facilitate enrolling children eligible for free and reduced school lunch in Medicaid by reducing the documentation burden and streamlining enrollment processes. Three school districts (Pueblo School District, Jefferson County Public Schools and Aurora Public Schools) were certified as MA sites in order to facilitate enrollment into Medicaid. The school districts have used information from the free and reduced school lunch program and/or their School Medicaid Program to identify

eligible families. Outreach workers contact the families and work with them to provide any additional information needed for enrollment into Medicaid and CHP+.

- **Get Covered, Get in the Game**. The U.S. Department of Health and Human Services (HHS) launched the pilot initiative in 2010 in Colorado, Florida, Maryland, New York, Oregon, Ohio and Wisconsin as part of the *Connecting Kids to Coverage* effort. Get Covered, Get in the Game is targeted towards the utilization of coaches, schools and communities to educate families with children eligible for Medicaid or CHP+. Specifically, this effort will provide coaches with informational materials about CHP+ and Medicaid to better inform families how to become involved.

Community-Based Efforts

There is a wide variety of outreach and enrollment activities occurring at the community level in Colorado. These are not typically distinct or separate from the state-led initiatives described above. Rather, communities tend to develop an approach to providing outreach and enrollment that combines available state and local resources and models. In some cases the only efforts at the local level are those directly related to state or county led initiatives. More commonly, however, local communities leverage several models and partnerships in order to provide these services. Elements of community-based efforts include:

- **Application Assistance Sites.** Community entities (public, non-profit or private) often combine their application assistance with community outreach activities, either alone or in partnership with other community organizations. Many of them also engage in "in-reach" strategies to identify and reach out to populations that are likely eligible for public insurance. For example, a public health department may be able to identify low-income families through its well child services, or a community health center may reach out to all parents of Medicaid eligible children with family incomes under 100% to identify newly eligible parents. Application assistance sites include community-based organizations, public entities (such as schools or public health departments), and medical providers (such as community health centers and hospitals).

- **Community Coalitions.** By and large, community-level efforts are driven by organizations that provide services (either medical or social services) to low-income families and children and are organized according to local capacity and needs. The services provided can include the provision of basic information about CHP+ and Medicaid, development of partnerships for outreach to eligible families, assisting families with completing an application, and, in the case of communities with PE and MA sites, facilitation of enrollment. In some communities the efforts are primarily those of a single entity (typically an entity that has certification as an application assistance site). In other communities, however, coalitions are formed to coordinate outreach and enrollment activities across various organizations. These coalitions typically have representation from application assistance sites (often the lead entity), county public health departments, county departments of human/social services, local CHP+ and Medicaid safety-net providers, such as community health centers or school-based clinics, local school districts (especially school nutrition and Medicaid programs), day care or head start programs, and other non-profit organizations serving families and children. These coalitions engage in

activities to streamline the application and enrollment process within their local communities and often will conduct coordinated or joint outreach and enrollment activities. Such activities may include conducting community outreach events to raise awareness of CHP+ and Medicaid, and targeted outreach to families who are eligible for programs with similar income limits as CHP+/Medicaid (such as free and reduced school lunch, family planning services or the Colorado Indigent Care Program). These coalitions are sustained in part through the staff and in-kind resources of the participating organizations. They often have a lead entity that receives funding from foundations or the Department to support and coordinate outreach and enrollment efforts.

- **Statewide Coalitions.** There are also two statewide coalitions, Covering Kids and Families (CKF) and All Kids Covered, which work to increase enrollment of children and families in CHP+ and Medicaid.
    - Covering Kids and Families was formed in 2002 as part of a nationwide outreach and enrollment initiative of the Robert Wood Johnson Foundation. CKF has representation from over 220 statewide and local organizations from across the state including community-based organizations, advocates, providers, schools, health policy experts, and members of the Department. CKF has two areas of focus: it supports local outreach and enrollment efforts by facilitating the sharing of best practices and identification of challenges through an Agency Partners work group; and monitors and seeks to inform legislation and regulations that impact Medicaid and CHP+ through its Health Policy Workgroup. Covering Kids and Families also distributed "core messages" developed and tested by the national Covering Kids and Families initiative that communities can use as part of their outreach messages and strategies.
    - All Kids Covered is a collaborative effort of nearly 40 organizations working to increase eligibility and enrollment in CHP+ and Medicaid. Like CKF, All Kids Covered supports legislative and rule changes to simplify CHP+ and Medicaid, and it also works to increase access to care. In the past it has supported specific enrollment strategies at the local level, including the KidsBlitz campaign which assisted communities in implementing enrollment fairs.

- **Health Foundations.** Colorado health foundations play an important role in outreach and enrollment activities by funding Department initiatives and statewide coalitions/local efforts that include both outreach initiatives and efforts to support enrollment simplification and streamlining. Foundations have funded, within their existing grant priorities and guidelines, local initiatives to provide outreach and enrollment services.
    - **Trusted Hand Approach.** For the most part, foundation funding of local initiatives, like the Department's MORE grants, is based on the "trusted hand" model which is the concept that community-based organizations have a relationship with eligible families and can provide trusted, culturally appropriate services. Numerous studies have demonstrated that community-based organizations have specific strengths that allow them to effectively reach populations eligible for health insurance including a trust relationship with families, the ability to reach populations at locations and times convenient to them, the ability to provide culturally-specific services, and the ability to deliver

messages tailored to the target audience[25]. However, there is limited research about the effectiveness of the trusted hand approach in delivering comprehensive outreach and enrollment, or about the characteristics needed at the local level to make such an approach successful. In 2009 the Colorado Trust began a three-year grant strategy to increase enrollment of children and youth in CHP+ and Medicaid. The initiative includes an evaluation, developed in coordination with the Department, to understand the populations reached by participating CBOs, the outreach and enrollment strategies they are using, and the effectiveness of the models and strategies employed. The evaluation will include both qualitative and quantitative analysis of client-level data gathered by funded CBOs and thorough the Colorado Benefits Management System.

Enrollment

Significant efforts have been made at the State level to modernize and streamline the enrollment process for Medicaid and CHP+. Specifically, the CO-CHAMP project dedicates resources to interface improvement, express lane eligibility, and simplified, automated enrollment, all of which expedite the enrollment process and reduce the burden on families. The following section provides an overview of key enrollment simplification and modernization efforts in Colorado.

Expanding opportunities to apply

- *Allow presumptive eligibility*: Presumptive Eligibility is a process that provides immediate access to health care services for children and pregnant women who appear to qualify for Medicaid or SCHIP while eligibility for the health care coverage programs is being determined. A "qualified entity" may make the "presumptive" determination about a child's eligibility based on the family's declaration statement that its income is below the state's income eligibility guidelines, and no verification of income is needed at the time the presumptive eligibility determination is made. Presumptive eligibility makes it possible for children to receive attention for a pressing medical condition or needed preventive care promptly, and assures providers that they will receive payment. Presumptive eligibility provides a crucial link to care and enables families to access services while awaiting final approval of their application, a process which could take weeks or months.[26]
- *No Wrong Door*: Streamlined collaboration between public assistance programs can allow applicants to apply for one or more programs through a variety of avenues, and reduces the need for applicants to use different avenues for different programs. This approach presents one process and "program" to the applicant, with varying program requirements and processes handled administratively in a way that is seamless to applicants.
- *Eligibility Expansion*: Expanding eligibility may provide an opportunity to reach out to previously eligible but not enrolled individuals in the same family. Several States which have expanding eligibility requirements to cover all children under individual SCHIP

[25] Trusted Hands: The Role of Community-Base Organizations in Enrolling Children in Health Insurance Programs. The Colorado Trust, Issue Brief, February 2010.

[26] Hess, Catherine, and Maureen Hensley-Quinn. "Building on Success to Effectively Integrate Current Children's Coverage with National Coverage with National Health Reform: Ideas Form State CHIP Programs." *State Health Policy* (2009): 1-8. *National Academy for State Health Policy*. Web. 23 Aug. 2010.

programs have found that a significant percentage of new applicants were eligible under the previous criteria. While media campaigns and targeted outreach efforts play a large role in reaching new populations, reaching currently eligible populations by expanding such criteria, known as the "welcome mat" effect, may play a significant role as well. For example, when Wisconsin increased eligibility for BadgerCare Plus to 300% of the FPL, they found that 80% of new enrollees were previously eligible. Similarly, when Illinois began covering all children in 2006, they found 70% of new applicants were previously eligible. Massachusetts experienced a similar phenomenon when 50% of new applicants for their Children's Medical Security Plan were previously eligible.[27]

While Colorado has made significant progress in these areas, significant work needs to address remaining barriers and gaps. While state-certified PE sites (of which there are 113 throughout the State)[28] can provide temporary enrollment status to potential beneficiaries pending a full application review by a certified MA site, the eligibility determination process must be completed by a County department of human/social services or the CHP+ eligibility and enrollment vendor. Key informants indicated that some counties routinely exceed the allowed 45 day determination period. It is not clear whether the determination period (which does not begin until the application is complete and submitted) is exceeded, or whether applications are in pending status for more than 45 days because they are incomplete. In either case, applicants experience substantial delays in eligibility determination. Further, while certified assistance sites offer facilitation services for enrollment in multiple programs at once, assistance with specific programs often varies by site. Information available online frequently leaves potential applicants confused as to where to seek assistance for any particular program.

Enrollment Simplification and Modernization

- *Shortened application*: Colorado has made significant progress in streamlining its combined Medicaid and CHP+ application, although the application is still 15 pages. Further shortening of the application may be difficult considering variation in programmatic requirements of the programs to which it applies, and the commitment to use a consolidated application that includes other medical programs.
- *Online application completion:* Online application submission both reduces the need for paper documentation and facilitates an applicant's ability to apply for multiple programs at once, at the same time eliminating transportation or access issues relating to the availability of CAAS, PE or MA sites. Once fully implemented, the Program Eligibility and Application Toolkit (PEAK) is expected to allow applicants to submit their applications online with no paper documentation required to initiate the process. This would represent a major step in simplifying and modernizing the enrollment process. It is not yet decided whether this system will be available to all expansion populations, such as AwDC.

[27] Arenales, Stephanie, and Stacey Moody. "The Maze: The Barriers That Keep Colorado's Eligible Children and Families Out of Medicaid and CHP+ and Recommendations to Create a Direct Path to Enrollment." *Colorado Covering Kids and Families* (2009). Apr. 2009. Web. 20 Aug. 2010.

[28] based on Department of Health Care Policy and Financing listing updated 8/2010, available at http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251649124096&ssbinary=true

- *Electronic signatures*: the PEAK Eligibility system is expected to allow electronic signatures when fully implemented. Allowing electronic signatures eliminates the need to print, sign or mail signatures.
- *Self-declaration of income*: States can elect to allow self-verification of income in lieu of requiring income documentation. Colorado does not allow self-declaration of income.
- *Eliminate the asset test*: This provision is among the eight bonus performance requirements for states to qualify for enhanced Federal dollars. In order to qualify, states must either eliminate or severely simplify the asset test within both Medicaid and CHP+.[29] Colorado has successfully met this requirement, except in its long term care and buy-in programs.
- *Eliminate face-to-face requirement*: Again, this is among the eight bonus performance requirements for states to qualify for enhance Federal dollars.[30] Colorado has also successfully implemented this provision.
- *Express Lane Eligibility*: The Express Lane option provides yet another avenue through which to expedite the enrollment process and reduce the burden placed on families. Express Lane Eligibility refers to the ability for state agencies to automatically determine a child's eligibility for Medicaid or CHP+ based on an entity designated as "Express Lane agency."[31] In Colorado, the Department is currently working with the Free and Reduced Lunch program to implement such a system. This effort is currently hindered by technical issues due to CBMS and delays in developing interfaces with other state agencies.[32]
- *Ex Parte renewals*: Another of the eight bonus performance requirements, Ex Parte renewal is a method by which states may renew eligibility based on documentation available from other program data bases or records such as nutrition assistance programs. This process has recently been implemented in Colorado, and the degree to which it is being used varies across counties.
- *Interface improvement/administrative verification of citizenship, identity and income*: The electronic verification of client documentation can significantly reduce the burden placed upon families to comply with tedious documentation requirements. The Department is currently working towards a number of specific systematic improvements to realize the potential of this tool. Information is expected to be shared between a number of programs to facilitate enrollment in Medicaid and CHP+. Specific interfaces under development include:
    - Income verification: Income and Eligibility Verification System (IEVS)
    - Citizenship verification: Social Security Administration (SSA)
    - Citizenship verification: Vital statistics
    - Identity verification: Department of Motor Vehicles (DMV)[33]

[29] Kaiser Family Foundation: Kaiser Commission on Medicaid and the Uninsured. *Medicaid Performance Bonus "5 of 8" Requirements.* Issue brief. 2009. Print
[30] ibid
[31] ibid
[32] *CO-CHAMP: Colorado Comprehensive Health Access Modernization Program HRSA State Health Access Program (SHAP) Grant*. Department of Health Care Policy and Financing. 2010. Print.

