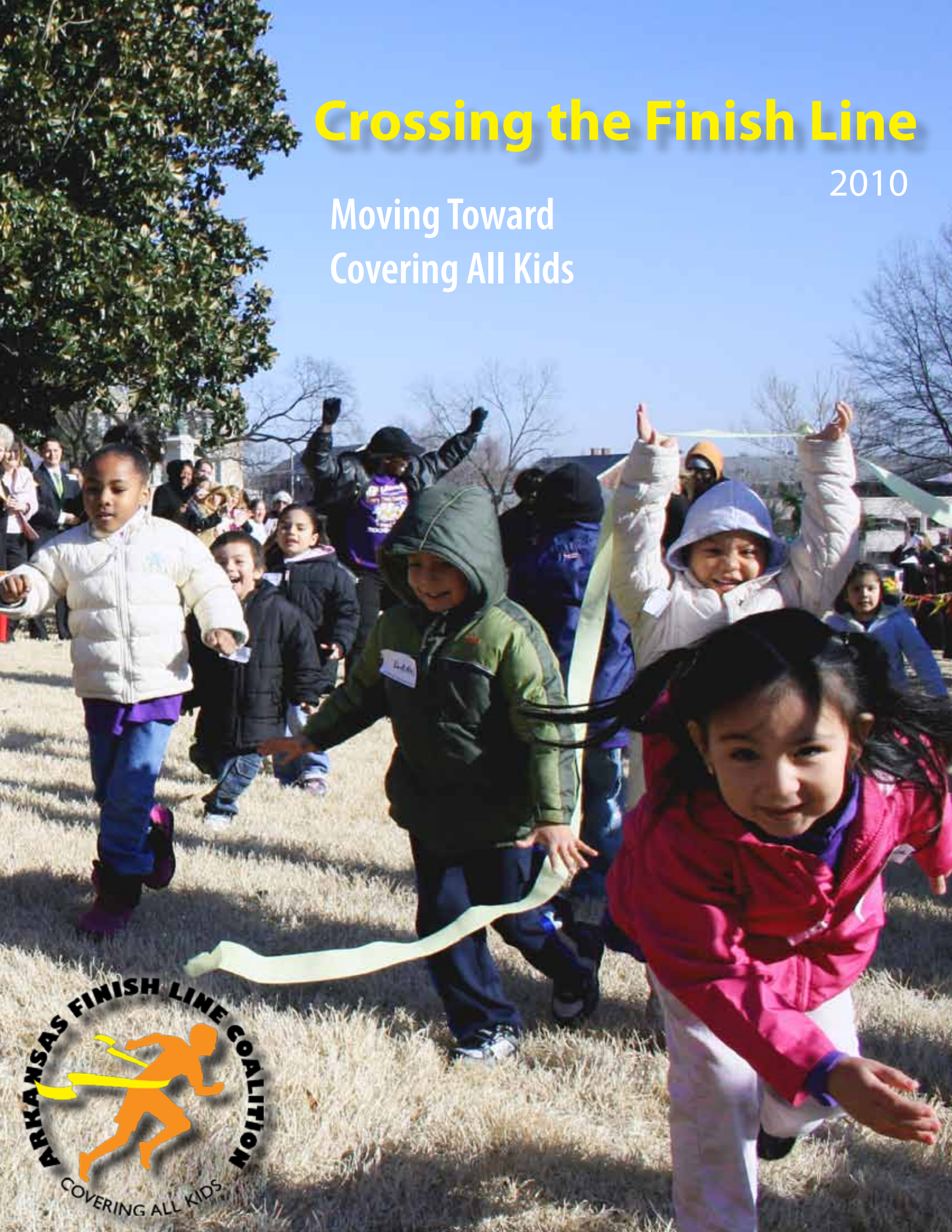
# Crossing the Finish Line

2010

## Moving Toward Covering All Kids



ARKANSAS FINISH LINE COALITION

COVERING ALL KIDS

## May 2010

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Thanks to children of Head Start in Little Rock for participating in the Arkansas Finish Line Coalition's Race to the Finish Line in February 2009. Photos by Tara Manthey.

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# Crossing the Finish Line 2010: Moving Toward Covering All Kids

## 2010 STATE OF CHILDREN'S HEALTH INSURANCE IN ARKANSAS

By ELISABETH WRIGHT BURAK

Health Policy and Legislative Affairs Director, AACF

## Summary and Introduction

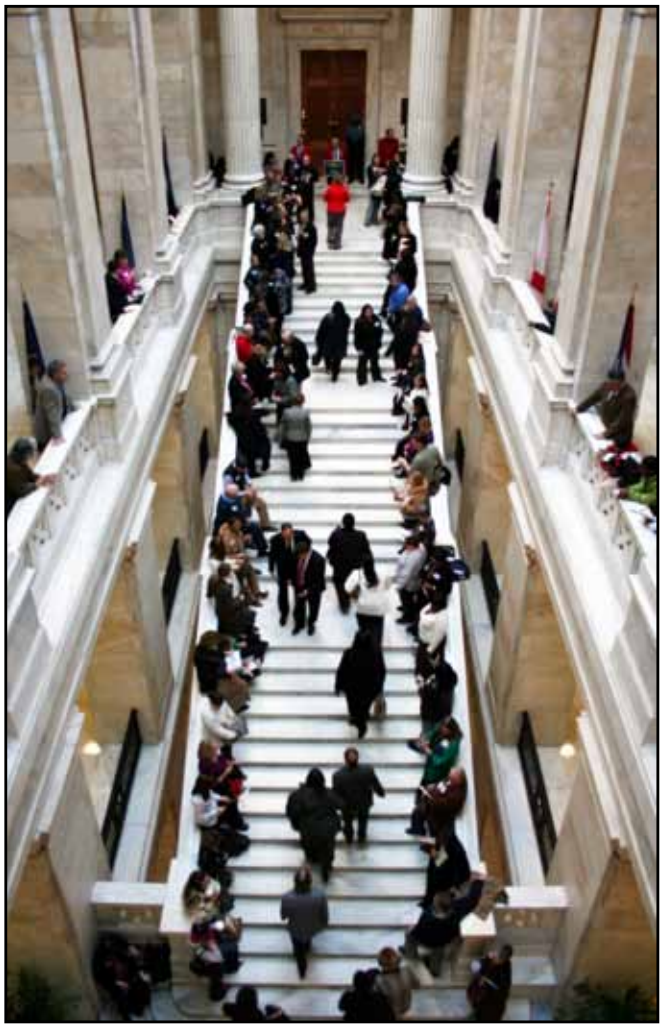
In 2009, federal and state leaders paved the way to cover more children and showed a strong commitment to protect and promote children's health. President Obama signed the Children's Health Insurance Program Reauthorization (CHIRPA) just as Arkansas lawmakers approved a 56 cent tobacco tax increase. Among other important health programs, the money would support an expansion of ARKids First, making thousands more uninsured Arkansas children eligible for coverage.

Yet the recession threatens progress. Because of rising health care costs and increased need, Arkansas Medicaid must reduce spending by as much as $400 million, including $100 million in state dollars and a loss of roughly $300 million in federal matching funds. But unlike the state, families have no reserves and no more room to cut. Arkansas families need help now more than ever as they lose jobs and insurance or see benefits cut due to rising premiums.

The state can still improve kids' health and help their families weather the financial storm while we wait for a better economy and full implementation of national health reform. We have the tools today to invest in children and set the stage for a healthier and more productive workforce now and years down the line. Lawmakers and agency leaders should join other states in making children and families a priority when they need this help the most. We must:

**Extend ARKids First to thousands more Arkansas children.** Families just over the income threshold need the coverage they were promised now more than ever. While the state budget is tight, family budgets are far worse off. Unlike the state, families don't have reserve funds or options to raise revenue to make ends meet. Policy makers should keep the tobacco tax funds promised to the ARKids First expansion, sign on the dotted line with the federal government and make ARKids First a reality for the families who need it now, by:

- Implementing the new eligibility levels passed in the 2009 legislative session.
- Taking advantage of significant new federal support to help legal immigrant children.



