Health care is one of the biggest issues facing the people of Colorado — 180,000 children lack health insurance — it's morally unacceptable and it's economically unacceptable.

—-Governor Bill Ritter, The Colorado Promise

health care

Health Care: Where We Are Now

Nearly 1 in 6 Colorado children are uninsured and have unmet healthcare needs. Without adequate access to preventive care and health services, underserved children are more likely to track into serious adult health disparities. Investments made in health prevention and intervention will produce dollar savings, reduce deaths due to disease, increase the quality of life, and lead to better allocation of public resources. The bottom line is that Coloradans want healthy kids. It's not just the right thing to do – it makes sense socially and financially. It's time for our government institutions, health care programs, schools, and recreation departments to develop the capacity for children's health and well being.

- A survey conducted by the American Academy of Pediatricians and the Colorado Medical Society found that Coloradans will vote for improvement in health, education and safety of children. Additionally, 73 percent believe that every child in Colorado should be covered by a government supported health care program if private health costs are not available.[1]

**This section includes concepts from and supports the recommendations put forth by "All Colorado Kids Covered: A Roadmap to Coverage by 2010" produced by the 2010 All Colorado Kids Covered Work Group and "Fulfilling the Promise: Opportunities and Strategies for Insuring Colorado's Kids" by the Colorado Children's Campaign.*

Goals: Where We Need to Go

1. **Raise the number of insured children** in Colorado.
2. Improve the **quality** of children's health care.
3. Increase the **efficiency and sustainability** of children's health services.
4. **Reduce preventable health disparities** that disproportionately affect ethnic and minority populations.

Governor Ritter and Colorado legislators proved in the 2007 legislative session that improving the quality of children's health care was a top priority. The state of Colorado is now poised to address children's comprehensive health care needs and make uninsured children in the state an immediate priority. We applaud the passage of the following legislation:

- Senate Bill 07-211, sponsored by Senator Bob Hagedorn and Representative Anne McGihon, establishes an advisory committee to develop a comprehensive health care reform plan for children in Colorado and immediately seeks to increase the number of children receiving health coverage and improve the quality of health care available to children.[2]
- Senate Bill 07-130, sponsored by Senator Betty Boyd and Representative Morgan Carroll declares that a medical home is important, defines a medical home for children, requires the Colorado Department of Health Care Policy and Financing (HCFP) to maximize number of kids enrolled in a medical home, and report back to the legislature on the progress.[3]

Raise the number of insured children in Colorado.

- In Colorado, in 2006, estimates show that nearly one in six, or 180,000 total children, are without health care coverage.
- Poor children are three times as likely as children who are not poor to have used hospitals as their usual source of care.[4]
- Two-thirds of uninsured children are eligible for public health care programs, but are not enrolled.
- The estimated cost of covering all children currently eligible but not enrolled in Medicaid and the Children's Health Plan Plus (CHP+) is approximately $142 million, or about one-eighth of the over $1.1 billion the Colorado Health and Hospital Association reported in uncompensated care (bad debt and charity care) for 2003.[5]
- Colorado accrued a reserve of $106 million from the federal CHP+ allotment by the end of the fiscal year 2005-2006.[6]

Legislative Recommendation 1A: Raise the Medicaid eligibility threshold for kids ages 6-18 from 100 percent to 133 percent of the federal poverty level (FPL) thereby creating a consistent standard of eligibility for all children.[7] Raising this income eligibility level would transfer 6,800 children from CHP+ to Medicaid. This move would result in a total cost savings for CHP+ of $9.9 million, of which Colorado would realize $3.5 million in savings with the remainder going to the federal government.[8]

Legislative Recommendation 1B: Expand the CHP+ parameters for eligibility to 300% of poverty level in order to provide insurance coverage to those children whose families are unable to purchase insurance through their employer or by other means. This change in policy would reduce Metro Denver child uninsured rates from nearly 16 percent to under 3 percent.[9] The Children's Agenda also supports ensuring the proven enrollment of at least 90% of eligible children living below 250% of the FPL as a step toward achieving the aforementioned recommendation.