[33] CO-CHAMP: Colorado Comprehensive Health Access Modernization Program HRSA State Health Access Program (SHAP) Grant. Department of Health Care Policy and Financing. 2010. Print.

- *Allow phone renewals*: Telephone renewals for Medicaid and CHP+ can greatly reduce paperwork and burden on families. Colorado allows telephone renewals for both Medicaid and CHP+.[34]
- *Joint application/renewal forms and same verification process between Medicaid and CHP+*: Colorado has also adopted a joint application for the Medicaid and CHP+ programs, making it easier for families to apply to either program at the same time. Significant work remains to be done, however, in correlating the verification process between programs.[35]
- *Automatic enrollment for newborns*: Colorado's Add-A-Baby program allows for the automatic eligibility of newborns within families already enrolled in Medicaid and CHP+.
- *12-month continuous coverage*: Also among the eight bonus performance requirements, Colorado will implement continuous coverage for children in the spring of 2012 due to the passing of H.B. 1293.

Facilitated Enrollment

States can play a critical role in supporting the efforts of community organizations that offer outreach and enrollment assistance. The types of support include:

- *Facilitator application tracking*: Some states have systems that support enrollment facilitators in tracking applications and produce aggregated data reports regarding outcomes of applications. In Colorado, however, only counties and MA sites have access to CBMS to track the progress of applications. Under the MORE grant, though, the Department is working to gather data requirements for developing a Client Application Tracking tool.[36] Further, despite the barriers in place to access tracking through CBMS, several assistance sites have managed to develop internal systems to track the progress of all applications, monitor volume and provide quality control for timely and accurate completion of applications.
- *Enhanced training for enrollment facilitators*: Facilitator training greatly reduces technician error and documentation problems. As enrollment facilitators provide direct, one-on-one contact with applicants, proper training also reduces misconceptions surrounding eligibility and documentation requirements.[37] The Department currently provides periodic standardized training on a regional basis. This training does not currently include best practices on reaching specific populations or methods for conducting outreach to eligible populations, two important topics for effectively enrolling expansion populations.

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[34] Colorado Covering Kids and Families. The Maze One Year Later: An Update on the Progress to Create a Direct Path to Enrollment for Colorado's Eligible Children and Families in Medicaid and CHP+ July 2010 Snapshot. Rep. Colorado Covering Kids and Families, 2010. Print.

[35] Arenales, Stephanie, and Stacey Moody. "The Maze: The Barriers That Keep Colorado's Eligible Children and Families Out of Medicaid and CHP+ and Recommendations to Create a Direct Path to Enrollment." *Colorado Covering Kids and Families* (2009). Apr. 2009. Web. 20 Aug. 2010.

[36] *CO-CHAMP: Colorado Comprehensive Health Access Modernization Program HRSA State Health Access Program (SHAP) Grant*. Department of Health Care Policy and Financing. 2010. Print.

[37] Colorado Covering Kids and Families. *The Maze One Year Later: An Update on the Progress to Create a Direct Path to Enrollment for Colorado's Eligible Children and Families in Medicaid and CHP+ July 2010 Snapshot.* Rep. Colorado Covering Kids and Families, 2010. Print.

- *Incentives for enrollment assistance*: Providing enrollment facilitators nominal fees for services provided could greatly enhance performance and service quality. Such incentives are not widely used in Colorado. Some providers, such as Federally Qualified Health Centers can receive nominal payments on a per application basis and some schools have been able to access Medicaid Administrative Claiming. Efforts could be increased, however, to provide incentives for the hundreds of employees working in CAAS and PE sites throughout the State.

Measuring Effectiveness

The outreach assessment identified ways in which current strategies are evaluated for success. On a macro scale, success can be measured by increases in total enrollment for CHP+ and Medicaid and by increases in the percent of eligible persons enrolled. In order to measure the success of specific outreach strategies on enrollment, however, it would be necessary to identify the number of applications that resulted from the strategy and the number of those applications that resulted in enrollment. Such measurement is challenging when the entities conducting outreach are not responsible for enrollment determination and data systems are not designed to track the outreach or enrollment strategy that lead to the enrollment, as is the case in Colorado.

The success of current and past outreach strategies has been measured primarily by process rather than outcome measures - whether the planned outreach activities were conducted, not whether or not it resulted in the hoped for enrollments. As noted in the table, there are substantial challenges in measuring the effectiveness of specific strategies.

Table 1. Measures of Success and Measurement Challenges for Outreach and Enrollment

Strategy	Measures of Success	Challenges of Measurement
Mass Media	• Number of media exposures (impressions) created • Estimated number of times a person within the targeted income and family demographic likely saw an ad (typically between 9 and 11 in various media campaigns) • Increase in applications submitted to the CHP+ enrollment contractor during and immediately following media campaigns • Increase in application downloads from the CHP+ website • Increases in total CHP+ enrollment immediately after a media campaign	• Difficult to assess the contribution of individual media events to subsequent applications or enrollment • Difficult to separate the effect of media campaigns on enrollment from the impact of program changes or of state economic changes (unemployment, etc.)

Strategy	Measures of Success	Challenges of Measurement
Department Partnership Activities	• Number of community partners participating in Department training or presentations • Increase in application assistance sites	• Sites vary greatly in size and capacity • Partnerships take time to develop, and their impact is difficult to measure
Application Assistance Sites	• Degree to which certification criteria is met (application process for each site type) • Accuracy of eligibility determinations (PE and MA sites) • Number of clients assisted with applications (CAAS, PE, MA) • Number of applications submitted for determination (CAAS sites)	• Only PE and MA sites are subject to quality review • Current oversight of PE and MA sites focuses on accuracy of applications, not effectiveness of outreach • Not possible or difficult for sites to get information on outcome of applications submitted, or reasons for denial
Healthy Communities	• Number of clients contacted • Number of clients referred to other agencies • Number of referrals referred from other agencies • Contacts with current and potential partners to provide program information and resources	• Difficult for sites to get information on outcome of applications submitted, or reasons for denial • Difficult to document impact of partner relationships on enrollment
Community Outreach Efforts	• Number of applications taken • Quantity of materials distributed • Degree to which goals identified in funding application are met	• Challenging to evaluate comparative effectiveness of outreach efforts when each has very distinct approach • Lack of common metrics by which program effectiveness is assessed • Difficult for sites to get information on outcome of applications submitted, or reasons for denial
Community and statewide enrollment efforts	• Increase in number of enrollees • Increased percentage of eligible individuals enrolled	• difficult to assess the contribution of specific outreach events to subsequent applications or enrollment

Strategy	Measures of Success	Challenges of Measurement
Expedited enrollment process (e.g. expedited enrollment of CICP parents in Medicaid)	• Number of expedited applications processed • Number of enrollments completed	• While overall enrollment numbers resulting from the process are available, time consuming and labor intensive to identify results by participating site.

A major gap in Colorado's ability to assess the effectiveness of various outreach and enrollment strategies is the lack of systematic data on which outreach and enrollment activities result in completed applications and the rate at which those completed applications are deemed eligible. CAAS sites do not have access to CBMS, and PE sites have only limited access to look up information on individual cases. While MA sites do have access to look up the outcome of applications on a case-by-case basis, there are no standard reports available that allow them to tie outcomes to specific outreach strategies or analyze their effectiveness in reaching specific demographic groups.

Several application assistance sites have developed their own tracking system to help them follow-up proactively on pending applications or to support specific outreach strategies. Substantial resources are required to develop such tracking systems and to maintain the data entry (often duplicative with state-required data entry) that makes them valuable to individual sites. Each system has utility for the site that employs it. However, these independent systems do not facilitate the type of sharing, comparison or cross-site aggregation that could be very powerful in identifying successful enrollment strategies and/or populations that are not effectively being reached.

The Department is requiring MORE grantees to complete an application tracking tool that will be used to capture client demographics and specific processes related to the application. The tool collects demographic data (gender, race/ethnicity), information about the type of application the client was assisted with (new, follow-up or renewal), notes regarding individual contacts with the client, and information about documentation that was included with the application. This information is intended to help the Department monitor the accuracy of applications completed and the effectiveness of specific grantees in providing application assistance. The tool will not facilitate feedback to the sites regarding the outcome of applications they assist families in completing. It will be used to support the Colorado Trust's evaluation of ~~MORE~~ grant effectiveness.

Colorado has a well established outreach and enrollment infrastructure that includes Department administration and oversight of the Medicaid and CHP+ programs and CHP+ administration, enrollment services provided by county departments of human/social services, and an extensive network of application assistance sites that are able to provide varying levels of assistance to eligible families in the enrollment process. Colorado has piloted initiatives to maximize enrollment of children, pregnant women, and families. It has also made many strides in streamlining program structures and modernizing enrollment systems. However, limited data exists on the effectiveness of specific strategies in increasing enrollment. Appendix C summarizes Colorado's current outreach and enrollment strategies. This table also provides an overview of the gaps in populations they reach and other challenges to their implementation, which are discussed in more detail in the next section.

OUTREACH AND ENROLLMENT GAPS, BARRIERS AND CHALLENGES

This section discusses the gaps in populations reached by Colorado's current and recent outreach efforts, the barriers to outreach and enrollment in Colorado, and the challenges that exist for the implementation of effective outreach and enrollment efforts. The analysis is based on the available literature on national best practices and the assessment of recent and current Colorado efforts. A detailed summary of gaps and challenges is presented in table format in Appendix C: Assessment of Colorado Medicaid/CHP+ Outreach Efforts.

Gaps in Population Served

JSI was asked to describe gaps as they relate to the capacity of current systems and efforts to reach specific demographic groups within the expansion population, including geographic, racial and ethnic, income and age groups. This analysis is complicated due to the fact that there is no systemic state-wide collection of information about the demographic groups reached by existing outreach efforts. There is also no systematic reporting through CBMS or other tracking mechanisms of the demographic characteristics of applicants or enrollees, other than at the state level. This analysis is drawn primarily from Department documents describing past efforts, lists of application assistance sites and information provided by key informants.

Geographic Groups

Overall, outreach and enrollment activities occur in all regions of the state, although the frequency and intensity of the efforts vary tremendously from community to community and depend on the resources that the local community is able to garner.

State-level media campaigns have historically included most major media markets in the state. In addition, some community coalitions and outreach entities have conducted their own media campaigns. Because media campaigns are expensive to design and run, such campaigns have taken place in regions where community agencies or partnerships have had the most success in securing needed funding, not necessarily in the areas with the highest level of eligible but not enrolled. State-level outreach activities, including CHP+ regional outreach coordinators, training of community partners, and now the Healthy Communities efforts, have historically included all regions of the state. Each county is part of a region with outreach support, even if the service provider is not housed within the county.

However, because community-based entities must apply to become application assistance sites, and the presence of organizations able and willing to take on that role varies greatly across the states, there is great variation from county to county in the number and type of application assistance available. There are fifteen counties in Colorado that do not currently have application assistance sites other than their county department of human/social services, and an additional five that have CAAS sites only.[38] These are primarily rural counties, located mostly in

[38] The counties without any sites are: Archuleta, Baca, Cheyenne, Custer, Elbert, Park, Hinsdale, Jackson, Kiowa, Mineral, Phillips, Pitkin, Rio Blanco, San Juan, Sedgwick. Those with CAAS sites only are Bent, Clear Creak, Conejos, Dolores and Gunnison. Source: HCPF list of Certified Application Assistance and Presumptive Eligibility Sites, http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197364127331.

the Southern and far Southeast and Northeast corners of the state, but they include population centers such as Meeker, Gunnison, Pagosa Springs, Springfield, Las Animas, Creede and Julesburg.

- Estimates of eligible but not enrolled (EBNE) children are not available for six of these counties, but of the remaining fourteen, eight have a larger portion of eligible children not enrolled (ranging from 32% to 72%) than the state average of 29.4%. The absolute numbers of EBNE in many of these counties are small, but 6 have over 300 estimated EBNE each.
- Estimates of the percent of EBNE parents in Medicaid up to 60% of the federal poverty level (the maximum eligible income level prior to the May 2010 expansion) are unavailable in 9 counties. The remaining 6 counties have relatively low populations overall, but 4 have EBNE rates above the state average of 31.3 %, ranging from 33.1% in Elbert to 60 % in Rio Blanco.