**Remove red tape to enroll children who already qualify for ARKids First but aren't signed up.** Two out of three uninsured children in Arkansas are eligible today for ARKids First but aren't yet signed up or are dropped for not promptly re-enrolling each year. Roughly half of children who leave ARKids First every year drop off because of paperwork and processing, not necessarily changes in a family's eligibility for the program. CHIPRA gives states new options and tools to make enrollment and re-enrollment easier for families:

- Offering 12-month continuous coverage for ARKids First A to minimize interruptions in care.
- Accelerating enrollment through immediate eligibility for children who likely qualify.
- Collecting and reporting data on outreach efforts to determine how children enroll, who enrolls them and shine a light on what works.
- Developing a comprehensive ARKids First outreach plan.

These strategies are discussed later in this report.

**Attract more health professionals to ARKids First to ensure kids get the care they need.** An ARKids First card is a critical step for families trying to get medical care for their children. But it does not necessarily guarantee that a health care provider will be available when they are needed. Every child needs a medical home—a place where they get regular care. The shortage of family practitioners, pediatricians and other primary care providers is a challenge that Medicaid cannot address alone. The Arkansas Department of Human Services (ADHS) should work with other stakeholders to develop a comprehensive plan to meet the shortage in the short- and long-run.

2009 saw gains in kids' coverage, but it wasn't enough. Struggling families can't wait any longer. It's time to cross the finish line and cover all Arkansas children.


## What a Difference A Year Can Make!

Before 2009, Arkansas was already seen as a leader in children's coverage. We cut the rate of uninsured kids by more than half since ARKids First was created in 1997 before the State Children's Health Insurance Program (now known as CHIP) was established at the federal level. In 2009, many federal and state actions paved the way to cover more children, highlighting a strong commitment among lawmakers to protect and promote children's health.

**The Children's Health Insurance Program (CHIP) was reauthorized with sufficient funds and new incentives for states to enroll all kids and keep them enrolled.** On February 4, 2009, President Obama signed the Children's Health Insurance Reauthorization Act (CHIPRA). The act continued and expanded funds to states to maintain and expand their children's health insurance programs. CHIP supports ARKids First B for low-income children who are not eligible for Medicaid, known as ARKids First A (see Appendix B) in Arkansas. Unlike Medicaid, CHIP gives states an annual allotment, or ceiling, that cannot be exceeded. Under CHIPRA, the Arkansas cap grew to $134 million for the 2009 federal fiscal year, an increase of 165 percent from before CHIPRA.[1] But while the allotment for Arkansas and other states has increased, the state cannot access funds without matching contributions by 19 percent. In fact, in the 2009 federal fiscal year (October 2008 to September 2009), Arkansas only spent 59 percent of its allotment.[2] In addition to the much-needed guarantee of federal funding, CHIPRA made enrolling children and keeping them enrolled a major priority, giving states new options and tools to get children in the door and keep them covered.

*Incentives to enroll eligible children and keep them enrolled.* The new law provides bonus payments to states that adopt at least five changes to make the enrollment and re-enrollment process easier for families.[3] The bonus payments are given for meeting targets in enrollment and re-enrollment of eligible children. Thus, states are no longer faced with hitting the federal matching cap and paying more in state funds when they successfully enroll or retain children. Instead, CHIPRA rewards states that use funding to successfully cover eligible children. Arkansas has already made some of these changes to simplify the process for families: eliminating the face-to-face interview requirement, providing a combined Medicaid/CHIP application and removing asset requirements. To be eligible for a bonus, Arkansas would need to also implement at least two of the following changes to ARKids First:

• Express Lane enrollment would allow the state to approve an ARKids First application when a family meets requirements for other state and federal programs such as school meals. Arkansas does this to some extent when re-determining whether families are eligible for food stamps, now known as the State Nutrition Assistance Program, or SNAP.

• Presumptive eligibility would allow immediate enrollment in ARKids First if families meet a pre-determined threshold based on clear, well-defined criteria. Normally it takes up to 45 or more days (usually less, according to ADHS) for eligibility to be processed for ARKids First. This would allow children to receive coverage immediately and decrease the chance that a family's application would fall through the cracks.

• Paperless or administrative renewal to verify whether a family continues to be eligible. Rather than put the onus on families to return a mailed form or call a number, this would rely on administrative databases (such as income through workforce databases) to determine eligibility when a family must renew. Parents would only be required to submit information if income or other changes occured.

• Twelve-month continuous eligibility for ARKids First A (traditional Medicaid for children). ARKids First B already provides 12-month continuous enrollment for children. This means that regardless of income changes, which are generally insignificant, a child remains on ARKids First for an entire year until eligibility is reviewed at the annual renewal. Families on ARKids First A only renew once a year, but are required to report income changes that may affect coverage as soon as they occur. In addition to ensuring that children have continuous coverage and care, offering 12-month continuous coverage for both ARKids First programs can save administrative costs when children don't churn on and off the program.

*Federal grants of $40 million annually to improve community-based outreach.* Grant money supports demonstration projects in states and communities using innovative, data-driven approaches to community-based outreach. The Community Clinic at St. Francis House in Northwest Arkansas received $163,000 to implement a community outreach project with an emphasis on reaching eligible Latino and Marshallese children and their families. The clinic developed a community-based outreach plan that will increase enrollment in ARKids First and Medicaid and improve access to culturally and linguistically appropriate preventive and primary health care.

*New support to help legal immigrant families.* CHIPRA now allows states to cover legal immigrant children. Before CHIPRA, only U.S. citizens and some undocumented immigrants (e.g. pregnant women) could receive coverage under Medicaid or CHIP. Legal immigrant children could only access federal Medicaid or CHIP once they lived in the U.S. for five years. The new law allows states to eliminate this five-year waiting period and use federal funds to cover legal immigrant children. The law also boosts federal reimbursement rates[4] for translation services to better serve non-English speaking families. The improved rate applies not only to enrollment and re-enrollment, but also to translation services for medical, dental and mental health office visits and outreach and educational materials for families.

*Option for states to create dental-only benefits packages.* Finally, CHIPRA acknowledges that many insured children are underinsured, with limited access to other services that are equally as important as primary healthcare. The law gives states the option to create dental-only benefits for children who have insurance that does not cover dental health.[5]

**Uninsured children and their families win at the state capitol.** In 2009, lawmakers and child advocates agreed that more children needed health insurance to improve health and protect family finances. During the 2009 legislative session, Gov. Mike Beebe increased the number of children eligible for ARKids First in his comprehensive health care proposal by increasing the family income limit from 200 percent to 250 percent of the federal poverty level (FPL) (See Appendix B). On Feb. 5, the Arkansas Finish Line Coalition rallied at the capitol to support the proposal. Parents and grandparents told stories of how ARKids First made a difference to their families while preschool

children participated in a race to the finish line to cover all kids. That same day, the Arkansas House of Representatives rose to the occasion, passing a 56 cent tobacco tax to pay for the health care package with the required a three-fourths vote of the chamber. The measure was passed by the Senate on Feb. 12 and signed by Gov. Beebe a few days later. Despite this important victory, the recession and slow negotiations between the state and federal governments have delayed the expansion by more than a year.