Executive Recommendation 1C: Increase outreach activities and innovative methods of enrollment. The Colorado Benefits Management System (CBMS) must be either improved or replaced with an effective enrollment and management program. Online E-application[10] systems can then be used more effectively to streamline the enrollment process and reduce logistical barriers. New gateways, including existing community programs such as, schools, emergency and community health centers, homeless shelters, recreation centers and libraries should be expanded for enrollment, parent education, and care coordination. Finally, targeted culturally-appropriate marketing could continue to reach out to underserved populations and promote cost savings associated with prevention and early intervention.[11]

Legislative Recommendation 1D: Provide families with a "Buy-In" option to CHP+ on a sliding scale basis. The median household income in the United States is $46,326.[12] A family of four earning greater than $40,000 per year currently are denied access to CHP+. With fewer employers providing health insurance and increasing costs of private insurance, working families have limited access to affordable health care. Seven other states operate State Children's Health Insurance Program (SCHIP) Buy-In Programs: Connecticut, Florida, Maine, North Carolina, New Hampshire, New York and Pennsylvania. In a buy-in program, families with incomes in excess of SCHP eligibility limits are allowed to purchase insurance coverage for their children through the state's SCHIP program. Families pay for a significant portion, or all of the cost incurred.[13]

Improve the Quality of children's health care.

- Only 11 of 47 rural counties are served by an organized public health department that includes comprehensive health department services.[14]
- According to the Colorado Children's Healthcare Access Program (CCHAP), only 20 percent of private pediatricians and family physicians accept Medicaid or CHP+ patients due to poor physician reimbursement rates and difficulties with system issues.[15]
- In 2000, Colorado reported 25 percent of children were "lost" from the CHP+/Medicaid systems during the renewal time because their parents failed to respond to re-enrollment efforts.[16]
- 17 percent of children were denied for failure to comply with re-determination procedures.[17]

Legislative Recommendation 2A: Increase the reimbursement rate for physicians and primary care providers. The Children's Action Agenda and its supporters champion the recommendations developed through SB07-211 and the 208 Commission revising the statute to increase reimbursement rates to physicians for health services provided to children enrolled in the Medicaid program.

Legislative Recommendation 2B: Increase Medicaid and CHP+ retention rates through automatic renewal or a program of continuous eligibility. According to a study by the Commonwealth Fund, ensuring that every child below 200 percent of FPL maintained insurance for an entire year would amount to a reduction of over 48,000 uninsured kids in Colorado.[18]

Increase the Efficiency and Sustainability of children's health services.

- Cost-shifting associated with uninsured children is estimated to be about $79 million in 2005, including $50 million paid by business and $29 million paid by government.[19]
- Children in Denver and across Colorado are more likely to suffer from certain serious but preventable outcomes when compared with the national average.[20]
- Of the amount spent on health care each year, estimates are that up to one-third is wasted through fragmented, inefficient care.[21]
- Currently, The Children's Hospital (TCH) operates the only day treatment program able to meet the complex needs of children with developmental disabilities with co-morbid mental illness as well as children with neuro-psychological disorders. The Neuro-Psychiatric Day Program at TCH is only able to serve 6-8 children in their day program due to current funding limitations. The current waiting list of 15 children places these children at risk of long-term consequences due to lack of treatment. The out-patient psychiatric treatment clinic at TCH, which is uniquely qualified to meet the out-patient needs of these children, is currently not taking any new patients due to funding constraints.
- It has been estimated that 40% to 70% of individuals with developmental disabilities have diagnosable psychiatric disorders.[22]

- A comprehensive, coordinated approach to the complex treatment needs of these children is supported by, if not required by, the federal policy and requirements known as EPSDT. Medicaid-eligible children under age 21 are entitled to receive Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). *See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43),1396d(a)(4)(B), and 1396d(r).