Thus, there is a disparity in assistance available to enroll rural eligible populations.

On the other hand, the counties in the state with the largest number of eligible but not enrolled children have a large number of assistance sites, including a mix of PE and CAAS sites. Three of these counties (El Paso, Arapahoe and Denver) also have MA sites. Because each application assistance site varies in its staffing and capacity, it is difficult to assess whether there are enough assistance sites, or sites of the right type, to meet the identified need. However, an analysis of the number of persons eligible but not enrolled in Medicaid or CHP+ per assistance site demonstrates wide variety in the degree to which some populations may have access to such assistance sites. Detailed tables comparing the Colorado Health Institute's analysis of population figures estimated to be eligible but not enrolled in CHP+ or Medicaid per county[39] with information available from the Department documenting the number of assistance sites, either CAAS, PE, or MA, per county[40] are provided in Appendix E. As seen in Appendix E - Table 1, in the 6 counties with the highest volume of eligible but not enrolled children, the number of such children per assistance site per county ranges from 411 in El Paso County to more than double that in Arapahoe County. A high ratio of eligible but not enrolled children to enrollment sites per county may indicate the potentially scarce availability of assistance sites for potentially eligible populations in certain areas of the State. Statewide, the median estimated average number of EBNE children per site per county is 319. Within the 16 counties with more than 1,000 estimated EBNE children, the number of EBNE children per application assistance site per county ranges from 186 in Boulder to 1,063 in Routt County.

The availability of assistance sites to eligible but not enrolled parents and guardians also varies considerably across the sate. Among those counties with the highest volumes of EBNE parents, the proportion of such parents or guardians to assistance sites per county ranges from 9 in Chaffee to 359 in El Paso. Appendix E, Table 2 provides details on the availability of application assistance sites to parents by county. It must be noted that the analysis of parents included in the expansion population, i.e. those between 60 and 100% FPL, is solely intended to inform future outreach and enrollment efforts. As the eligibility threshold for Medicaid has increased only

[39] Colorado Health Institute: Center for the Study of the Safety Net. *Colorado Children's Health Insurance Status: 2010 Update*. Issue brief. 2010. Print.

[40] based on Department of Health Care Policy and Financing listing updated 8/2010, available at http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251649124096&ssbinary=true

recently, as of May 2010, outreach strategies to this specific expansion population have not yet fully matured. Further, the estimations provided by the Colorado Health Institute were made available before this population became eligible for Medicaid in May of this year and so does not include the extent to which this population has been able to successfully apply for and enroll in Medicaid.

Finally, if current application assistance sites will also be utilized to provide the same type of assistance to Adults without Dependent Children (AwDC) upon Medicaid eligibility expansion in early 2012, it may be prudent to also look at the potential availability of such sites as it pertains to this population as well. In other words, if eligibility expansion were in place today, and the AwDC population below 100% FPL had access to currently available application assistance sites, how would the "availability" of such sites vary throughout the state?

As can be seen in Appendix E, Table 3, significant variation does exist across counties in the availability of assistance sites to future eligible AwDC . In fact, the number of assistance sites per AwDC below 100 percent FPL ranges from 254-1581 among those counties with the highest volume of potentially eligible AwDC in 2012. Again, it must be noted that this analysis is not a prognostication of the availability of such sites in 2012, but is instead intended solely to identify potential future geographic challenges in reaching out to and assisting AwDC. In this sense, such analysis is intended to provide direction for future outreach and enrollment efforts, which will increasingly incorporate this population in the years to come.

Race and Ethnicity

There is a clear need, given the racial and ethnic diversity of Colorado's population and the disproportionate lack of insurance among Black and Latino residents of Colorado, to ensure outreach efforts are effectively reaching communities of color and residents whose primary language is not English.

Efforts to target specific racial/ethnic groups have primarily focused on serving Spanish-speaking Latino populations. CHP+ marketing materials including program brochures, radio and television advertisements and PSAs are available in both Spanish and English. Telephone customer service is offered in Spanish as is the Colorado Application for Medical Assistance. While the Department "Clients and Applicants" webpage includes links to Spanish-language resources (including the Spanish version of the Application for Medical Assistance and information about the availability of Spanish-speaking customer service), the links themselves are in English, most resources provided are in English, and there is no Spanish-language version of the page. The CHP+ website does have a Spanish version, readily accessible through a link at the top of the main page. While it includes some information on Medicaid, it does not include all of the information available on the Department page. The Colorado PEAK website is currently only available in English.

While many application assistance sites employ bilingual staff and PE sites are required to be capable of assisting non-English speaking clients, there is no systematically collected information about the languages in which assistance is available at each site or how the sites provide non-English language assistance.

Some community-based outreach efforts have developed culturally-specific outreach strategies tailored to specific racial and ethnic groups. For example, Community Voices developed a campaign to enroll Native American Families and the Colorado Multi Ethnic Cultural Consortium is leading an effort to conduct enrollment fairs in communities of color. These efforts, however, are driven by locally identified need and interest, and the availability of grant funds to support them, rather than a specific statewide strategy to reach these populations.

Socioeconomic Status

As with race and ethnicity, statewide enrollment data has not been analyzed to identify the degree to which specific income groups are reached by media and outreach efforts. The most recent eligible but not enrolled estimates for children, however, indicate that 21.9% of children eligible for Medicaid are not enrolled, compared to 47.7% of CHP+. Medicaid eligible children are by definition (with a few possible exceptions) in lower income families than CHP+ eligible children.

Colorado's current outreach and enrollment strategies have been most effective in enrolling the lowest income children, despite the fact that all recent media campaigns have targeted CHP+ eligible individuals as the primary audience. This speaks to the findings in the literature that eligible individuals with higher incomes may not readily consider that they or their families are eligible for public health programs, or have an established relationship with county departments of human/social service organizations that can help them apply. None of the application assistance sites interviewed track or analyze the income level of families they serve. However, all of those interviewed felt their current approaches could be effective in reaching children and parents in the expanded eligibility categories.

Eligibility Category

Colorado's past marketing efforts have focused on enrolling families and children and the majority of current outreach efforts are led by organizations whose primary interest is families and children. Thus, marketing efforts to date have not included messages specifically designed to reach adults without dependent children or people with disabilities. One major exception is safety-net primary care and hospital sites that provide care for uninsured adults.

While the sites interviewed had ideas about how to engage parents in outreach activities, they do not generally perceive themselves as having the same existing relationship with adults without dependent children. Sites varied greatly in their interest or intent to work with adults without dependent children, with sites operated by primary care providers or with links to hospitals being the most likely to have specific ideas and interests. Key informants noted that they would need to engage additional strategies and shift their current outreach venues in order to effectively reach adults without dependent children. Nonetheless, some adults without dependent children may be part of a household with children, or already engaged with other services of application assistance providers.

Almost none of the sites interviewed had specific ideas about how to engage people with disabilities in their activities. Most sites expressed the view that there are other organizations with better understanding of and ties to people with disabilities. As with adults with dependent children, however, it is likely that sites may not be aware of how readily they might reach people with disabilities through their existing efforts and networks. Thus, two gaps exist: a gap in understanding among sites of how their existing efforts might be leveraged to reach these expansion populations, and a gap in strategies tailored specifically to adults without dependent children and people with disabilities.

Barriers to Effective Outreach and Enrollment

Barriers to effective outreach and enrollment in Colorado were identified through key informant interviews and a review of Colorado-specific reports and documents. Numerous barriers that impact the ability of outreach and enrollment programs to assist were identified, ranging from challenges in reaching eligible populations, to those related to current state enrollment systems and their capacity. The barriers identified in Colorado are consistent with those outlined in national research.

Barriers related to Media and Outreach

Two types of media and outreach barriers were identified: those related to the experience and perceptions of eligible or potentially eligible persons, and those related to the way current systems and efforts are organized or delivered. The most frequently cited barriers include:

- **Perceptions of eligible populations about their eligibility**. People who have not accessed other government programs for low-income persons, especially higher-income individuals, and adults may not think they are eligible. This is especially true if marketing materials do not contain messages or images that they readily relate to. Changes in eligibility thresholds and rules can also contribute to this barrier – once individuals think they are not eligible they may not feel that future messages about the same program apply to them, even if they subsequently become eligible.
- **Immigration status and related requirements**. Families with undocumented or non-citizen immigrant members may hesitate to access services in fear of impacting their immigration status or deportation. The implementation of the federal Deficit Reduction Act of 2005 requirements for documentation of legal status and identity have heightened this barrier in recent years.
- **Stigma related to accessing public programs**. This is especially important among those who have not accessed public programs in the past, or feel that programs are not for people "like them."
- **Language barriers.** Marketing materials are not available in languages other than English and Spanish. Additionally, some Spanish-language materials are written at too high a literacy level.
- **Prior negative experiences with outreach, enrollment or health care services**. This barrier is of particular relevance for persons of color who may have experienced a lack of cultural or linguistic competence previously and are reluctant to risk such an experience again.

- **Mobility of eligible populations**. Many eligible families move frequently, especially homeless and very-low income families. In addition, some communities, such as the Latino community, extended family members often care for children. This extended family network means that children may move often among family members or live with family members who are not authorized or otherwise charged with ensuring that they have health insurance, making completion of an application challenging.
- **Lack of data at county and sub-county to support outreach efforts**. Most application assistance sites interviewed provided outreach to the population(s) their broader organization strives to serve. They are not able to tailor their efforts to specific income or racial or ethnic groups that have higher rates of eligible but not enrolled populations because they don't have information about those groups.
- **Lack of tracking system to assess effectiveness of various outreach and enrollment strategies.** Sites lack data on which outreach and enrollment activities result in higher percentages of completed applications and enrollments. CAAS and PE sites do not have access to CBMS to look up the status of an application. While MA sites do have access to look up the outcome of applications on a case-by-case basis, there are no standard reports available that allow them to tie outcomes to specific outreach strategies or analyze their effectiveness in reaching specific demographic groups.

Barriers Related to Enrollment

The identified enrollment barriers fall into two broad categories: those that have to do with the actual systems and processes used to accept applications and determine eligibility, and those related to assistance with the enrollment process.

Barriers faced in the application process include:

- **Language barriers for non-English speaking persons**. Application assistance sites vary considerably in their ability to provide assistance in languages other than English. Many sites may be unaware of legal requirements to provide language accessibility and need more education regarding these requirements.
- **Limited availability of application assistance**. There are a limited number of sites with hours and locations convenient to eligible populations. Key informants noted that many assistance sites take applications by appointment only and have limited appointment availability.
- **Time and expense incurred in obtaining required documentation.** The cost of birth certificates was mentioned frequently, as well as the difficulty of obtaining birth certificates from other states.
- "**Gatekeeper" mentality**. In some county enrollment sites, especially in counties where program compliance is the dominant culture, customer service was not considered a high priority in the enrollment process.
- **The inability of CAAS and some PE sites to get information regarding the status or outcome of an application**. In particular, application assistance sites are frustrated by their inability to see if an application is denied due to a need for additional information or documentation, and thus unable to assist the family in completing the process. Some sites

have requested updates directly from the CHP+ enrollment contractor, but are frustrated by the inability to get status updates on more than a few applications at a time and by the time involved in making numerous status requests.

Barriers related to enrollment systems and processes include:

- **Application length**. While the Application for Medical Assistance has been streamlined considerably, it is still a daunting application for many families to complete.
- **Documentation requirements**. Colorado still requires documentation of income and residency status. While counties are able to use available data for some verification, the degree to which counties utilize the expedited renewal option varies greatly. In addition to creating a barrier for application completion, the requirements entail that application assistance sites spend considerable time and resources educating clients about the documentation needed and certifying the documentation.
- **Multiple hand-offs in the application process**. Since only the CHP+ eligibility contractor, ACS (MAXIMUS as of 10/15/2010) and a limited number of MA sites, are able to make eligibility determinations, many applications must be handed-off from an assistance site to a site that is able to determine eligibility, breaking the direct link of communication between the applicant family and the entity determining eligibility. These hand-offs are often "cold," meaning that there isn't an opportunity for the application assistance site to work with the eligibility site to clarify or provide any additional information or to provide the applicant with information about the outcome of the process.
- **Colorado Benefit Management System (CBMS) household update challenges**. CBMS is an integrated system that supports other programs, such as nutrition assistance and temporary aid to needy families (TANF) as well as CHP+ and Medicaid. Updates in household eligibility for other programs can result in changes in Medicaid eligibility and disenrollment. This barrier is aggravated by the fact that 12-month continuous enrollment has not yet been implemented for Medicaid.
- **CBMS system capacity and functions**. There is general recognition that the CMBS system is at capacity and that the inability to readily reflect rule or program changes in CBMS leads to delays in application processing, multiple "work-arounds," overtaxed county staff, and sending incorrect or confusing notices to clients. The impact on the enrollment process vary by county but can include limited appointment availability at counties, lack of compliance with the 45-day determination requirement, expiration of PE spans before eligibility is determined, and delays and misinformation due to CBMS capacity issues and notices.