**Families face less confusion when applying for ARKids First.** In April 2009, the Arkansas Department of Human Services made the application process one step easier for families. Previously, each family applying for ARKids First was asked to select whether they preferred ARKids First A or ARKids First B for their child. ARKids First A, or traditional Medicaid, offers very comprehensive benefits for lower-income families, mostly with incomes under 100 percent of the federal poverty level.[6] ARKids First B is available for low-income families whose incomes exceed the limit for ARKids First A. ARKids First B offers a smaller benefits package, as well as co-pays of $10 or more for some services and prescriptions (refer to Appendix A). Inevitably, some poorer families opted for the less robust benefits package and higher co-pays with ARKids First B, even though they were eligible for A. Families are no longer asked to choose between A and B in their application. Instead, children are automatically enrolled in the program with the best benefits available to their income level. Once enrolled, families then receive information on exactly what benefits their child can receive.

**Health reform proposals would give all kids—and their parents— an insurance card.** While state lawmakers and advocates were helping working families at the state capitol, the Obama Administration and U.S. Congress began addressing national health reform. The goal: expand coverage options to all Americans, make coverage more affordable and accessible to all families and curb the ever-rising costs of health care. The final bill, signed by President Obama on March 23,[7] would ensure some type of affordable coverage for every child and many of their parents, either through Medicaid or financial supports to purchase private insurance.[8] Some parts will not take effect until 2014, but a number of important changes will take effect in 2010. That includes: a ban on insurance companies will denying coverage to children with pre-existing conditions (which will also eventually also apply to adults). Also, young adults can remain on their parents' health insurance plan up to age 26.

## Hillary's Story

Without ARKids First, six-year-old Beau and three-year-old Avery would not have health insurance—even though their father's employer provides a private health insurance option.

"We checked into it, it was like $560 every three weeks for coverage for the kids through his private insurance," said their mother, Hillary. "That's more than a week's pay, almost as much as two weeks' pay. We wouldn't be able to afford it."

Both children have chronic asthma and allergies. Just one of their regular medications would cost more than $300 per prescription without insurance. Surgeries for ear infections, adenoid and tonsil removals – all would have been too expensive for the family on their own.

"I don't know that we would even be able to take them to the doctor to get them diagnosed," Hillary said.

Hillary and her husband have struggled with an onslaught of challenges: the closure of their family business, Hillary's diagnosis of cervical cancer and most recently, a fire that burned their family home. Knowing their children's health is taken care of provides rare peace of mind.

When the house was destroyed by fire, the children "lost their Nebulizer, they lost all their medication and ARKids had it replaced the next day," Hillary said.

"It really is a blessing," she said.

## Many Families Still Wait for Affordable Coverage and Care

While we have made important progress—ranking in the top half of states for our low rate of uninsured children[9]—many children still need coverage.[10] Declining state revenues are giving some lawmakers second thoughts about moving forward with the planned ARKids First expansion, despite the fact that it is a popular and effective program. National health reform won't go into full effect for several years. Meanwhile, the rate of uninsured children in Arkansas is unchanged, but some kids are better off than others.

**ARKids First is doing its job, providing support to thousands of families during the financial crisis.** The recession hit Arkansas later than other states, but by mid-2008, Arkansas began to feel the slowdown. ARKids First lessened the blow and offered health insurance stability for the many families facing layoffs, insurance cuts and unaffordable health insurance. Between July 2008 and December 2009, enrollment of children in ARKids First and Medicaid increased by more than 8 percent, providing over 30,000 more uninsured children with care (see Table 1 below). The program has provided consistent support to families during this time of need, and prevented many of them from financial disaster due to high medical bills. Appendix C at the end of the report shows county-level enrollment as of January 30, 2010 for ARKids First A, ARKids First B, and other Medicaid categories serving children under 19; Appendix D shows county-level growth in ARKids First and Medicaid enrollment among children under 19 between July 2008 and January 2010.

Enrollment increases, especially among the lowest-income, or ARKids First A eligible children, mirror the decline in uninsured children under 200 percent of the federal poverty level in 2008. The state's rate of uninsured children remained steady at 9 percent, yet the percentage of uninsured children under 200 percent FPL actually decreased. Yet, while total enrollment is up, enrollment in ARKids First B has decreased by 5 percent. This likely reflects the fact that family incomes have decreased with the recession, thereby making them eligible for ARKids First A. But it also suggests more can be done to ensure that eligible families over the poverty line know about the availability of ARKids First B through improved outreach.

**Table 1: Growth in Medicaid Enrollment Among Children Under Age 19 Since July 2008**

| Category | July 2008 | Jan. 2009 | July 2009 | Jan. 2010 | Percent change since July 2008 |
|---|---|---|---|---|---|
| ARKids First A | 225,162 | 236,129 | 257,278 | 257,507 | 14.37 % |
| ARKids First B | 74,557 | 70,604 | 66,242 | 70,530 | -5.4 % |
| Other Medicaid categories | 67,840 | 69,324 | 70,406 | 70,772 | 4.32 % |
| Total all categories | 367,559 | 376,057 | 387,926 | 398,809 | 8.5 % |

Source: Monthly snapshot data from ADHS Division of County Operations.

**More and more children just over the ARKids First income limit have no affordable insurance options.** Between 2006 and 2008, an additional 2,000 children between 200 percent and 250 percent of the federal poverty level were uninsured, increasing from 9 percent to 14 percent, for a total of 9,000 children in 2008. This is the highest percentage of uninsured children at this income level in ten years.

Since ARKids First was created, the rate of uninsured families just over the ARKids First eligibility line saw the smallest decline compared to children in other income levels (Figure 1). The rate of uninsured children in this income range is increasing as the overall rate of uninsured children remains constant (Figure 2). Between 2007 and 2008, the number and percentage of uninsured children at every income level decreased, except children between 200 percent and 250 percent of the federal poverty level.

## Mothers like Tina Need ARKids First for their Children Now

Tina watches with extra care when her daughter goes out to play. She can't afford not to worry.

"I am so over-protective that I have to watch her closely to make sure she doesn't do anything that may cause her to get hurt," she said, "because I cannot afford to go to the emergency room."

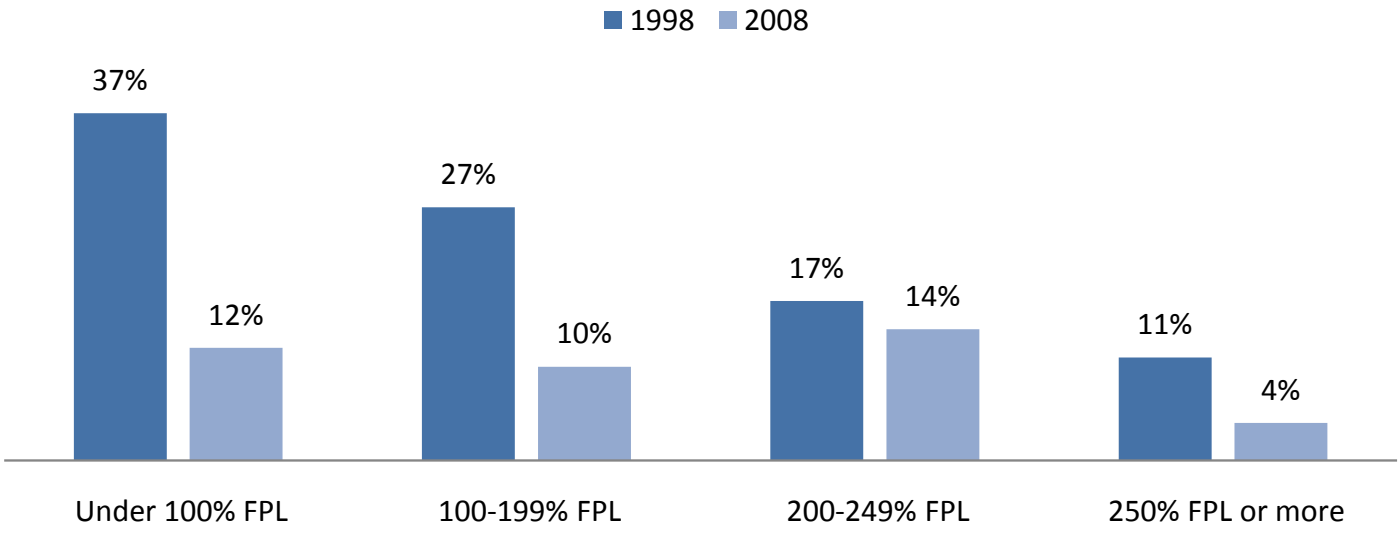
A single mother of two, Tina lost her job in 1996 but was able to still provide coverage for her 9-year-old daughter through ARKids First. During that time, Tina's daughter had to have her tonsils and adenoids removed, several hearing tests performed to make sure her permanent hearing was not damaged, and she suffered a sprained ankle. ARKids First covered the majority of the cost.