Legislative Recommendation 3A: Implement and sustain statewide interoperable health information exchange through a non-profit organization that improves the health infrastructure and children's services through the application of technology. Following CORHIO's plan for a statewide system for electronic health information exchange used to promote and protect Coloradan's health and continuously improve the quality, cost-effectiveness and accessibility of health care services.[23] Amendment 35, approved by voters in 2004, imposed a significant tax increase on tobacco product sales. These new revenues provided an estimated $175 million, of which 19 percent goes to safety net clinics each year. Because applications required the inclusion of extensive data, safety net providers that lacked the technology to quickly collect and analyze vast quantities of information were largely unable to qualify for Amendment 35 funds.[24]

Legislative Recommendation 3B: Streamline application methods and simplify enrollment requirements. Utilize the information developed by SB07-211 and the recommendations of the 2010 Commission to create standardized forms and uniform application procedures to be implemented on a state-wide basis. A single state program to function as a delivery system for both programs will improve enrollment, management, and retention for children enrolled in public health programs. A centralized system would ensure families and children a common benefit package and comprehensive provider networks.[25]

Legislative Recommendation 3C: To provide comprehensive health care for children with complex needs: Require Health Care Policy & Financing (the state Medicaid agency) to develop a comprehensive plan that coordinates physical health, mental health, and dental care and is specifically designed to meet the needs of children with developmental disabilities who have co-morbid mental illnesses and children with neuro-psychological disorders (such as Autism and Tourette's Syndrome). Children with complex needs require immediate access to health care teams equipped to diagnose and treat the combination of developmental, physical and mental illness associated with their disorders, regardless of the cause and whatever the symptom. To be effective for children with complex needs, services must be integrated and coordinated across disciplines and systems. This new comprehensive complex children's health care plan must be developed with participation from community experts, family members, mental health consumers and advocates. Results of such coordination will facilitate access and reduce redundancies in services, improve total health care for children, and create greater efficiencies for both families and health care professionals.

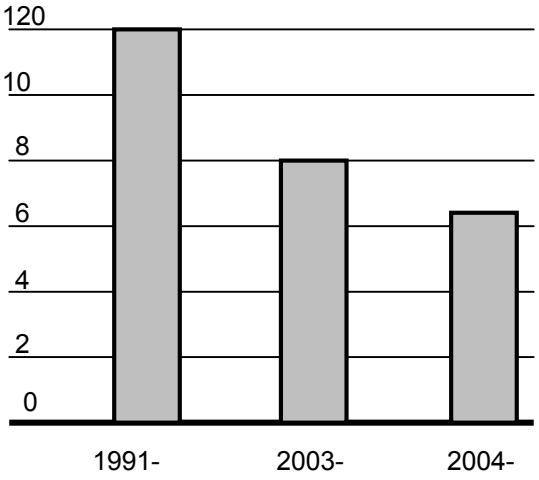
In the interim, all current Behavioral Health Organizations should be required to provide or arrange for the provision of appropriate Medicaid covered services to this population, and would be authorized to bill Medicaid on a fee-for-service basis for services it or its sub-contractors provide that are not covered by their current Medicaid contract. BHOs would be required to contract with and refer appropriate patients to The Children's Hospital for comprehensive services. Children's Hospital is currently the sole provider of coordinated mental and physical health services for children with complex and multiple needs, including children with developmental disabilities and/or neuro-psychological disorders.

Reduce Preventable Health Disparities that disproportionately affect ethnic and minority populations.