Challenges

In addition to the specific gaps and barriers discussed, the outreach analysis identified a number of challenges for effective outreach and enrollment. These include:

- **Development of effective messages to reach eligible populations**. The development of messaging for specific sub-populations can be a costly process and must be done professionally in order to be effective. Outreach and enrollment partners struggle to identify what those messages are and how to convey to eligible persons that the program

is "for them." Key informants recognized that effective outreach campaigns should use tested messages, but also be tailored to local needs, and that they should include education about the benefits of health insurance.

- **Limited information about successful outreach and enrollment strategies generally, and for specific income and racial and ethnic groups**. Community partners employ a wide range of strategies and methods, but are largely unable to assess which are most effective and why. Data on what strategies work well in Colorado is just emerging and there are limited opportunities for outreach and enrollment partners to learn from each other regarding best practices. Even where there is data regarding what strategies are effective, there is heavy reliance on community partners who are not compensated for their work.
- **Making effective use of community partners**. Colorado has built an outreach and enrollment strategy that relies heavily on community-based resources. This "trusted hand" approach embraced by Colorado is based on the premise that community organizations know best how to reach their local communities and have existing relationships with eligible populations. The challenges related to using such an approach and maintaining the engagement of community partners include:
    - the need to ensure consistent and timely training across sites;
    - ensuring that the application assistance role of each organization is appropriate given their overall resources and focus;
    - the need for ongoing communication mechanisms that both update partners on changes in state program or processes and facilitate sharing from partners to the Department on emerging challenges or issues;
    - creating opportunities to identify local best practices and share them with other partners;
    - sharing of timely and substantive information about the structure and benefits of new expansion efforts;

- **Ensuring adequate availability of outreach and enrollment services.** Availability of outreach and enrollment assistance varies greatly across the states and in relation to the needs of specific populations of eligible individuals. The Department is able to identify, at the state level, enrollment numbers by family income, participant gender, and race/ethnicity. However, current reports don't facilitate linking that data to specific enrollment strategies or venues, or distinguishing the impact of other program changes, such as simplification or modernization, that facilitate enrollment. Thus, the over-riding gap identified is the lack of information on which to assess the impact of specific outreach and enrollment mechanisms on geographic or demographic sub-groups within the eligible but not enrolled population.

- **Providing feedback to sites about who they are (and are not) reaching and serving effectively**. The Colorado Benefits Management System (CBMS) is the system that ultimately determines eligibility for all Medicaid and CHP+ applicants. CBMS includes information on the gender, race/ethnicity and family income of all applicants. However, the reports available to CBMS end users focus on the completion of the determination process, the timeliness of application, the type of application filed, and the number of applications received from PE sites, and overall CHP+ enrollment by county. The CHP+

[41]. Thus it is difficult to analyze the specific gaps that exist, which type of outreach venue or process might be most effective in reaching specific demographic groups, or whether there are causes of incomplete or denied application that should be addressed in outreach efforts to specific groups.

- **Sustainability of application assistance sites.** Most outreach and enrollment efforts rely on grant funding (either from foundations or the state) to sustain at least some of their core activities, making them vulnerable to fluctuations in funding priorities.

- **Making use of social media**. There is a general sense that social media can be used to support outreach and enrollment activities, there is little information about how new media can be effectively employed. At least one application assistance site uses its agency's Facebook page to inform partners of outreach and enrollment services, but none of the key informants interviewed have used social media to outreach to clients. However, one MORE grant recipient received funds to incorporate advertisements on Facebook that will direct potential applicants to their Facebook page and website. Social media has been effectively utilized in HIV prevention and Women's Health Campaigns, and those models could be adapted to outreach and enrollment. The P.O.S.T.T. (people, objectives, strategy, technology, and tools) methodology could be used to further identify the effectiveness of social media in reaching specific outreach objectives. Further information regarding social media and P.O.S.T.T. is presented in Appendix D.

The analysis indicates that Colorado's current outreach efforts and systems are not able to reach all of the expansion populations adequately, and identifies barriers and challenges that must be addressed when moving forward. The next section provides an overview of strategies that communities are already using to address these gaps, barriers and challenges.

[41] Skubal, Andrea. "Follow-up Questions." 27 Sept. 2010. E-mail.

STRATEGIES TO ADDRESS GAPS, BARRIERS AND CHALLENGES

Community strategies for overcoming the gaps, barriers and challenges previously outlined were identified in the course of this project. Strategies employed that are related to specific areas are detailed below. The one strategy that was identified over and over again was the use of partnerships to maximize the impact of outreach and enrollment activities, which supported all of the other strategies identified.

- **Partnership.** Key informants repeatedly cited the value of substantive, explicit partnerships in leveraging additional resources, identifying creative solutions to barriers, and ensuring that outreach results not only in completed applications but in enrollment of eligible children. Partnerships are critical to building trust, and trust is needed for strategies that require substantial commitment from multiple entities (such as when a school district agrees to share free and reduced school lunch with an enrollment site). Key informants also cited the lack of substantive partnership as a cause for failure of past initiatives. Partnerships were supported by regular communication (through meetings or efforts to build and maintain relationships with key individuals in the partner organizations) and by maintaining a presence in community coalitions and networks. In a few cases social networking (Facebook) was used to keep partners informed of upcoming or current outreach and enrollment activities.

- **Addressing cultural and language barriers**. Many outreach and enrollment sites employ bilingual/bicultural outreach and enrollment workers and use Spanish-language media to raise awareness of available programs. While most outreach partners do not employ culturally-specific strategies or track their activities in relation to specific communities reached, the MORE grant program and foundation funding guidelines provide flexibility for applicants to propose a culturally-specific approach.
    - Several grantees have secured foundation, MORE and Department funding to conduct outreach within Communities of Color, including to Colorado Multi-Ethnic Cultural Consortium for enrollment fairs, and various past Community Voices campaigns for specific ethnic groups.
- **Addressing fear related to immigration status**. Effective strategies include focusing on building a relationship of trust with the community. Key informants also noted that the information provided on the current Colorado Application for Medical Assistance is helpful in allaying fears and that training of enrollment sites on the required documentation is also helpful.
- **Delivering services where eligible populations live and work.** A wide variety of strategies were identified, including:
    - Advertising in local venues where eligible families spend time (bus shelters, grocery bags, Valpak® coupons) and in local media, including Spanish language media;
    - Providing enrollment services at homeless shelters, in schools and in clinics. These were cited as most effective when both application assistance and enrollment services were provided;
    - Partnering with local medical providers to provide enrollment services, including out stationing of county eligibility staff at safety-net clinics.

- Using a mobile health enrollment van to provide targeted outreach and enrollment services in community settings. In this model community-based organizations identify potentially eligible individuals. The individuals are screened for eligibility, provided information about eligibility requirements, and scheduled for an appointment with the enrollment van. In this way the enrollment van is providing targeted enrollment services to people are already screened for eligibility, in a familiar and friendly location.
- Providing outreach and enrollment workers with laptops with cellular wireless connections and scanners so they can complete as much of the enrollment process (including scanning of required documentation) in the field, and cell phones so that they can be reached while in the field.
- Use of text messaging to remind families of appointments or of documentation needed to complete their applications.

- **Tracking Application Progress and Enrollment Status**. Several application assistance sites have developed their own tracking system to help them follow-up proactively on pending applications, or to support specific outreach strategies, including re-enrollment. Many of these strategies require access to CBMS to secure the specific information they require, such as tracking re-enrollment dates, reminding families of those dates, and assisting with re-enrollment.
- **Using Existing Data to Identify Eligible Clients.** Many sites use data that other programs within their organization or community partners have to identify children and parents, including those eligible for the recent CHP+ and Medicaid Expansions.
  - Partnering with individual schools or school districts to obtain lists of uninsured children enrolled in free and reduced school lunch, and providing targeted assistance to their families. (Note, this strategy requires that a process be established whereby the families provide information about their insurance status and there is an agreement regarding sharing information between the enrollment assistance site and the school.)
  - County-led outreach projects (typically through public health departments) have identified potentially eligible families through other programs and conducted targeted outreach to them. For example, county child support divisions are often able to identify children without insurance, and women's health programs using a sliding-fee scale.
  - Obtain lists of potentially eligible persons through other local programs and educating those program staff about Medicaid and CHP+ eligibility.
    - County child support divisions (which often have information on children without insurance);
    - Insurance programs targeting low-income families, such as Health Access Pueblo;
    - Community colleges to identify young adults loosing eligibility from their parent's insurance.
  - Maintaining lists of applicants who did not qualify for CHP+ because they were over income, in order to contact them and help them apply when the income threshold increased.

- In addition to screening patients for Medicaid and CHP+ eligibility, safety-net medical providers are able to leverage data in their practice management systems to identify families eligible under expansions. For example:
  - Using existing data from other programs (such as CICP) to identify individuals eligible for expansions. CICP providers used their own practice management systems to identify CICP program participants with family incomes below 100% FPL and children enrolled in Medicaid. CICP worked with either their local count or the Department's vendor to facilitate their enrollment in Medicaid.
  - Tracking presumptive eligibility spans and helping patients follow up to ensure full enrollment is granted within the span.
  - Incorporating enrollment assistance services with hospital case-management programs, targeting both emergency room and general admissions.

- **Focusing on targeted, comprehensive outreach.** Many key informants noted that they had moved away from general awareness activities (such as holding enrollment fairs at community festivals), to very targeted enrollment strategies because they have found them to be much more effective. They noted that the most effective enrollment efforts:
  - Ensure families have the information and documents they need prior to sitting down to complete an application. This may require multiple, substantive contacts with families and prescreening families for eligibility.
  - Maximizing initial contacts with potentially eligible families to accomplish as much as possible. One enrollment site noted that when families call to schedule an enrollment appointment they conduct a pre-screening over the phone and complete as much of the application as possible over the phone so that the only portions pending are the applicant signature and document submission. They have found that if they can tell the applicant that the application is complete except for those two items, the applicant is much more likely to complete the process.
  - Directly linking application assistance events with enrollment. This is achieved by having a county enrollment technician or MA site enrollment technician available to immediately complete the enrollment process.
  - Denver Community Voices has conducted an exhaustive study of the value of health navigators in ensuring that patients understand and utilize their health insurance and available health care systems, and has developed a model for including community health navigators as an integral part of its enrollment services.
- **Addressing barriers in current eligibility systems and processes.** Community partners spend considerable resources helping clients navigate current systems and eligibility requirements. They are also engaged in helping to promote and pilot streamlining efforts. They recognize that enrollment modernization and simplification are crucial to increasing enrollment.
  - Participation in local and state-wide coalitions that identify and work to address barriers to enrollment, including both process barriers and barriers related to program structure.
  - Because the ability to link outreach and application assistance with eligibility determination is so critical, many sites have developed creative ways to ensure

eligibility determination is as much a part of their services as possible. This is especially true for application assistance sites that are part of a safety-net provider. Ensuring timely determination helps to meet an immediate patient medical need and secures needed reimbursement for the provider. Strategies include:

- Securing a commitment from the local county to out station eligibility workers on site (typically at a safety-net provider), sometimes paying for part or all of the worker's time or salary. These sites maximize the availability of the out stationed eligibility worker by ensuring that applications are accurate and complete before they are handed off to the out stationed worker.
- Certification as an MA site.
- Establishing strong working relationships with county eligibility staff, including specific points of contact.

- **Increasing sustainability.** While most community partners rely on grant dollars to sustain their activities, several have been able to secure ongoing funding for a portion of these operations by documenting the value of their services.
  - One MA site has an arrangement with a private hospital system to facilitate enrollment of uninsured patients in Medicaid. It uses a tracking system to identify successful enrollments and is able to quantify the financial value to the hospital system of the insurance payment for services rendered. Based on this information the site has negotiated a payment rate for each application it completes.
  - A school Medicaid program has been able to track increased reimbursement to its school district resulting from the application assistance it provides and has secured a commitment from the school district to financially support the enrollment services.
  - Community Health Centers are able to include some costs related to application assistance in their Medicaid Cost Report, and secure some limited reimbursement for those services as part of their reimbursement rate.