"Without this coverage, there is no way in the world, as a single mother, that I would have been able to get all of these medical concerns taken care of," Tina said.

Since then, Tina has found a job. However, she no longer qualifies for ARKids because she earns $36,000 annually. She has insurance through work but the rates are unaffordable. She doesn't have the extra $300 a month. Under the ARKids First expansion, Tina would re-qualify for the program and be able to provide coverage for her family.

"I struggle to pay my bills as it is," Tina said. "I don't know who sets the eligibility guidelines but they need to be reassessed. Try to survive, pay all the bills, and still be able to afford medical insurance … I cannot wait to get her covered again."

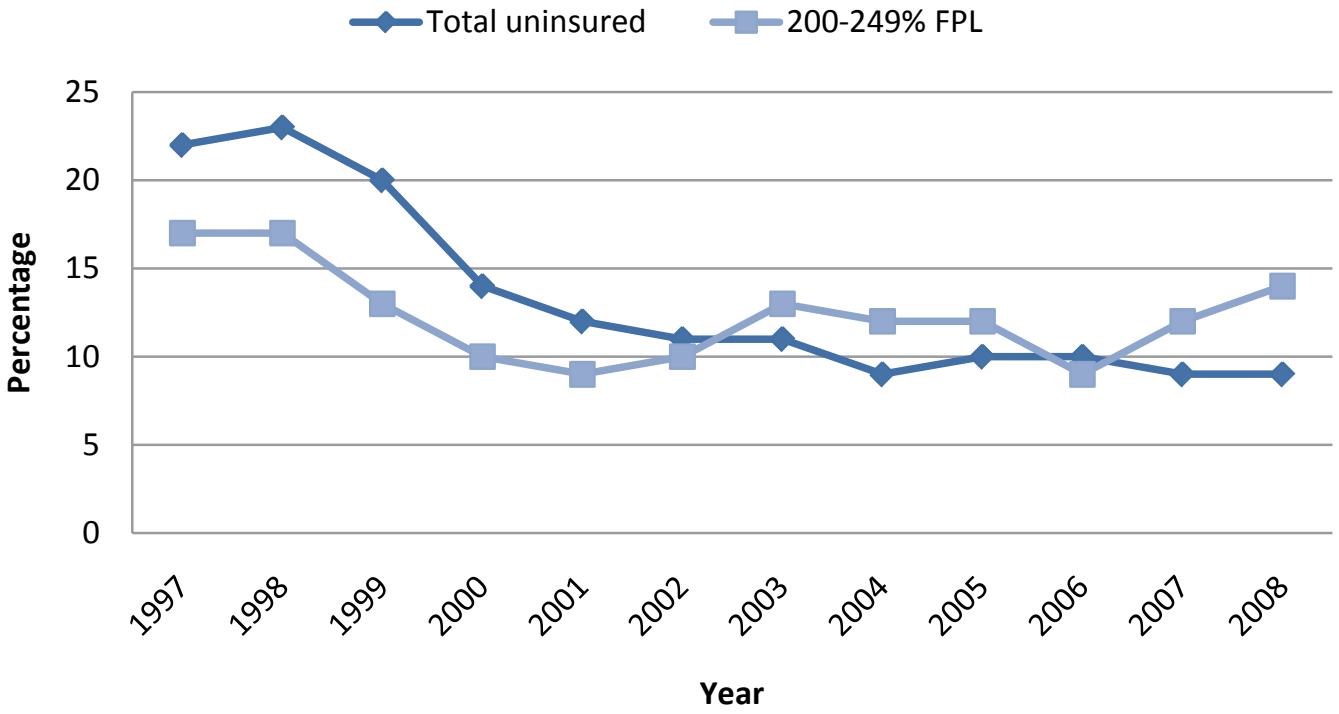
**Figure 1: Percent Change in Uninsured Children by Poverty Level**
Children between 200 % and 250% FPL see the smallest decline




Note: Percentages in this table show the percentage of uninsured children within each income level, not percentage of all uninsured children. Source: Analysis of Current Population Survey data by the Annie E. Casey Foundation, using three-year rolling averages.

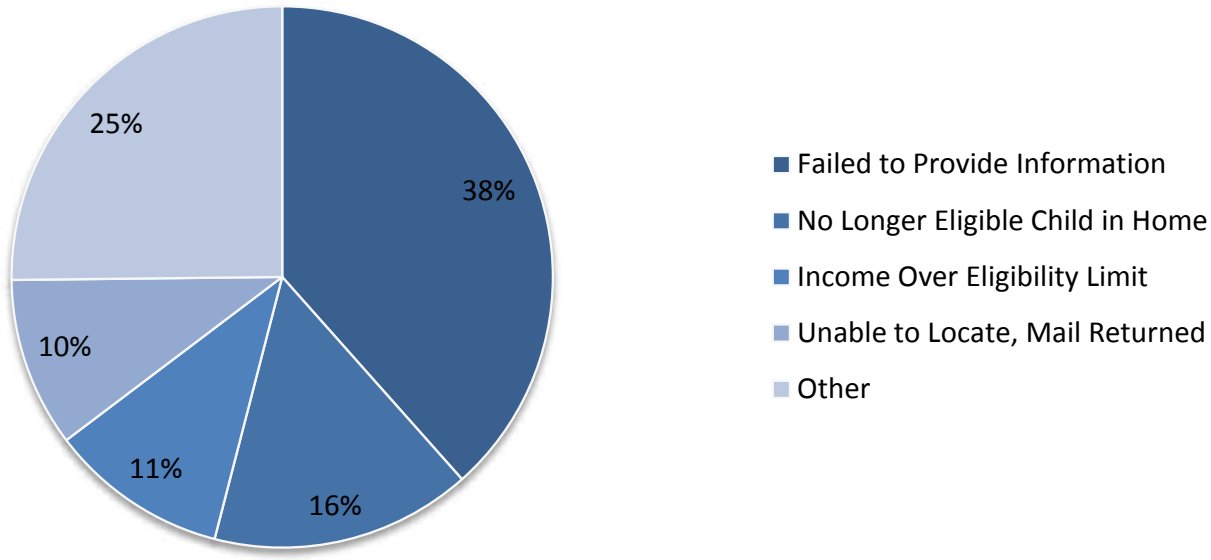
**Figure 2: Uninsured Children Under Age 19 in Arkansas**

Children between 200% and 250% FPL increasing as overall rate declines




Source: Unpublished reports from the Annie E. Casey Foundation with Current Population Survey (CPS) data on uninsured, using a three-year rolling average.