- According to CDC statistics, of children born in the US in 2000, the following are likely to develop diabetes at some point in their lives:[26]
- 31% of white girls and 27% of white boys
- 49% of African American girls and 40% of African American boys
- 53% of Hispanic girls and 45% of Hispanic boys.
- There are substantial racial differences in the prevalence of overweight children and adolescents associated with health insurance status.[27] 60% of overweight youth have one risk factor for coronary

heart disease, 25% have 2 or more risk factors. Short term consequences include hypertension, Type 2 Diabetes, and psychological effects, while long term implications involve an increased risk for some cancers, cardiovascular disease (CVD), and adult obesity.[28]

- In Colorado 14.8% of Hispanic children ages 2-14 are overweight.[29]
- In Colorado 80.8% of students do not eat the recommended five or more servings of fruits and vegetables per day.[30]
- It is estimated that increasing vegetable and fruit consumption may reduce cancer incidence by 6% to 28% and cardiovascular mortality by 6% to 22%[30] and may be associated with reduced adult cancer risk.[31]
- "Lowered sucrose, synthetic food/color/flavor, and 2 preservatives (BHA and HFT) over 4 years in 803 public schools was followed by a 15.7% increase in mean academic percentile rating…"[32]
- There is a direct correlation between physical activity, brain activity, and general health. Studies suggest that school recess has been shortened on average by forty percent over the past decade.[33]



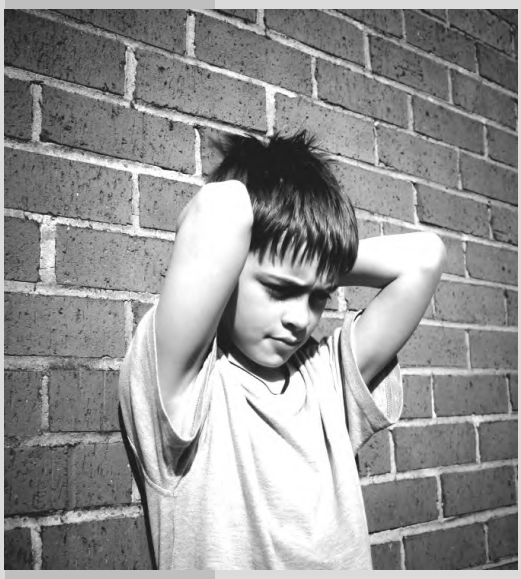
RECESS IN DENVER PUBLIC SCHOOLS

Legislative Recommendation 4A: Increase state funding for reimbursable school meals to 21 cents -- Colorado currently spends 4 cents. This would enable Colorado to supplement the actual costs of operating a school breakfast and lunch program. Nutritional guidelines for school lunches and breakfasts should be re-determined at this time.

Legislative Recommendation 4B: Match Federal Financial Participation dollars from the US Department of Agriculture's Food Stamp Program with state contributions to create innovative partnerships among community-based organizations and school districts. This recommendation is modeled on the California Nutrition Network for Healthy, Active Families (Network), www.dhs.ca.gov, which assists local public entities to enhance their nutrition education programs and promote physical activity and a healthy lifestyle for low-income parents and children. A three-year CATCH study demonstrated that improved diet and physical activity initiated in the elementary school years promoted behavioral changes that persisted to early adolescence.[34] Eliminating health disparities decreases significant costs associated with treating diseases that minority and ethnic groups experience at a higher rate than Caucasians.

- **Executive Recommendation 4C: Revise Colorado's education standards to reflect the importance of recess and physical activity. Standards of play and exercise should be enforced through district accreditation contracts. Studies spanning four decades have established incontrovertibly that creative play is a catalyst for social, emotional, moral, motoric, perceptual, intellectual, linguistic, and neurological development.[35] The National Association of State Boards of Education recommends 150 minutes per week of PE for elementary students and 225 minutes per week for middle and high school students.[36] Protecting children's play time costs nothing, and supports the physical and mental health of our children.**

Brady's Story/ Robin Bolduc, Boulder, CO



Our son, Brady, was involved with Child Protective Services prior to his birth and continuing until our family adopted him in March 2007. At the time Brady was placed with us in 2005, he had multiple placements due to his escalating behavior - with his mother who is developmentally disabled and mentally ill, his aunt, and several foster homes. He was diagnosed with mild developmental disabilities and PTSD and provided weekly (sporadic) play therapy with a student intern. Upon entering our home, we noticed that Brady consistently made "odd" noises. He had been punished for his constant noises (barking) and inability to focus for more than a few seconds. We immediately requested an evaluation at Children's Hospital Special Care Clinic where he was diagnosed with Tourette's Syndrome, Intermittent Explosive Disorder, OCD, PTSD, and mild-moderate developmental disabilities as well as several medical conditions including severe reflux, esophageal strictures, scoliosis, hearing loss, malformation of his mouth, dental problems, just to name a few. He was put on medication, we addressed his physical needs, we discontinued services through our BHO and his behavior began to stabilize.