Communities have employed a wide range of strategies to overcome gaps, barriers and challenges. For the most part, however, the strategies have not spread widely to other assistance sites, and many have not yet been modified to the specific characteristics and needs of the expansion populations. In many cases, additional information is needed to assess the effectiveness of these strategies or to understand in which circumstances and with which target populations they are most effective. The next section makes recommendations for maximizing outreach to the expansion populations.

RECOMMENDATIONS

As discussed, Colorado has a well established outreach and enrollment infrastructure that can be drawn upon to reach populations eligible for the recent and planned Medicaid and CHP+ expansions. The national literature and Colorado's experience to date lend themselves to the following recommendations for outreach approaches. Some of these recommendations can be helpful in reaching all of the expansion populations (children, parents, adults without dependent children and people with disabilities). However, because Colorado's current outreach and enrollment systems have been built largely in the context of the CHP+ program, and are focused on families and children, specific measures are needed to ensure that adults without dependent children and people with disabilities are effectively reached and enrolled.

- **Continue Enrollment Simplification and Modernization Efforts.** Many of the challenges related to effective outreach and enrollment are a direct result of the current design of Colorado's Medicaid and CHP+ programs (for example stair-step eligibility for Medicaid, different income disregard and enrollment requirements) and the various and distinct documentation and process requirements that result. Complex program rules and requirements make it difficult to develop clear and simple marketing messages and require extensive application assistance that could otherwise be focused on more extensive outreach or re-enrollment activities. The planned implementation of 12-month continuous enrollment in Medicaid, and of administrative verification of income, identity and citizenship, and to streamline enrollment and re-enrollment processes will result in more straightforward enrollment processes. As these efforts move forward, several considerations are important:
    - **Consistency across counties.** To the extent possible, the Department should use its role as program administrator to ensure that all counties are utilizing the expedited processes, even if they use different business processes to accomplish them.
    - **Ongoing education of outreach and enrollment partners regarding implementations.** Ongoing conversations with community partners ensure that they are able to provide consistent and clear information to their clients and other community providers about the current process and rules, and also to plan for upcoming changes. Additionally, regular communication forums, even in the absence of progress at the state level, provide an important opportunity for the Department to gain the perspective and insight of its community partners.

- **Employ targeted and clear marketing messages.** As discussed, the Department has developed clear, simplified messages for marketing of CHP+ to families and children. As expansion populations are added the department should:
    - Ensure that the overarching message it uses for Medicaid and CHP+ reinforces the value of the programs, and the importance of health.
    - Develop clear, simple messages for each expansion population. The most recent marketing theme "Keeping Colorado Kids Healthy" may not resonate with parents, and is not directly relevant to adults without dependent children or people with disabilities.

- Employ social marketing research and techniques to develop and test messages for the expansion population. While such research can be costly, it is critical to ensuring that the messages employed are effective and that dollars spent on securing media are well spent.
- Address structural differences in the programs. The benefit design for adults without dependent children will likely differ from family Medicaid, and the buy-in program for people with disabilities will have an entirely different structure. While an overarching marketing message is critical, it is also important that program-specific outreach and marketing materials can concisely and clearly describe the program designs.
- Provide clear and timely information materials for community partners. Like the current desktop guide, these materials should help application sites and other community partners understand the structure and requirements for each program so that they can provide accurate information and assistance to families and their own community partners.
- Employ media and venues relevant for the expansion populations. While higher-income parents of eligible children can be reached through many of the same venues historically used to reach eligible children and lower-income parents, they may not reach the expansion populations. Marketing research should be conducted with the expansion populations to better reach these groups, and the results used to guide both mass media and community-led strategies.

- **Ensure availability of application assistance sites for the newly eligible populations.** While the number of application assistance sites, especially CAAS sites, has increased substantially in the last year, the growth has not been targeted to geographic regions with the highest eligible but not enrolled expansion populations, or to include organizations with specific ties to those populations. In order to ensure adequate outreach to and enrollment of adults without dependent children and people with disabilities the Department should:
  - Assess availability of application sites by EBNE populations for each expansion populations, and actively encourage or recruit application assistance sites to serve the expansion populations, keeping in mind that current sites may not have the networks or expertise to effectively reach new populations;
    - The interest and ability of current sites (especially PE and MA sites) to conduct outreach to parents of eligible children should be assessed and additional sites recruited or encouraged as needed;
    - Application assistance should be recruited with established relationships to low-income adults without dependent children. These can include: safety net clinics and hospitals participating in CICP, homeless shelters, employment assistance sites, nutritional assistance sites.
  - Because the most effective outreach strategies are those that have a direct path to enrollment, the Department should build on the breadth of reach that has been developed with the addition of many new CAAS sites, and work to strengthen their depth of reach. The department should:

        - Consider increasing the number of application assistance sites with look-up ability in CBMS and advocate for the development of "batch" updates for application assistance sites.
        - Work to increase the number of out stationed eligibility and MA sites, facilitating the sharing of best practices by those entities that currently are MA sites. Also, actively supporting the development of additional sites in more regions of the state, especially those with delayed application determination and very high eligible but not enrolled populations.
    - Ensure an interface between PEAK and application assistance venues. Application assistance sites can play a critical role in assisting families to utilize PEAK to check their benefits and to apply for assistance. However, the full implementation of PEAK may diminish the level of assistance some sites are currently able to provide. Only county departments of human/social services or the CHP+ eligibility and enrollment vendor will be able to finalize eligibility determinations for applications submitted through PEAK. This is of concern to MA sites, since they would lose the ability to work meaningfully to assist families who submit the application on line, or to follow-up on their applications.

- **Support existing outreach and enrollment partners in reaching out to Adults without Dependent Children.** Most key informant interviews had already expanded their efforts to reach the higher income children and parents who became eligible in spring 2010. They also had a number of ideas about ways in which they could extend their reach to include adults without dependent children. This may not be a universal inclination among CAAS sites (especially those that are exclusively focused on children), but the Department should support this momentum where it exists and especially among community partners who provide medical services to these populations. Support can include:
    - Provide training on the "culture" of adults without dependent children, and how it impacts outreach and enrollment efforts;
    - Assist sites in identifying strategies and venues for reaching these populations; Key informants identified the following venues as good candidates:
        - Laundromats, homeless shelters and low-income housing programs, unemployment offices, vocational training centers, and workplaces that pay lower wages and don't offer health insurance;
        - Venues identified by the CHP+ at work pilot as having eligible parents.

- **Continue to Provide Systemic Support to Community Application Assistance Sites.** With the shift from the Regional Outreach Coordinator model to both enrolled and eligible but not enrolled families, it is important that all application assistance sites, including Healthy Communities sites, receive consistent and clear information and training, and are able to share best practices. Community partners can be assisted in furthering their reach by:
    - Regularly distributing an informational update to community partners, similar to the *CHP+ Highlights* that was distributed by the CHP+ marketing contractor, with both program updates and highlights of best practices or available resources;

- Providing in-person and web-based training, on a regular basis, including opportunities for application assistance sites to share best practices with each other;
- Continue to engage community partners in workgroups to inform the development of the program and benefit design for the remaining expansion populations and in workgroups to address enrollment barriers and modernization efforts.

- **Design an outreach strategy specific to people with disabilities with incomes below 450% FPL.** Because the income parameters for this population are so much higher than those for other populations, and because the structure of the program as a buy-in program will be distinct from current programs, it requires a distinct outreach strategy, albeit one coordinated with CHP+ and Medicaid. The need for a strategy specific to this group was underscored by key informant interviews. While most interviewees were able to identify ways in which they could build on their current programs to reach out to adults without dependent children that was not the case for people with disabilities. Key informants noted that they were aware that groups outside their usual partners were very successful in working with people with disabilities, but they did not know who those groups were. To better reach this population:
  - Application assistance sites with established relationships to people with disabilities should be utilized. To be most effective these sites should:
    - Be organizations that already work extensively with people with disabilities;
    - Be familiar with the SSI requirements related to disability status. Ideally, they would be able to assist with both disability applications and with applications for Medicaid and CHP+;
    - As mush as possible, attain MA site status or establish a very close relationship with and MA site in order to more closely follow the enrollment process.
  - As noted, market research should be conducted to identify the most effective messages and communication mechanisms for reaching this population, and to identify venues where they would be likely to seek application assistance.

- **Increase the ability of the state and individual application assistance sites to identify and adopt effective practices.** The outreach and enrollment infrastructure Colorado employs to enroll expansion populations over the next several years should become the platform upon which federal health care reform expansion, effective in 2014, is implemented. Given limited state resources, and the high stakes involved, an investment should be to establish mechanisms for measuring and identifying successful sites. While there are practices and systems within existing sites that could be built up on to complete the steps outlined below, some additional expertise and resources would also be needed.
  - **Increase ability of CAAS and PE sites to obtain outcome data on applications.** This will help sites understand their effectiveness (in terms of eligible persons enrolled) as they work with expansion populations, and assist them in helping clients with transitioning from PE spans to regular enrollment and with re-enrollment. Options for doing this include strategically increasing the

access of the most active sites to use look-up capabilities within CBMS or development of a batch update process.

- **Systematically catalogue and share best practices among application assistance sites.** This catalogue, or compendium, should include practices that have proven effective, along with what they require to be implemented and the components that made them effective; identify the types of application assistance sites and partners critical to the practice; and identify the specific demographic and/or eligibility groups to which they apply. The Department should facilitate opportunities for sites to share best practices (either at regional conferences or through peer learning opportunities), and take advantage of existing resources such as the KidsBlitz Enrollment Fair Tool Kit.
- **Encourage sites to adopt best practices, and document outcomes.** For sites funded through MORE grants, the Department should consider funding criteria that supports the use of best practices, as well as the use of outcome data to refine and focus outreach and enrollment efforts. Findings from the Colorado Trust evaluation of the Trusted Hand approach could be used to inform and support this effort. Healthy Communities sites could provide support to other community partners in the adoption of best practices.
- **Support application enrollment sites in adopting and utilizing common data elements.** The availability of this data is critical to sites' ability to monitor their progress toward enrollment goals and to inform internal quality improvement processes. The data systems already developed by several application assistance sties could be used as a template. Data tracked should include key process indicators (such as how clients were engaged and the types of contacts that result in completion of an application), characteristics of applicants (including race, gender, income and eligibility category), and whether or not the application was approved and, if applicable, reasons for denial. Canned reports should be available so that sites can readily identify which populations they are reaching, the types of outreach strategies that result in applications, and the rate at which applications they submit result in enrollment.

- **Support the use of a case management approach to outreach and enrollment.** This approach includes the critical component of educating eligible individuals about the benefits of health insurance and how to access those benefits. The Department is already supporting this approach in the Healthy Communities model and several MA sites are incorporating aspects of case management and patient navigation into their systems. The Department should seek ways to support and encourage this model, particularly among application assistance sites that are, or have very direct links to, medical providers. Federal funding available to prepare for implementation of Insurance Exchanges to support federal healthcare reform may be an avenue of support for such efforts.

This section provides specific recommendations on adapting past strategies to support enrollment of the expansion populations, and identifies ways in which existing gaps, barriers and challenges can be addressed.

SUMMARY

Colorado's recent and upcoming health insurance expansions provide an opportunity to ensure Colorado children, families, adult without dependent children and adults with disabilities have access to health care, and to ensure that the state's outreach and enrollment infrastructure is prepared to accommodate full implementation of federal health care reform in 2014.

Colorado has a well established outreach and enrollment infrastructure that includes Department administration and oversight of the Medicaid and CHP+ programs and CHP+ administration, enrollment services provided by county departments of human/social services, and an extensive network of application assistance sites. These application assistance sites range from those that offer information and application assistance site only, to Presumptive Eligibility sites that can assist families with obtaining presumptive coverage and critical services, to Medical Assistance sites that are able to complete the enrollment process for eligible families. Colorado has piloted initiatives to maximize enrollment of children, pregnant women, and families. Many of these efforts can be leveraged to conduct outreach and enrollment to activities for Adults without Dependent Children, and to inform outreach efforts for the Buy-In Programs for Individuals with disabilities.

In order to maximize the impact of outreach and enrollment to the expansion populations, it is critical that Colorado:

- Develop targeted, clear and consistent messaging to support outreach to the expansion populations;
- Move forward with planned enrollment simplification and modernization efforts, which help to address current barriers and gaps in enrollment;
- Continue to foster and support partnerships among the various state and local partners who play a role in outreach and enrollment;
- Decrease the number of hand-offs that take place between outreach and enrollment;
- Address the current gaps in application assistance sites and strategies related to the expansion populations;
- Employ known best practices to develop strategies that are specific to the expansion populations.