**Figure 3: Top Reasons for Case Closures ARKids First A and B in 2009**




Source: Monthly closure data from DHS Division of County Operations

**Bureaucratic red tape drops many children off ARKids First who still qualify.** Many children fall through the cracks during re-enrollment for ARKids First because of paperwork and procedural requirements, not changes in eligibility. ARKids First requires families to re-enroll in the program each year by returning a form mailed to the home address on record. Between 2007 and 2009, roughly half (49 percent) of children leaving ARKids First rolls were dropped for paperwork or procedural reasons—like when a family does not return a renewal form or has moved without a forwarding address. On average, more than 20,000 children between 2007 and 2009 lost ARKids First coverage not necessarily because they were no longer eligible, but because their parents did not return a form or provide other information. For families whose children receive ARKids First B, which provides benefits for higher income families, even more children were dropped (57 percent) for paperwork or processing reasons. It is likely that many of these children lost their insurance coverage during this critical renewal period.[13] The result is that thousands of children are dropped and lose continuity and consistency of their health care, not to mention the added administrative cost to the state of processing the children time after time.

Complicating these data trends are questions about exactly why cases are closed or denied. Thanks to efforts to simplify the enrollment process in the early 2000s, families are required to give little, if any, information about their income or eligibility. ADHS caseworkers take income information from the ARKids application and verify it against state administrative databases. For example, a pay stub is not required for an ARKids First application. Also, first-time and renewal applicants are not required to have face-to-face interviews for ARKids First. However, some of the reasons cited for closure of a case or denial include "failed to attend interview" or "failed to provide information."[14] This raises questions about whether caseworkers are asking for information that is not required to apply for, or renew, ARKids First. It also raises questions about whether caseworkers are adequately trained on ARKids First eligibility and how to code closures and denials. Data on case closures alone cannot answer these questions, but they highlight the need for further discussion and research.

Arkansas does well when it comes to the overall closure rate. While the state has work to do to minimize case closures due to red tape, overall we have fewer closures than other states. In 2009, 14 percent of ARKids First cases were closed compared with as much as 33 percent in other states.[15] With new priorities and investments under CHIPRA, states are putting energy into improving recipient retention. ADHS also has several initiatives that could impact the state's ability to enroll eligible children and keep them enrolled.

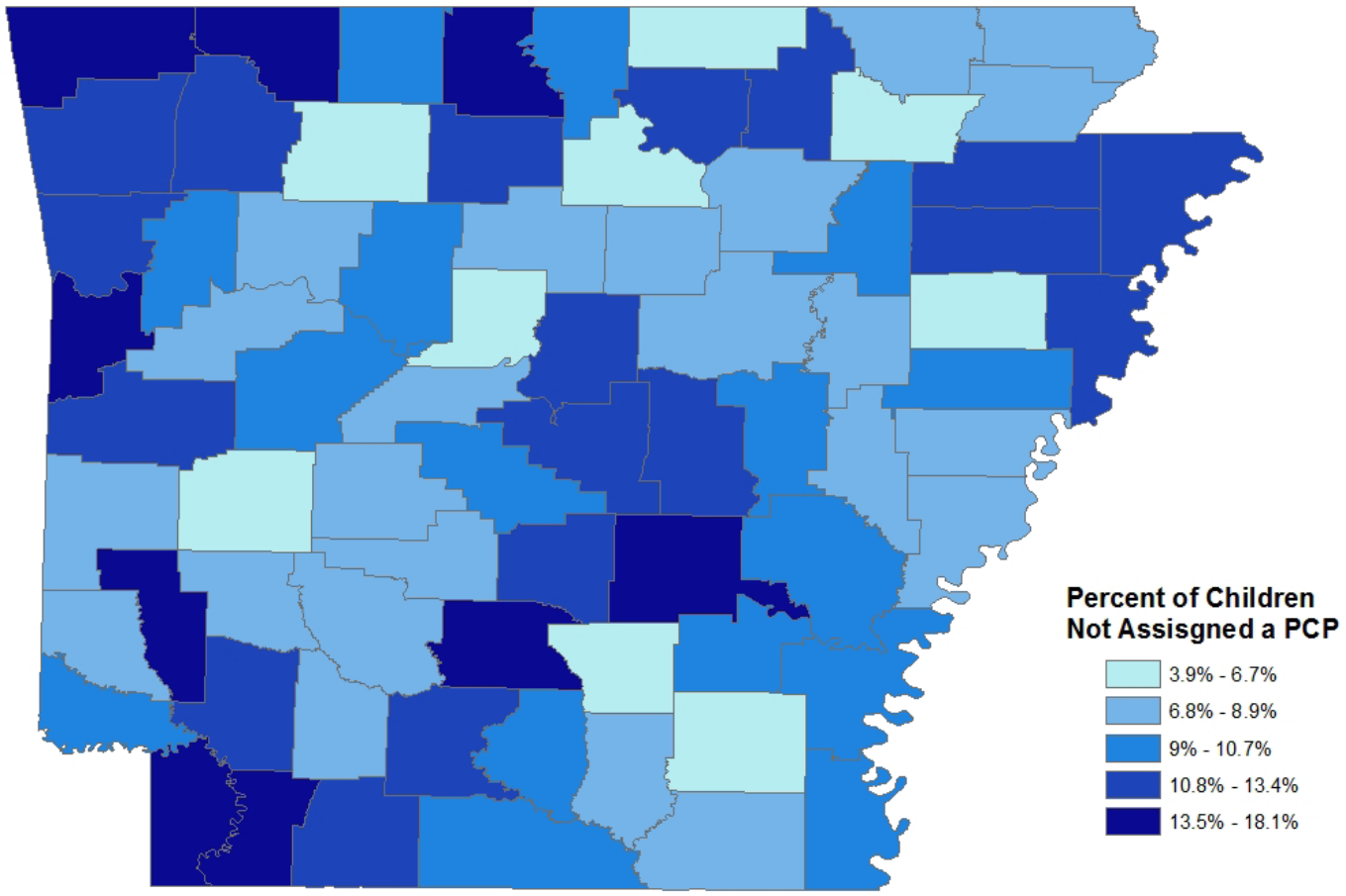
- *ACCESS Arkansas*[16] is an online screening and enrollment tool that families can use now to apply for ARKids First, along with a number of other ADHS programs and services, at https://access.arkansas.gov. With very little advertising, ACCESS Arkansas has already been used to process many enrollees for ARKids First. Over the coming years, ADHS will expand the initiative to include processing centers so that families have multiple ways to enroll and re-enroll: online, by phone, in person or by mail.

- *Electronic Health Information Exchange*. Thanks to the American Recovery and Reinvestment Act (ARRA), also known as the stimulus bill, Arkansas will get money to improve the exchange of health information, such as electronic medical records, across public and private insurance systems. This initiative has important potential to aid enrollment and retention rates for ARKids First—and all Medicaid categories—if the state chooses to include Medicaid eligibility and renewal information. (At this time, it is not clear whether Medicaid eligibility information will be included in the exchange). If doctors and other medical professionals have access to the same information on a child, it could help to notify families of the need to re-enroll. The system could allow certain offices or helpers access to enrollment and re-enrollment records. Doctors' offices, school staff, social workers, or others, if properly trained, could help to re-enroll children as they attend checkups or receive health screenings, for example. Of course, data systems could also help better manage and improve the quality of care children receive once on ARKids First.

**An ARKids First card does not guarantee a regular doctor in many counties.** Data and anecdotal feedback from around the state suggest that an ARKids First card alone doesn't guarantee access to regular health care or necessary medical referrals. Arkansas requires children receiving ARKids First to have a primary care physician to ensure that every child has a 'medical home,' or a regular doctor to manage the quality and availability of their care.[17] More than 40,000 children enrolled in ARKids First last year did not have a primary care physician on record.[18] These doctors regularly see a child for checkups, treat chronic illnesses or make referrals for specialist care. This could be because not enough physicians take ARKids First recipients, however, there are many reasons a child may not have a primary care physician. For example, it may be that the doctors families choose are not taking additional Medicaid recipients.