During a weekend in early 2007, Brady became extremely violent in our home and I called the MHC of Boulder/Broomfield crisis line. I was advised that they did not treat children with developmental disabilities - at this time, Brady was punching, kicking, taking pictures off the wall and throwing them, threatening me with a knife, and digging scissors in his mouth in order to pull out his teeth. MHC suggested that I take him to our local community hospital and have an evaluation done to determine whether Brady's behavior was due to his developmental disabilities or mental illness. I asked who would evaluate him and make that determination since no one from MHC had seen him in several years and since Children's Hospital had determined that his behavior was a result of multiple issues which were part of a whole package. My experience with my other foster children has been that mental needs are considered developmental disability related and care is refused. Instead, we opted to have Brady taken to Children's Hospital via ambulance. When Children's called MHC, they were told that they would not authorize a hospitalization since they held no contract with Children's. They offered no alternative - but left open the possibility of Fort Logan (which does not have a hospital to address his medical needs and has never seen him before). We were able to "stabilize" (tranquilize) Brady to allow me to address his issues during weekday business hours. It was from sheer determination, an in depth understanding of the system, and my contacts in the field that we were eventually able to develop a single contract for Brady at Children's Hospital in the Neuro-Psych day treatment program.

During his stay at Children's, our family was trained in a behavior program that greatly reduced his outbursts. Several medical conditions (including an abscessed tooth) were also identified and treated. Brady was stabilized both mentally and physically. Today, Brady is a happy, pleasant little guy. I can't even remember the last time that he had a meltdown. Brady continues to be seen at the Children's outpatient clinic.

The difficulty in treating children with multiple diagnoses is accessing both physical and mental health care needs at the same time. I have to call each clinic individually to get an appointment, and fill out paperwork with the same information for many of the clinics including: Special Care Clinic, Dental Clinic, Rehab, GI, Neurology, Nutrition, Metabolic Disorder, Clef Palate, Audiology, and Orthopedic. Billing policies disallow payment for physical and mental health services given in the same day. There is a shortage of mental health providers uniquely qualified to meet the needs of children with complex and multiple needs, including low-incidence disabilities such as Autism, Tourette's Syndrome, and other neuro-psychological disorders. As a result, there are too few programs and facilities, and children in crisis are being placed inappropriately, or too often denied any placement at all. Neglecting the children who are at the greatest risk has ramifications for teachers, doctors, families, case-workers and the future of these children. We simply can't afford to continue to do nothing and neither can they.

[1] All Colorado Kids Covered: A Roadmap to Coverage by 2010 (2010 All Colorado Kids Covered Work Group), p.6.

[2] Colorado State Legislature, SB07-211, <http://www.leg.state.co.us/CLICS/CLICS2007A/csl.nsf/fsbillcont3/1AF412833E6BDC7387257251007B87E1?Open&file=211_enr.pdf>.

[3] Colorado State Legislature, SB07-130, <http://www.leg.state.co.us/CLICS/CLICS2007A/csl.nsf/fsbillcont3/0D6C0763661C3BB3872572600080A512?Open&file=130_enr.pdf>.

[4] Colorado Children's Campaign, Fulfilling the Promise: Opportunities and Strategies for Insuring Colorado's Kids, p. 3 citing US Department of Health and Human Services, Centers for Disease Control and Prevention, Summary Health Statistics for US Children: National Health Interview Survey, 2005, <http://www.cdc.gov/nchs/data/series/sr_10/sr10_231.pdf>.