Appendix A:
Key Informant Interview Spreadsheet

Appendix A. Key Informant Interview Spreadsheet

Contact Name	Organization	Type of Application Assistance Site
Tonya Bruno	HCPF	
Monica Owens	HCPF	
Heather Hewitt	HCPF	
Pam Kurth	Tri County	CAAS Site and PE Site
Gretchen Hammer	CCMU	
Brenda LaCombe	Pueblo StepUp	Centura is a CAAS Site, PE Site, and MA Site
Michelle Trujillo	Mesa County	CAAS Site
Liz Whitley	Denver Health	MA Site
Katie Jacobson, Brittney Peterson and Christy Timmer	Covering Kids and Families	
Christina Ostrom	Boulder County	PE Site
Christy Blakely	Family Voices	CAAS Site
Nina Ervin	Advanced Patient Advocacy-Rose Medical Center	Contracted with Centura Health: 12 CAAS Sites, 1 PE Site
Debbi Main	The Colorado Trust	

Appendix B:
National Best Practices for Medicaid/CHIP Outreach and Enrollment

Appendix B. National Best Practices for Medicaid/CHIP Outreach and Enrollment

National Best Practice	Implementation Level	Strategy	Expansion Population	Colorado Implementation	Description
Outreach					
Marketing					
Clear, simplified messages	State, County, Local	Ex: "All kids are covered" "You are wanted" "New Medicaid Program" "rules have changed"	All potential enrollees	Some progress	"Keeping Colorado kids healthy" marketing message for CHP+
Targeted marketing	State, County	States have moved away from mass messaging aimed at generalized populations and towards targeted marketing approaches for men, women, minorities and specific income groups	Minority populations and newly eligible populations, including higher income groups and AwDc	Some progress	Targeted marketing efforts have been made to the Spanish speaking community Periodic targeted marketing campaigns at local level
Re-packaging of public health care	State	Re-naming Medicaid program may reduce stigma associated with "Medicaid as welfare"	AwDC, expansion population	No	
Increase publicity on value and importance of health insurance	State, County	Persons with no previous experience with public programming or the "young invincibles" may not think Medicaid or CHIP is for them	AwDC, higher income families	Planning stages	Prior state-level media campaigns were CHP+ focused, ended in mid-2009
Engage community leaders in public messaging.	State, County, Local	Community leaders have consistently been effectively utilized to reach specified target populations	All potential enrollees	Some progress	Governor Ritter and Lt. Governor Barbara O'Brien have participated in several Public Service Announcements
New outreach venues	State, County, Local	Adults without Dependent Children (AwDC) must be reached where they are: unemployment offices, assisted housing programs, job training programs,	AwDC	Planning stages	
Use of new media	State, Local	Populatons not traditionally connected to public programs may be effectively reached through new media, such as text messaging, twitter, blogs, etc.	All potential enrollees, especially AwDC and youth	No statewide efforts	Limited use of text messaging by some enrollment sites to contact clients
Community Outreach					
Provide a direct link to enrollment	State	Providing a link from outreach to enrollment is a key step to ensuring that outreach activities are effective and that completed applications are handled properly and in a timely fashion.	All potential enrollees	Some Progress	Denver Health has been able to implement a system in which enrollment facilitators are linked with eligibility technicians, providing a direct link to enrollment once assistance is provided. This is only possible, however, because Denver Health is an MA s
One-on-one contact	County, Local	Direct, one-on-one contact has been found to be among the most effective strategies in reaching eligible populations, correcting misunderstandings and assisting with applications	All potential enrollees	Yes	Counties, CBOs, community partners and enrollment assistant sites frequently provide in-person enrollment assistance. There has been a large recent increase in Colorado CAAS sites
Promote cultural competence	State, County, Local	Cultural competency can reduce barriers associated with race, ethnicity and limited English proficiency.	All potential enrollees	Little progress	While some community partners have developed culturally-specific projects, there is no systematic process for assuring or promoting cultural competence (other than language assistance) in outreach strategies or services.

Appendix B. National Best Practices for Medicaid/CHIP Outreach and Enrollment

National Best Practice	Implementation Level	Strategy	Expansion Population	Colorado Implementation	Description
Community Outreach					
Reducing language barriers	State, County, Local	Outreach materials written at or above the 9th grade level have been shown to present significant barriers for persons with limited proficiency, lower education, or poor literacy rates. Further, providing materials written in multiple languages can increa	All potential enrollees	Some progress	The joint application for Medicaid and CHP+ is available in Spanish, as are many outreach communities. There is no systematic process for assessing the linguistic competency of outreach services, or of training outreach providers in related requirements.
Targeted community partnerships; CBOs, hospitals, schools, private employers, unions	State, County, Local	School partnerships in particular have been found to be effective CBOs engaged must be familiar with the expansion populations and be trusted sources of information	All potential enrollees	Some progress	Colorado has partnered extensively with CBOs throughout the state through CAAS, PE and MA site programs. MORE grants and Colorado foundation grants have supported community partnerships.Composition and level of partnerships varies greatly across state
Expand enrollment sites	State, County, Local	Expanding the location, variation and availablility of assistance sites can greatly enhance programmatic ability to reach vulnerable populations	All potential enrollees	Some progress	Significant efforts have been made to expand CAAS and PE sites. Pilots to expand MA sites Healthy Communities combines outreach and enrolment for Medicaid and CHP+
Promote a culture of coverage	State, County	Move away from a culture of "gatekeeping" and towards a culture of enrollment encouragement	AwDC, expansion populations	Some progress	Targeted internal efforts could be implemented at county level to promote consistency in culture of coverage
Enrollment					
Expand Opportunities to Apply					
Allow Presumptive Eligibility*	State	Allows schools, CBOs, and health care providers to provide temporary eligibility for Medicaid and CHIP pending an evaluation of the full application	Families and children	Yes	Counties and state-certified PE sites can grant PE
No Wrong Door policy	State	Program collaboration can allow families to apply for any program via any any agency involved with enrollment.	All potential enrollees	Some progress	Assistance sites still offer varying degrees of assistance. Families may still be confused as to where they can go for assistance for any particular program
Eligibility expansion	State	When expanding eligibility, states found expansion provides an opportunity to reach out to previously eligible but not enrolled individuals in the same family	Expansion populations	In progress	Existing sites focusing on famlies and children readily expanded outreach to higher income eligibility categories for 2010 expansion. H.B. 1293 will expand eligibility in 2011 and 2012

Appendix B. National Best Practices for Medicaid/CHIP Outreach and Enrollment

National Best Practice	Implementation Level	Strategy	Expansion Population	Colorado Implementation	Description
Enrollment/Re-Enrollment Modernization and Simplification					
Shorten application	State	Lengthy applications allow more opportunities for technician or applicant error	All potential enrollees	Some progress	Commitment to using a consolidated application, and variation in requirements across programs makes it challenging to further shorten the combined application
Online application submission	State	Allows potential enrollees to submit applications entirely online, without paper documentation	Parents and children; AwDC and persons with disabilities may not benefit	Some progress	The PEAK eligibility system has experienced some delays, but applicants are expected to be able to submit an online application late 2010 or early 2011. PEAK system may not be used for all expansion populations
Electronic signatures	State	Eliminates the need to print, sign or mail signatures	All potential enrollees	Planning stages	The PEAK eligibility system will allow electronic signatures once fully implemented
Self-declaration of income	State	Proof of income eligibility is among the greatest barriers to enrollment. This practice relies on other data sources to document income	All potential enrollees	No	
Eliminate asset test*	State	Neither state Medicaid and CHIP programs may have asset tests, or such tests must be significantly simplified to qualify for this bonus requirement	All potential enrollees	Yes	
Eliminate face-to-face requirement*	State, County	Requiring applicants to meet face-to-face with an enrollment specialist has been shown to have severe negative effects on enrollment	All potential enrollees	Yes	
Express Lane eligibility*	State	States may use eligibility determinations from other programs, such as TANF, to determine that a child is eligible for either Medicaid or CHIP	Eligible persons previously involved with public programs. School-age children. Families filing tax returns.	Some progress	Currently, eligibitiy for free and reduced school lunch is used to identify eligible children for targeted outreach. HCPF is working with Colorado Department of Education, DOR and OIT on future implementation. Legacy system technical issues are impacting
Ex Parte renewals*	State	Process by which states may renew eligibility based on currently available information, such as other program data bases or records	previously enrolled	Some progress	Ex Parte renewals have recently been authorized.
Administrative verification of identity, citizenship, and income	State, County	Verify identity through interface with vital statistics, department of motor vehicles, social security administration	All potential enrollees	Planning stages	New Application for Medical Assistance includes identity affidavit for children under 16. HCPF is develping interfaces with IEVS, SSA, Vial Statistics, DMV
Allow phone renewals	State	Telephone renewal for Medicaid and CHIP can greatly reduce paperwork and burden on families	previously enrolled	Yes	Telephone and online re-enrollment is allowed for both Medicaid and CHP+
Joint application and renewal forms and same verification process between Medicaid and CHIP*	State	Beyond the joint application form, this calls for the same renewal and supplemental forms, and the same process for verifying information across both Medicaid and CHIP, making it easier for families to understand procedures	Parents and children	Some progress	Colorado has a joint application, but verification and renewal process is different between programs
Automatic enrollment for newborns	State	Allows newborns within families already enrolled in Medicaid or CHIP to become automatically enrolled	All enrolled families	Yes	The baby-on program allows automatic eligibility for new additions to families already enrolled in Medicand and CHP+ by providers of parents, on-line, by phone or by fax
12-month continuous coverage*	State	More than simply continuous enrollment, this requires 12 months of continuous *eligibility* for children enrolled in Medicaid or CHIP, despite changes in financial circumstances	Children	Some progress	H.B. 1293 will allow continuous eligibily for children on Medicaid beginning in Spring of 2012

Appendix B. National Best Practices for Medicaid/CHIP Outreach and Enrollment

National Best Practice	Implementation Level	Strategy	Expansion Population	Colorado Implementation	Description
Facilitated Enrollment					
Tracking of application through enrollment process	State, County	Some states have allowed enrollment facilitators to track applications and even produce aggregated data reports	All potential enrollees	Some progress	Of assistance sites, only Counties and MA sites have access to CBMS to track progress of applications. HCPF is gathering data requirements for an Application Tracking tool. Several applicaiton assistance sites have developed systems to track progress of
Enhanced training of enrollment facilitators	State, County, Local	Providing extensive training for facilitators greatly reduces technician error and documentation problems	All potential enrollees	Some progress	HCPF provides periodic standardized training
Incentives for enrollment assistance	State	Providing enrollment facilitators nominal fees for services could greatly enhance performance	All potential enrollees	Limited	Some providers receive nominal per-application payment School can access Medicaid Administrative Claiming for Medicaid outreach and enrollment activities
Access					
Eliminate Financial Barriers					
Offer premium assistance option*	State	States may subsidize qualified group and employer sponsored coverage using Medicaid or CHIP funds	All potential enrollees	In progress	CHP+ At Work; assistance to CHP+ eligibles enrolled in employers insurance plan; 39 families enrolled in pilot, with plans to expand statewide.
Reduce or eliminate cost sharing	State	Cost sharing requirements have been found to be a significant barrier for low income families in accessing services	All potential enrollees	Some progress	Families below 151% FPL are not required to pay premiums
Incentives for patients	State	Some states provide incentives for patients to seek services, such as a wellness plan, within a given timeframe, thus ensuring follow-up and linkages to care	All potential enrollees	Not at state level	HMOs providing care may utilize such incentives
Provide Links to Care					
Incentives for providers	State	States have found they must increase reimbursement rates to assure access to care. Incentives could be used as one method by which to increase reimbursements and assure physicians actively pursue care plans for patients	All potential enrollees	Some progress	Participating CHP+ plans provide incentive payments of up to $21 for primary care physicians and obstetric providers seeing members for specific annual well visits
Educate eligible populations about their benefits and how to use health care	State, local	States expanding care to new populations find it is necessary to educate populations on both the importance of health care and how to use the health care system.	Expansion populations	Some progress	State outreach plan, *Healthy Communities* will help families learn about and appropriately use their benefits.
Managed Care Practices	State	Managed care can provide crucial linkages to	All potential enrollees	Yes	The State Managed Care Network (SMCN)

* indicates that this activity is one of 8 requirements for a performance bonus enhancement under CHIPRA