Statewide, about 11 percent of ARKids First enrollees were not assigned to a primary care physician in September 2009, according to ADHS records. The percentage varies from county to county, from less than 4 percent in Conway County to more than 18 percent in Marion County. Medicaid officials emphasize that the number of children who do not have assigned primary care physicians does not necessarily represent the number of children who cannot access one. Rather, there are myriad reasons that a child may not have an assigned primary care physician, including dismissal from a provider, moving out of the area, closure or relocation of the doctor's office or others.

**Figure 4: Percent of Arkansas Children Enrolled in ARKids First Not Assigned a Primary Care Physician**




Source: Arkansas Department of Human Services. Data reflect a point-in-time snapshot from Sept. 2009

The following counties hold the highest percentages of children enrolled in ARKids First who are not assigned a primary care physician:

**Table 2: Arkansas Counties With Highest Percentage Children Not Assigned PCP**

| County | Total ARKids enrollment | Without Assigned PCP | % Without Assigned PCP |
|---|---|---|---|
| Marion | 1,977 | 357 | 18.06% |
| Miller | 6,196 | 1,073 | 17.32% |
| Benton | 22,264 | 3,772 | 16.94% |
| Carroll | 3,507 | 568 | 16.20% |
| Lafayette | 1,199 | 183 | 15.26% |
| Jefferson | 12,777 | 1,897 | 14.85% |
| Sebastian | 16,886 | 2,396 | 14.19% |
| Howard | 2,202 | 312 | 14.17% |
| Dallas | 1,310 | 181 | 13.82% |
| Washington | 23,445 | 3,135 | 13.37% |
| State total | 396,080 | 43,907 | 11.09% |

The northwest Arkansas region, with its growing population, has some of the state's highest percentages (as well as total numbers) of children who are not assigned a primary care physician. For years, school officials, social workers, child advocates, health providers and parents looked for solutions that could open up "slots" to allow more children to be assigned to a primary care physician. Without those openings, parents like Paris Golec of Rogers jump on the telephone just after midnight each month, hoping an automated system will indicate there's been an opening with a local doctor for her child. Effective January 1, 2010, Medicaid increased the cap on PCP caseloads to help alleviate the challenge of limited slots from 1,000 to 2,500 per physician.

This issue is not confined to one region of the state, or even to Arkansas. Nor is it a matter of insurance type. Nationwide, the shortage of primary care physicians has slowed access to family health care for people with private and public insurance alike. The U.S. Department of Health and Human Services reports that the United States is short about 16,000 doctors today, given the total population.[19] The Association of American Medical Colleges predicts that without growth in the number of medical school graduates, the nation-wide doctor shortage could grow to as much as 159,000 by 2025.[20]

While access to primary care is a critical issue, it's worth noting that children with any type of insurance are far more likely to see a doctor than their uninsured counterparts. National data show that access to primary care is also not limited to publically-supported insurance programs like ARKids First.[21] In fact, access to primary medical care for children on Medicaid/CHIP and private insurance is very similar. Children with any kind of health insurance are much more likely to access preventive medical care than uninsured children. The major exception is access to dental care, which remains a significant and critical challenge for Arkansas and other states alike.

## Jacque's story

Jacque, a single mother making about $24,000 a year, couldn't afford to add her 12-year-old son to her health insurance policy when her employer, a city in southeast Arkansas, switched providers.

It wasn't just the monthly premium—which would have been more than $100—that stopped her. It was also the thought of the $1,000 deductible that she would have to cover before the insurance would kick in.

For a year she went without, with fingers crossed and frequent prayers that nothing bad would happen to her son and require a visit to the doctor—or the emergency room. She treated a sprained ankle by telling him to put his feet up for four or five days and shooing his friends away. A jammed finger was supported with a Popsicle stick. A sprained wrist— well, that just had to work itself out. She was lucky, in a way, she said.

"My mom stays out of town, and she's a nurse. So I have to call her and say, 'Mom, look, this is what's going on. Do I need to take him or what?'"

Her son, Justin, though, is of the age where he wants to join the school's sports teams— football, basketball, baseball. He has also taken a job mowing yards. She said she worries more now that he might get hurt, and she won't be able to fix him on her own.

"There are some things moms can't do," she said. "Fix a broken bone if they go out there and get hurt, basketball injuries and what not. … He needs a physical. I can't give that."

Her boss told her to apply to ARKids First and she just recently received a letter saying her application to enroll Justin was approved. Opening the letter and reading it, she said, took a huge burden off her shoulders.

"I hugged my son like I paid off my house," she said.

# RECOMMENDATIONS:

## Arkansas Can Make Progress Today to Cover More Kids and Help Struggling Families

While we wait for national health reform, Arkansas can take steps now to improve kids' health and help families weather the financial storm. Arkansas has the tools today to invest in children and set the stage for a healthier and more productive workforce now and years down the line. The 2009 CHIP reauthorization has already helped 26 states move forward to enroll more children in their Medicaid and CHIP programs despite the economic strain of the recession.[22] Arkansas lawmakers and agency leaders should join these states in making children and families a priority when they need help the most. The following steps would cover more kids and give families peace of mind and firmer financial footing.

### 1. Extend ARKids First to thousands more Arkansas children.

**Implement the new income eligibility levels passed in the 2009 legislative session.** In the current fiscal climate, it makes sense that lawmakers keep every option on the table to meet the challenge of revenue shortfalls. Abandoning the ARKids First expansion is not the answer. The benefits of expanding ARKids First to families up to 250 percent of the federal poverty level far outweigh the costs. First, Arkansas will leave millions on the table if it drops the promised expansion. Every dollar that the state invests in ARKids leverages up to $4 in federal matching funds. Those dollars flow to doctors, hospitals, and clinics in our state, generating additional economic activity and supporting jobs. The roughly $11 million increase in state spending would pay for itself many times over, bringing an estimated $57 million in federal match and related business activity.[23]

Secondly, most funds to expand ARKids First would pay for children who are already eligible—not those who will be eligible for the first time. When states increase income eligibility for programs, the majority of enrollees are children who were already eligible; this was reflected in the estimated cost of expansion. Funds provided by the tobacco tax increase would provide insurance to 25,000 more uninsured children—not just to the 9,000 uninsured in the new income bracket. This means more than two-thirds of the proposed budget increase, roughly $9 million, would cover children who the state is already committed to serving.

Families just over the income threshold need the coverage they were promised now more than ever. While the state budget is certainly tight, family budgets are far worse off. And unlike the state, families don't have reserve funds or ways to raise revenue to make ends meet. Policy makers should keep their promise to allocate tobacco tax funds to ARKids First expansion, sign on the dotted line with the federal government, and make ARKids First a reality for the families who need it now.

**Take advantage of new support to help legal immigrant children.** With increasing numbers of immigrant families, especially in Northwest Arkansas, agency leaders should make the most of the new CHIPRA law. Removing the five-year ban on coverage for documented immigrant children would pro-

vide as many as 1,000[24] legal immigrant children in Arkansas access to preventive health care. Eighteen states have already made the decision to cover these children using the new funds available under CHIPRA.[25] But eligibility alone won't do the job. ADHS already provides translation services for outreach and access to services, and should continue to take full advantage of the increased translation services match rate. ADHS can also ensure all outreach, enrollment and re-enrollment materials, both printed and online, are translated into Spanish, Hmong, Marshallese, Vietnamese and other languages spoken in communities across the state. Translation services should also be offered in these languages to ensure kids get the care they need. Increased federal reimbursements for translation services make this more affordable for Arkansas.