[5] Colorado Children's Campaign, Fulfilling the Promise, p. 11 citing Department of Health Care Policy and Financing. Supplemental/Budget Amendment Request. February 15, 2006.

[6] Colorado Children's Campaign, Fulfilling the Promise, p. 6.

[7] All Colorado Kids Covered: A Roadmap to Coverage by 2010 p. 13.

[8] Colorado Children's Campaign, Fulfilling the Promise, p. 14.

[9] Kids' Health Care Access: Diagnosis and prescription for Improvement, (Caring for Colorado Foundation, The Colorado Health Foundation, The Colorado Trust and Rose Community Foundation.) <http://www.coloradohealth.org/pdf-public/KidsHealthNow-FinalFullReport-2-2007.pdf>, February 2007.

[10] Joanne Lindsay, Colorado Department of Health Care Policy and Financing, June 27, 2007.

[11] *Health Care Access: Diagnosis and prescription for Improvement.* "Education and Outreach" p. 9.

[12] Health Care Twenty Years From Now: Taking Steps Today to Meet Tomorrow's Challenges, (The United States Government Accountability Office), September 2007, <http://www.gao.gov/new.items/d071155sp.pdf>.

[13] Colorado Children's Campaign, Fulfilling the Promise, p. 15

[14] All Colorado Kids Covered, p. 6.

[15] Berman, S., Brock, C., Armon, C., & Todd, J., "Factors Influencing Access to Healthcare for All Colorado's Children, 2000-2003," State of the Health of Colorado's Children, 2004.

[16] Colorado Children's Campaign, Fulfilling the Promise, p. 12.

[17] Colorado Children's Campaign, Fulfilling the Promise, p. 12.

[18] Colorado Children's Campaign, Fulfilling the Promise, p. 12.

[19] Colorado Children's Campaign, Fulfilling the Promise, p. 9.

[20] Kids' Health Care Access. p. 3.

[21] Colorado Children's Campaign, Fulfilling the Promise, p. 18.

[22] Szymanski L., Malow L., Mallory G., et al. Psychiatric services to adult mentally retarded and developmentally disabled persons (Report of APA Task Force #30). Washington, DC: American Psychiatric Association; 1990

[23] CORHIO Colorado Regional Health Information Organization 1576 Sherman Street Suite 300, Denver Colorado 80203, "Colorado's Strategy to Achieve Statewide Interoperability," <http://www.corhio.org/Portals/0/HITResources/CORHIO%20Preez%20to%20Health%20Care%20Task%20Force%2009-11-07.pdf>.

[24] Health Information Technology: A Strategy for Creating a Healthier Colorado, (The Colorado Health Foundation,), February 2007.

[25] Colorado Children's Campaign, Fulfilling the Promise, p. 18.

[26] Narayan,KMV, Boyle, JP, Thompson, TJ, Sorenson, SW, Williamson, DF., "Lifetime Risks for Diabetes mellitus in the United States," JAMA, 2003; vol. 290, p. 1884-90.

[27] Childhood Obesity: Advancing Effective Prevention and Treatment, (National Institute for Health Care Management Foundation (NIHCM)); Action Brief Nov 2003.

[28] Childhood Obesity: Advancing Effective Prevention and Treatment, (National Institute for Health Care Management Foundation (NIHCM)); Action Brief Nov 2003.

[29] Alyson Shupe, Ph.D, Colorado Department of Public Health and Environment, Health Watch 2006, No. 60. Health-Related Behaviors of Colorado Adolescents: Results from the Youth Risk Behavior Survey, 2005..

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[34] Three-Year Maintenance of Improved Diet and Physical Activity, the CATCH cohort, (American Medical Association), Vol. 153, July 1999.

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[36] "Healthy Schools: Sample Policies to Encourage Physical Activity," (National Association of State Boards of Education), <http://www.nasbe.org/HealthySchools/Sample_Policies/physical_activity.html>.