Appendix C:
Assessment of Colorado Medicaid/CHP+ Outreach Efforts and Gaps

Appendix C. Assessment of Colorado Medicaid/CHP+ Outreach Efforts and Gaps

Outreach Strategy	Effectiveness as Cited by Key Informants	Key Strengths	Key Challenges	Key Components for Success	Gaps in Populations Reached	Considerations Related to Expansion Populations	Measures of Success	Challenges Related to Measuring Success
Mass Media								
Media ads and PSAs (television, radio, bus shelter)	Helpful in raising general awareness	Potential for reaching people not otherwise engaged in health care systems	Expensive and time-consuming to develop effective, tailored messages	Messages must be professionally developed, and tested with target population	Populations not in urban centers Non-English speaking	Targeted media messages could be used in media markets that target young adults, adults without dependant children (AwDC) and people with disabilities	Increase in application downloads, from website Increase in enrollments during/after campaign Estimated number of times a person within the targeted income and family demographic likely saw an ad	Difficult to assess the contribution to subsequent applications or enrollment Difficult to separate the effect from that of program changes
Telenovela (Encrucijada)		Targeted message and venue for Spanish-speaking families	Sustainability Facilitating application submission as a result of television exposure	Telephone line coupled with the novela	Populatons other than Spanish-speaking Latinos	Similar targeted approach could be used for AwDC	Calls to toll-free number Increase in enrollments during/after campaign Estimated number of times a person within the targeted income and family demographic likely saw	Difficult to assess the contribution to subsequent applications or enrollment
CHP+ brochures	Successful in providing basic program information to eligible families	Concise information regarding CHP+, useful to both families and entities conducting outreach and enrollment	Maintaining current information with ongoing eligibility changes Literacy level may be too high for many eligible families	Maintain current	Languages other than Spanish and English Medicaid eligible	Current materials do not speak to expansion populations, may not be relevant for how those programs implemented	Number distributed	Difficult to assess the contribution to subsequent applications or enrollment
CHP+ Highlights Newsletter	Effective in keeping community partners updated on program changes and status	Provide program updates, regular communication mechanism	Sustainabilty Did not address Medicaid	Timely, relevant information		Important to support community partners and spread best practices	Number distributed	Difficult to assess the contribution to subsequent applications or enrollment

Appendix C. Assessment of Colorado Medicaid/CHP+ Outreach Efforts and Gaps

Outreach Strategy	Effectiveness as Cited by Key Informants	Key Strengths	Key Challenges	Key Components for Success	Gaps in Populations Reached	Considerations Related to Expansion Populations	Measures of Success	Challenges Related to Measuring Success
Application Assistance								
CAAS sites	Important for providing one-on-one assistance, securing a presence in the community	Ability to provide assistance in a location familiar to/welcoming to applicants	Sustainability of resources needed to provide this assistance, especially if application assistance not core to organization's mission Application sites lack ablity to track application throughout process	Ability to reach the local community Staff must remain up-to date on program, receive regular training, have strong partnerships with entities that complete the enrollment process	Focus of and availabilty of CAAS sites varies widely. Not currently focused on adults without dependent children or people with disabilities.	Traditional CAAS sites are focused on families and children, may have limited connections to adults without dependent children or people with disabilities	For HCPF: Number of CAAS certified, number of CAAS trainings and trainees For CAAS: Number of applicants assisted, or number of applications completed	Difficult to track ultimate outcome of applications
PE sites	Effective in linking eligible persons to PE and care.	Provide enrollment assistance in location where eligible persons seek care, facilitate access to care	Limited ability to track and follow-up on application status Frequent expirations of PE span without eligibility determination	Link to CBMS to determine application outcome	Limited focus: some exclusively on pregnant women, others exclusively on children, some on both. Thee number of PE sites per county varies greatly, and not in proportion to the EBNE population. Of the twenty counties with the highest percent of EBNE, 11 do not have PE sites.	Some PE sites focus on children only, could not readily expand to reach AwDC or people with disabilities. Many PE sites are primary health care providers that also serve AwDC and may also serve people with disabilities	Accuracy of presumptive eligibility determinations per HCPF standards Volume of applications completed	Difficult for PE sites to track ultimate outcome of applications
MA sites	Effective in completing entire application process, including eligibility determination	Most located in community settings (community health centers or school districts) Ability to make eligibility determination Ability to access CBMS information	MA site requirements are extensive, requires substantial resource commitment	Commitment of sponsoring organization, technological capacity, ability to demonstrate increased enrollment	Very few sites throughout the state. With exception of Denver, no MA site in counties with over 30% EBNE. None of the 20 counties with the highest EBNE populations have MA sites (although 4 of the 10 counties with the highest number of EBNE have MA sites	Could play a key role if located in appropriate venues for expansion populations	Accuracy of eligibility determinations per HCPF standards Volume of eligibility determinations	

Appendix C. Assessment of Colorado Medicaid/CHP+ Outreach Efforts and Gaps

Outreach Strategy	Effectiveness as Cited by Key Informants	Key Strengths	Key Challenges	Key Components for Success	Gaps in Populations Reached	Considerations Related to Expansion Populations	Measures of Success	Challenges Related to Measuring Success
Application Assistance								
PEAK enrollment website (Current deployment)	Enrollee able to access own information through "Check my Benefits"	"Am I Eligible" is Powerful tool for potential eligibles Available in Spanish	Requires internet connectivity All determinations will be made through counties, MA sites won't be able to make determinations on application submitted through PEAK	Ability for other enrollment assistance services to integrate PEAK functionality into their work as appropriate	Populations that don't read English Populations with limited computer or reading literacy	Useful for expanded Medicaid and CHP+ income levels Not clear how AwDC or buy-in program for people with disabilities will be incorporated		
Expedited enrollment through FQHCs for parents of Medicaid and CHP+ enrolled children, now eligible through expansion through "add a parent" process	Very focused effort to use existing data to enroll newly eligible population	Leveraged existing relationship between families and expansion population	Process requirements in expedited process still cumbersome. In some cases other existing local processes were more streamlined. Documentation requirements for expedited applications	Medical partner ability to pull together family and parent information. HCPF establishment of alternative process. Direct communication between the provider and eligibility technician to support the process	Populations other than ewly eligible parents	Similar in-reach could be used to facilitate enrollment of AwDC, leveraging CICP applications	Number of enrollments parents enrolled	

Appendix C. Assessment of Colorado Medicaid/CHP+ Outreach Efforts and Gaps

Outreach Strategy	Effectiveness as Cited by Key Informants	Key Strengths	Key Challenges	Key Components for Success	Gaps in Populations Reached	Considerations Related to Expansion Populations	Measures of Success	Challenges Related to Measuring Success
State-led efforts								
Regional CHP+Outreach Coordinators	Effective in supporting outreach and enrollment sites	Able to support local staff and events with information, training	Sustainability Focus limited to CHP+					
Healthy Communities projects	Too new to assess	Ability to build on EPSDT model	Ability to extend EPSDT model to much broader client base with limited resources	Establish effective outreach plan to enroll expansion populations	Focus on families, does not explicitly include AwDC at this time	Charged with outreach to expanded income categories within Medicaid and CHP+	Percent change in eligible but not enrolled population	Other factors and efforts will impact attainment of measure
Enrollment fairs	Limited effectiveness unless closely linked with ability to complete enrollments	Raise community awareness of programs	Attendees of community events/celebrations not usually interested in applying for health insurance	Couple enrollment fairs with pre-screening, partnership with trained enrollment staff (preferably with ability to determine eligibility) Combine enrollment fair with health screenings or other health fair	Varies, depending on venue and audience for enrollment fair	Other mechanisms likely more successful in directly engaging expansion populations	Applications taken	Depending on enrollment fair model, may be difficult to track ultimate outcome of applications
School enrollment pilots	Effective in connecting with families Ability to secure enrollments varies	Personal link to eligible children Ability to leverage school data regrading free and reduced school lunch eligibility, and insurance status	Ability to complete application and determination process varies across sites.		Do not focus primarily on adults, or families with non-school aged children	Have information and strategies to reach expanded CHP+ and Medicaid income groups. Not designed to reach AwDC or people with disabilities	Measured primarily in terms of applications completed or family contacts	Depending on model, may not be able to track outcome of applications
HCPF-sponsored information forums and training (including issue-specific work groups)	Effective in engaging partners, providing updates	Provide consistent informaiton to community members Provide opportunity for HCPF to gain perspective of partners at various levels	Require Department staff time, hard to sustain in face of other priorities	Regular occurance Use for community input as well as provision of information	Many current partners are focused on families and children Few community partners are focused primarily on AwDC or people with disabilities	Current partners that provide primary care services could in-reach to AwDC and, potentially, people with disabilities	Number of trainings counducted, increase in CAA sites	

Appendix C. Assessment of Colorado Medicaid/CHP+ Outreach Efforts and Gaps

Outreach Strategy	Effectiveness as Cited by Key Informants	Key Strengths	Key Challenges	Key Components for Success	Gaps in Populations Reached	Considerations Related to Expansion Populations	Measures of Success	Challenges Related to Measuring Success
Community Based Efforts								
County-level outreach and enrollment partnerships	Successful where partnerships are strong and involve decision-makers	Can maximize available resources, leverage the strength of each partner	Sustainability of efforts that may not be the core work of one partner	Combining outreach and application assistance with ability to determine eligibility quickly	Varies depending on partners involved	Depending on partners involved, could readily expand to include expansion populaitons	Increased enrollment of eligibles in community	Difficult to track impact of partnership on increased enrollment of eligibles - each partner tracks their own effort
State-level partnerships with outreach and enrollment coalitions (All Kids Covered, Covering Kids and Families)	Effective in supporting policy change, providing information from the field to support improved enrollment processes	Provide conduit for communication with community Provide mechanism for understanding experience of community-level outreach and enrollment efforts	Sustainability	Involvement of key decision makers from state agencies and partners	Coalitions may not represent all stakeholders or be representative in membership	Important to spread best practices and monitor success of efforts	Passage of legislation or estabishment of rules that expand eligibility and simplify eligibility and enrollment	Multiple entities impact success
"Trusted Hand" model	Effective in reaching target population Ability to have success in enrollment may vary considerably	Can build on existing relationship with community	Sustainability of resources needed to provide this assistance, especially if application assistance not core to organization's mission Application sites lack ablity to track application throughout process	Ability to complement application assistance with eligibility determination, directly or through partnerships	Varies, depending on each agency's geographic and populaiton focus	Important to engage CBOs with established connections within expansion populations	Applications taken	Depending on organizaton's scope of service and partnerships, may be difficult to track ultimate outcome of applications
Enrollment Vans	Highly effective	Able to support local staff and events with information, training	Resource intensive	Partner with community agencies to recruit and pre-screen applicants at each site Ability for van staff to offer comprehensive application assistance, and eligibility determination	Currently in limited metro areas Not financially feasible for widely dispersed rural communities	Would require partnerships with CBOs that have established connections with expansion populations	Applications completed, Individuals enrolled	
Outstationed eligibility workers	Varies depending on model	Ability to determine eligibility at community sites in timely fashion	Competing priorites for outstationed staff, and overall caseload of eligibility worker	Dedicated FTE to focus on applications generated at site where outstationed Well established partnership to support outstationing		Expensive and difficult to sustain	Applications completed, Individuals enrolled	

Appendix D:
Social Media

Appendix D. Social Media

Using Social Media to Reach Eligible Populations

Social Media is a relatively new tool which may potentially be a highly potent manner in which to reach newly eligible populations. It's effectiveness in assisting with outreach and enrollment in health insurance has not, however, been proven, and several considerations must be made before making the leap into this new format. A common methodology for approaching such considerations is P.O.S.T.T., or people, objectives, strategy, technology, and tools.

People – The very first considerations to be made when implementing a social media campaign are, "who is my target audience?" and "do they utilize social media?" Social media may well be targeted directly at the population one is attempting to reach, such as adults without dependent children or single parents eligible for Medicaid. Social media may also be targeted, however, towards intermediaries, such as health departments, providers or health professionals.

Objectives – The next major consideration, which may well depend on who one is attempting to target, revolves around your final objectives. These objectives must be clear and delineated and will help guide the strategic process for implementing a campaign.

Strategy – Social media involves a great deal of time, effort and variety. Websites must be consistently updated and monitored for both quality control and content. A clear strategy can reduce the costs associated with program implementation by creating efficient, streamlined methodologies. A social media strategy should consider cost-benefit analyses across tools, technology and objectives to determine which combination of resources would best be utilized to achieve your goals

Technology – Includes, but may not be limited to, cell phones, websites, video cameras, laptops, and flyers.