## 2. Remove red tape to enroll children who already qualify for ARKids First but aren't signed up.

The 2009 CHIPRA[26] legislation signals the Obama Administration's commitment to serving eligible-but-unenrolled children through more aggressive outreach, simplified enrollment and renewal for families, and a commitment to enroll the hardest-to-reach children. At the one-year anniversary of CHIPRA, federal officials unveiled "The Secretary's Challenge: Connecting Kids to Coverage," a five-year campaign that calls on government officials at all levels, representatives of community organizations, faith leaders and concerned individuals to find and enroll the five million children who are eligible but remain uncovered. The challenge, along with a report of state progress on CHIPRA one year after passage,[27] encourages states to make the changes described below to make enrollment and re-enrollment seamless for families. Arkansas should answer the call (and set the stage to receive bonus funds in the future) by taking the following next steps:

**Offer 12-month continuous coverage for ARKids First A.** Currently children are covered for a full year under ARKids First B, regardless of income changes during the year. This ensures that income fluctuations do not disrupt coverage. This same procedure should be extended to children covered under ARKids First A, and other categories of Medicaid, to keep coverage consistent and to avoid the administrative costs of children moving in and out of coverage. Twenty-two states offer 12-month continuous coverage for both Medicaid and CHIP programs.[28]

**Implement Express Lane enrollment.** Express Lane enrollment would allow case workers to use approved applications from other programs like school lunch to approve ARKids First enrollment, preventing families from duplicated forms and processes.

**Accelerate enrollment through immediate eligibility for children who likely qualify.** Using trained screeners in schools and community-based organizations, Arkansas should screen applicants and provide immediate coverage to children whose families clearly qualify. If families meet a pre-determined threshold—where it is clear they are eligible for ARKids First—the screener would provide an ARKids First card and then give the completed application to ADHS for verification. This process, also referred to as "presumptive eligibility," allows children to be covered immediately and decreases the chance that a family's application will fall through the cracks.

**Implement paperless or administrative renewal to verify ongoing eligibility,** rather than requiring families to re-enroll through a paper form each year. This would rely on administrative databases (such as income through workforce databases) to determine eligibility at renewal and could be easily integrated into the Access Arkansas system online. Parents would be asked to report only on changes to their income rather re-enroll their child each year. By making these and other simple changes to their renewal system, Louisiana now loses less than one percent of kids at renewal due to paperwork or administrative reasons, compared with 49 percent in Arkansas.[29]

Some state officials are concerned about that simplifying enrollment could result in increased errors, or the enrollment of families who are not eligible. Many states that have found ways to make enrollment easier for families have not sacrificed program integrity. They use state databases and other information to their fullest. In fact, Louisiana has made many of these enrollment simplifications and still boasts the lowest error rate in the country at 1.56 percent.[30]

**Collect and report data on outreach efforts to determine how children enroll, who enrolls them, and shine a light on what works.** Many organizations across the state work to connect children to ARKids First. Some, such as community health centers or Area Health Education Centers, have staff dedicated to outreach and application assistance. Many hospitals and clinics house ADHS workers or have designated enrollment staff of their own. Still others, like Head Starts or community mental health centers, train local schools and other community-based groups who encounter eligible children. Additional opportunities exist to help families connect or reconnect with ARKids First through school wellness centers, doctors' offices or other community-level partners to help families get ARKids First. Access Arkansas[31] and the state's new health information exchange[32] efforts could also provide the vehicles to track exactly how and where children enroll in ARKids First. Better data would help the state determine what works and where it's working, showing what types of community-based organizations are having the most success helping families, and helping determine how best to target resources.

**Develop a comprehensive ARKids First outreach plan.** ADHS and its partners should work together to develop a five-year outreach plan to boost the rate of enrollment, especially among the state's hardest-to-reach children. States like Iowa and Kansas held state-wide summits to bring state agencies, providers, child advocates and others together to create and advance such a plan. Finding consensus on outreach priorities could also help Arkansas receive an outreach grant under CHIPRA. A plan could also outline action steps to enhance the availability of primary care physicians.

## 3. Attract more health professionals to ARKids First to help kids get the care they need.

The shortage of family practitioners and pediatricians is a systemic challenge that Medicaid alone cannot address, but ADHS should work with other stakeholders to develop a comprehensive plan to meet the shortage in the short- and long-run. There are promising initiatives to build on. The Arkansas Foundation for Medical Care is working with Medicaid officials and doctors to clear provider records of patients who have aged out, moved or become ineligible for ARKids. Clearing those records could help open up slots for new patients.

The University of Arkansas for Medical Sciences Area Health Education Centers, Arkansas Children's Hospital, community health centers and others are finding ways to get more children the care they need. Some communities are bringing services to schools, helping families who struggle with time off work or transportation necessary to get their child care. Tactics including using nurse practitioners in partnership with physicians, using new funds to make more slots available to serve ARKids First children and opening new clinics in the most underserved areas of the state. Improving access can help more children get care that will catch complications early, improve their health and also save the state long-term costs of poor health and disease. [33]

## Conclusion

We cannot ignore the children who remain uninsured today while we wait for the full implementation of health reform and state leaders look for ways to cut Medicaid costs. By reducing the number of kids covered, or even by doing nothing, the state will pay in the long run with lost federal money and lost economic activity, as well as a less healthy workforce. Arkansas can act now to cover all children and help thousands of Arkansas parents afford quality care. Struggling families can't wait any longer. We need to cross the finish line and cover all Arkansas children.

## Additional Resources

Arkansas Finish Line Coalition: www.aradvocates.org/arkansas-finish-line-coalition

Federal CHIPRA policy resources by the Georgetown Center for Children and Families: http://ccf.georgetown.edu/index/federal-schip-policy

Crossing the Finish Line 2009: How Arkansas Can Cover all Children by Arkansas Advocates for Children and Families. Available at www.aradvocates.org/arkansas-finish-line-coalition

Health Insurance for Children: the Arkansas Success Story, 1997 – 2005 by Arkansas Advocates for Children & Families (2006). Available at www.aradvocates.org/arkansas-finish-line-coalition

# Appendices

## Appendix A

**ARKids First Covered Services**

| Service | ARKids A | ARKids B (co-pay) |
|---|---|---|
| Ambulance (emergency only) | X | X ($10/visit) |
| Ambulatory surgical center | X | X |
| Chiropractor | X | X |
| Dental care (orthodontia included only for ARKids A) | X | X |
| Durable medical equipment | X | X up to $500/year (20%) |
| ER services | X | X |
| Family planning | X | X |
| Federally qualified health center | X | X |
| Hearing services | X | |
| Home health | X | X ($10/visit), up to 10 visites each year |
| Hospice | X | X |
| Immunizations | X | X |
| Inpatient hospital | X | X (20% first inpatient day) |
| Inpatient psych | X | |
| Lab and X-Ray | X | X |
| Medical supplies | X | X |
| Nurse midwife | X | X ($10/visit) |
| Occupational therapy | X | |
| Outpatient mental and behavioral health | X | X, up to $2,500 ($10/visit) |
| Physical therapy | X | |
| Physician services | X | X |
| Preventative health screens (EPSDT under ARKids A | X | X |
| Psych services | X | |
| Podiatry | X | X ($10/visit) |
| Prescription drungs | X | X ($5/prescription) |
| Rural health clinic | X | X ($10/visit) |
| Speech therapy | X | X ($10/visit) |
| Transportation | X | |
| Vision Care | X | X ($10/visit) |

Note: Many services require a PCP referral or other prior approval. Visit http://www.arkidsfirst.com/bene.htm for more information. For non-ARKids First categories that cover children under 19, visit https://www.medicaid.state.ar.us/. These include SSI, TEFRA, newborns, TEA/AFDC, medically needy, foster care, and others).