Tools – A variety of tools exist for use in social media. Specific tools include, but are not limited to, MySpace, Twitter, Facebook, text messaging, live chats, YouTube, blogs, podcasts, videos and photo-sharing sites, such as Flickr. One or all of these tools are potentially potent avenues through which to reach new populations, and each has specific implications for the time, cost, and reach associated with a campaign.

Excellent examples of the use of social media for outreach purposes abound. Two specific examples include AIDS.gov, managed by JSI, and whitehouse.gov. AIDS.gov is an extremely efficient website which utilizes social media to inform the public about current issues surrounding HIV utilizing blogs, podcasts, newsfeeds and social networking tools such as Facebook and Twitter. This website also offers multiple tools and suggestions for utilizing new media, which can be found here. Whitehouse.gov offers a similar variety of social media outlets, including Facebook, YouTube, Flickr and LinkedIn.

Appendix E:
Availability of Enrollment Assistance Sites

Appendix E. Availability of Enrollment Assistance Sites

Table 1. Estimated Eligible but Not Enrolled Children and the Availability of Assistance Sites					
	County	A) Percent of eligible children who are not enrolled in CHP+ or Medicaid	B) Number of eligible children who are not enrolled in CHP+ or Medicaid*	C) Number of assistance sites**	D) Number of eligible but not enrolled children per assistance site (B/C)
1	Denver	35.2%	26,107	75	348
2	Arapahoe	29.0%	12,317	14	880
3	Jefferson	40.8%	11,955	14	854
4	Adams	22.6%	10,606	21	505
5	El Paso	23.6%	9,462	23	411
6	Weld	32.7%	8,290	14	592
7	Boulder	31.9%	4,467	24	186
8	Larimer	21.4%	3,353	10	335
9	Mesa	23.3%	2,746	3	915
10	Pueblo	13.6%	2,402	10	240
11	Garfield	46.3%	2,365	4	591
12	La Plata	42.2%	1,705	5	341
13	Montrose	26.4%	1,297	5	259
14	Fremont	30.5%	1,258	4	315
15	Delta	34.2%	1,080	3	360
16	Routt	65.4%	1,063	1	1,063
17	Douglas	22.1%	993	7	142
18	Eagle	37.9%	951	3	317
19	Montezuma	29.1%	925	4	231
20	Otero	27.7%	832	5	166
21	Moffat	45.4%	712	1	712
22	Las Animas	34.8%	623	1	623
23	Alamosa	23.8%	613	6	102
24	Teller	35.5%	560	4	140
25	Summit	38.0%	537	4	134
26	Broomfield	26.0%	517	1	517
27	Rio Grande	24.4%	508	2	254
28	Morgan	18.0%	479	3	160
29	Chaffee	38.5%	443	9	49
30	Park	41.4%	396	0	-
31	Archuleta	33.5%	384	0	-
32	Logan	21.5%	362	1	362
33	Elbert	37.5%	350	0	-
34	Conejos	22.7%	344	1	344
35	Pitkin	72.6%	339	0	-
36	Rio Blanco	52.9%	323	0	-
37	Huerfano	33.5%	322	2	161
38	Gunnison	37.8%	319	1	319
39	Grand	39.8%	284	3	95
40	San Miguel	54.1%	256	2	128
41	Prowers	12.8%	255	6	43
42	Saguache	26.1%	242	1	242
43	Baca	37.6%	185	0	-
44	Lake	26.2%	178	2	89
45	Yuma	19.3%	174	1	174
46	Costilla	27.6%	150	2	75
47	Kit Carson	17.6%	141	3	47
48	Lincoln	23.9%	107	2	54
49	Bent	16.8%	106	1	106
50	Crowley	20.5%	97	1	97
51	Custer	32.8%	96	0	-

Appendix E. Availability of Enrollment Assistance Sites

Table 1. Estimated Eligible but Not Enrolled Children and the Availability of Assistance Sites					
	County	A) Percent of eligible children who are not enrolled in CHP+ or Medicaid	B) Number of eligible children who are not enrolled in CHP+ or Medicaid*	C) Number of assistance sites**	D) Number of eligible but not enrolled children per assistance site (B/C)
52	Washington	24.9%	87	1	87
53	Ouray	38.0%	85	2	43
54	Jackson	Not Available	85	0	-
55	Phillips	22.1%	79	0	-
56	Dolores	38.0%	72	1	72
57	Sedgwick	24.3%	48	0	-
58	Cheyenne	22.6%	39	0	-
59	Kiowa	Not Available	29	0	-
60	San Juan	Not Available	22	0	-
61	Mineral	Not Available	19	0	-
62	Hinsdale	Not Available	18	0	-
63	Clear Creek	1.3%	4	1	4
64	Gilpin	Not Available	2	1	2

*data taken from the Colorado Health Institute's Issue Brief, *Colorado Children's Health Insurance Status: 2010 Update*, printed in April 2010

**based on Department of Health Care Policy and Financing listing updated 8/2010, available at http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251649124096&ssbinary=true

Appendix E. Availability of Enrollment Assistance Sites

Table 2. Estimated Eligible but Not Enrolled Parents and the Availability of Assistance Sites						
County	A) Percent of eligible parents not enrolled in Medicaid (0-60% FPL)*	B) Number of eligible parents not enrolled in Medicaid (0-60% FPL)*	C) Number of parents eligible for Medicaid with expansion (61 to 100% FPL)	D) Number of parents eligible but not enrolled and eligible with expansion (B+C)	E) Number of assistance sites**	F) Number of parents per assistance site (D/E)
Denver	32.6%	4571	4006	8577	75	114
El Paso	27.5%	3017	5249	8266	23	359
Adams	36.0%	3224	3080	6304	21	300
Weld	29.4%	1253	3339	4592	14	328
Arapahoe	31.0%	2581	1883	4464	14	319
Jefferson	32.7%	1848	2031	3879	14	277
Larimer	40.1%	1883	1188	3071	10	307
Pueblo	18.2%	985	1295	2280	10	228
Boulder	20.4%	434	1433	1867	24	78
Garfield	69.7%	756	302	1058	4	265
Mesa	25.6%	658	366	1024	3	341
La Plata	44.3%	352	397	749	5	150
Douglas	24.6%	254	458	712	7	102
Montrose	31.0%	268	302	570	5	114
Routt	83.1%	340	136	476	1	476
Delta	33.2%	223	252	475	3	158
Montezuma	31.3%	191	215	406	4	102
Moffat	58.7%	228	91	319	1	319
Otero	38.5%	282	32	314	5	63
Broomfield	45.8%	237	66	303	1	303
Eagle	27.1%	39	200	239	3	80
Las Animas	42.8%	211	24	235	1	235
Alamosa	31.6%	208	24	232	6	39
Fremont	0.0%	0	224	224	4	56
Rio Grande	30.0%	172	20	192	2	96
Archuleta	45.9%	79	89	168	0	-
Rio Blanco	60.1%	103	41	144	0	-
Summit	20.3%	22	113	135	4	34
Conejos	29.7%	116	13	129	1	129
Morgan	24.4%	113	13	126	3	42
Huerfano	36.4%	109	13	122	2	61
San Miguel	Not Available	53	60	113	2	57
Teller	0.0%	0	100	100	4	25
Logan	23.1%	85	10	95	1	95
Elbert	33.1%	83	9	92	0	-
Saguache	38.9%	82	9	91	1	91
Pitkin	Not Available	14	71	85	0	-
Gunnison	12.4%	13	67	80	1	80
Chaffee	0.0%	0	79	79	9	9
Grand	14.7%	12	60	72	3	24
Baca	40.6%	63	7	70	0	-
Park	0.0%	0	70	70	0	-
Prowers	15.0%	60	7	67	6	11
Costilla	32.5%	51	6	57	2	29
Yuma	30.4%	41	5	46	1	46
Lake	10.5%	7	37	44	2	22
Jackson	Not Available	27	11	38	0	-
Kit Carson	25.4%	33	4	37	3	12
Dolores	Not Available	15	17	32	1	32
Bent	14.9%	25	3	28	1	28
Lincoln	26.9%	25	3	28	2	14

Appendix E. Availability of Enrollment Assistance Sites

Table 2. Estimated Eligible but Not Enrolled Parents and the Availability of Assistance Sites						
County	**A) Percent of eligible parents not enrolled in Medicaid (0-60% FPL)***	**B) Number of eligible parents not enrolled in Medicaid (0-60% FPL)***	**C) Number of parents eligible for Medicaid with expansion (61 to 100% FPL)**	**D) Number of parents eligible but not enrolled and eligible with expansion (B+C)**	**E) Number of assistance sites****	**F) Number of parents per assistance site (D/E)**
Crowley	21.3%	23	3	26	1	26
Washington	35.1%	20	2	22	1	22
Ouray	Not Available	4	18	22	2	11
Phillips	Not Available	19	2	21	0	-
Clear Creek	0.0%	0	19	19	1	19
Custer	0.0%	0	17	17	0	-
Sedgwick	Not Available	11	1	12	0	-
Cheyenne	Not Available	9	1	10	0	-
Gilpin	0.0%	0	10	10	1	10
San Juan	Not Available	4	5	9	0	-
Kiowa	Not Available	7	1	8	0	-
Hinsdale	Not Available	1	4	5	0	-
Mineral	Not Available	1	4	5	0	-

*data taken from the Colorado Health Institute's Issue Brief, *Health Insurance Coverage Among Low-Income Adults in Colorado*, printed in April 2010

**based on Department of Health Care Policy and Financing listing updated 8/2010, available at http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251649124096&ssbinary=true

Appendix E. Availability of Enrollment Assistance Sites

Table 3. Estimated Number of Adults without Dependent Children (AwDC) Potentially Eligible for Medicaid in 2012 per Currently Available Assistance Sites				
	County	A) Number of AwDC between 0 and 100% FPL	B) Total Assistant Sites**	C) Number of AwDC per Assistance Site (A/B)
1	Denver	19046	75	254
2	Arapahoe	14645	14	1046
3	El Paso	13206	23	574
4	Adams	11097	21	528
5	Jefferson	10582	14	756
6	Boulder	6671	24	278
7	Larimer	6118	10	612
8	Mesa	4743	3	1581
9	Weld	4427	14	316
10	Douglas	4283	7	612
11	Pueblo	4272	10	427
12	Garfield	1404	4	351
13	La Plata	1321	5	264
14	Montrose	1005	5	201
15	Otero	942	5	188
16	Fremont	900	4	225
17	Delta	837	3	279
18	Eagle	798	3	266
19	Morgan	727	3	242
20	Montezuma	717	4	179
21	Las Animas	705	1	705
22	Alamosa	694	6	116
23	Routt	631	1	631
24	Rio Grande	576	2	288
25	Broomfield	562	1	562
26	Logan	549	1	549
27	Elbert	532	0	-
28	Summit	451	4	113
29	Moffat	423	1	423
30	Teller	401	4	100
31	Conejos	390	1	390
32	Prowers	388	6	65
33	Huerfano	365	2	183
34	Chaffee	317	9	35
35	Archuleta	298	0	-
36	Pitkin	285	0	-
37	Park	283	0	-
38	Saguache	274	1	274
39	Gunnison	267	1	267
40	Yuma	263	1	263
41	Grand	238	3	79
42	Kit Carson	214	3	71
43	Baca	210	0	-
44	San Miguel	198	2	99
45	Rio Blanco	192	0	-
46	Costilla	170	2	85

Appendix E. Availability of Enrollment Assistance Sites

Table 3. Estimated Number of Adults without Dependent Children (AwDC) Potentially Eligible for Medicaid in 2012 per Currently Available Assistance Sites				
	County	A) Number of AwDC between 0 and 100% FPL	B) Total Assistant Sites**	C) Number of AwDC per Assistance Site (A/B)
47	Lincoln	163	2	82
48	Bent	161	1	161
49	Lake	150	2	75
50	Crowley	148	1	148
51	Washington	132	1	132
52	Phillips	120	0	-
53	Clear Creek	94	1	94
54	Sedgwick	74	0	-
55	Ouray	72	2	36
56	Custer	68	0	-
57	Cheyenne	60	0	-
58	Dolores	55	1	55
59	Jackson	51	0	-
60	Gilpin	48	1	48
61	Kiowa	43	0	-
62	San Juan	17	0	-
63	Mineral	16	0	-
64	Hinsdale	15	0	-

*data taken from the Colorado Health Institute's Issue Brief, *Health Insurance Coverage Among Low-Income Adults in Colorado*, printed in April 2010

**based on Department of Health Care Policy and Financing listing updated 8/2010, available at http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251649124096&ssbinary=true

Appendix F:
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