**Appendix B**

## ARKids First Income Eligibility, Current and Pending

ARKids First A/Medicaid (Federal funding source: Medicaid)

| 2009 Federal Poverty Level | Age | 1 person | 2 people | 3 people | 4 people | 5 people | 6 people | Each add'l person |
|---|---|---|---|---|---|---|---|---|
| Up to 100% | 6 to 19 | $10,830 | $14,570 | $18,310 | $22,050 | $25,790 | $29,530 | $3,470 |
| Up to 133% | Under 6 | $14,404 | $19,378 | $24,352 | $29,327 | $34,301 | $39,275 | $4,615 |

ARKids First B: Current eligibility as of early 2010
(Federal funding source: Children's Health Insurance Program)

| 2009 Federal Poverty Level | Age | 1 person | 2 people | 3 people | 4 people | 5 people | 6 people | Each add'l person |
|---|---|---|---|---|---|---|---|---|
| 100% to 200% | 0 to 19 | $21,660 | $29,140 | $36,620 | $44,100 | $51,580 | $59,060 | $6,940 |
| 133% to 200% | Under 6 | | | | | | | |

ARKids First B: New eligibility passed in 2009, **not yet implemented**
(Federal funding source: Children's Health Insurance Program)

| 2009 Federal Poverty Level | Age | 1 person | 2 people | 3 people | 4 people | 5 people | 6 people | Each add'l person |
|---|---|---|---|---|---|---|---|---|
| 100% to 250% | 0 to 19 | $27,075 | $36,425 | $45,775 | $55,125 | $64,475 | $73,825 | $8,675 |

**Appendix C**

**January 2010 Enrollment Data: Children under 19**

| County | ARKids First A | ARKids First B | Other Medicaid Categories | Total Children under 19 - ARKids First or Medicaid |
|---|---|---|---|---|
| ARKANSAS | 1864 | 445 | 433 | 2742 |
| ASHLEY | 2489 | 543 | 592 | 3624 |
| BAXTER | 2654 | 929 | 658 | 4241 |
| BENTON | 15136 | 5090 | 2455 | 22681 |
| BOONE | 2794 | 917 | 656 | 4367 |
| BRADLEY | 1267 | 283 | 314 | 1864 |
| CALHOUN | 355 | 157 | 107 | 619 |
| CARROLL | 2454 | 704 | 347 | 3505 |
| CHICOT | 1452 | 319 | 512 | 2283 |
| CLARK | 1662 | 458 | 490 | 2610 |
| CLAY | 2814 | 870 | 624 | 4308 |
| CLEBURNE | 1927 | 636 | 371 | 2934 |
| CLEVELAND | 723 | 191 | 182 | 1096 |
| COLUMBIA | 2214 | 518 | 886 | 3618 |
| CONWAY | 1908 | 501 | 575 | 2984 |
| CRAIGHEAD | 8356 | 2068 | 2560 | 12984 |
| CRAWFORD | 5721 | 1568 | 1092 | 8381 |
| CRITTENDEN | 6665 | 1269 | 2663 | 10597 |
| CROSS | 1698 | 594 | 577 | 2869 |
| DALLAS | 786 | 198 | 340 | 1324 |
| DESHA | 1706 | 359 | 526 | 2591 |
| DREW | 1633 | 524 | 572 | 2729 |
| FAULKNER | 7002 | 2293 | 1814 | 11109 |
| FRANKLIN | 1659 | 402 | 319 | 2380 |
| FULTON | 974 | 267 | 299 | 1540 |
| GARLAND | 8193 | 2362 | 1844 | 12399 |
| GRANT | 1235 | 445 | 250 | 1930 |
| GREENE | 4131 | 1046 | 957 | 6134 |
| HEMPSTEAD | 2628 | 577 | 708 | 3913 |
| HOT SPRING | 2951 | 963 | 590 | 4504 |
| HOWARD | 1537 | 362 | 354 | 2253 |
| INDEPENDENCE | 3129 | 980 | 882 | 4991 |
| IZARD | 1096 | 328 | 233 | 1657 |
| JACKSON | 1676 | 426 | 519 | 2621 |
| JEFFERSON | 7428 | 1696 | 3475 | 12599 |

| | | | | |
|---|---|---|---|---|
| JOHNSON | 2740 | 785 | 442 | 3967 |
| LAFAYETTE | 796 | 161 | 237 | 1194 |
| LAWRENCE | 1650 | 512 | 462 | 2624 |
| LEE | 975 | 202 | 524 | 1701 |
| LINCOLN | 1132 | 303 | 330 | 1765 |
| LITTLE RIVER | 1057 | 289 | 339 | 1685 |
| LOGAN | 2355 | 591 | 455 | 3401 |
| LONOKE | 4866 | 1665 | 1156 | 7687 |
| MADISON | 1500 | 479 | 253 | 2232 |
| MARION | 1367 | 357 | 245 | 1969 |
| MILLER | 3778 | 822 | 1604 | 6204 |
| MISSISSIPPI | 5536 | 1295 | 2433 | 9264 |
| MONROE | 857 | 236 | 272 | 1365 |
| MONTGOMERY | 877 | 323 | 135 | 1335 |
| NEVADA | 986 | 258 | 218 | 1462 |
| NEWTON | 706 | 272 | 136 | 1114 |
| OUACHITA | 2614 | 621 | 771 | 4006 |
| PERRY | 826 | 276 | 215 | 1317 |
| PHILLIPS | 3132 | 610 | 1609 | 5351 |
| PIKE | 1145 | 356 | 159 | 1660 |
| POINSETT | 2946 | 715 | 827 | 4488 |
| POLK | 2121 | 604 | 446 | 3171 |
| POPE | 5086 | 1667 | 1141 | 7894 |
| PRAIRIE | 746 | 202 | 174 | 1122 |
| PULASKI | 32903 | 8882 | 13157 | 54942 |
| RANDOLPH | 1692 | 620 | 359 | 2671 |
| SALINE | 6423 | 2268 | 999 | 9690 |
| SCOTT | 1241 | 291 | 216 | 1748 |
| SEARCY | 800 | 284 | 140 | 1224 |
| SEBASTIAN | 11899 | 2587 | 2696 | 17182 |
| SEVIER | 2439 | 555 | 324 | 3318 |
| SHARP | 1641 | 532 | 479 | 2652 |
| ST. FRANCIS | 2905 | 594 | 1739 | 5238 |
| STONE | 1236 | 343 | 161 | 1740 |
| UNION | 4328 | 1024 | 1143 | 6495 |
| VAN BUREN | 1517 | 431 | 249 | 2197 |
| WASHINGTON | 17269 | 4306 | 2634 | 24209 |
| WHITE | 6192 | 1992 | 1375 | 9559 |
| WOODRUFF | 754 | 216 | 300 | 1270 |
| YELL | 2557 | 716 | 442 | 3715 |
| TOTAL | 257507 | 70530 | 70772 | 398809 |

Source: Jan. 2010 snapshot data from ADHS Division of County Operations.

**Appendix D**

**Children under 19 Enrolled in ARKids First or Medicaid**
**July 2008 - January 2010**

| County | Jul-08 | Jan-09 | Jul-09 | Jan-10 | % change since July 08 |
|---|---|---|---|---|---|
| ARKANSAS | 2606 | 2648 | 2767 | 2742 | 5.22% |
| ASHLEY | 3493 | 3556 | 3578 | 3624 | 3.75% |
| BAXTER | 4030 | 3957 | 4071 | 4241 | 5.24% |
| BENTON | 18898 | 19856 | 21211 | 22681 | 20.02% |
| BOONE | 4149 | 4118 | 4226 | 4367 | 5.25% |
| BRADLEY | 1755 | 1771 | 1853 | 1864 | 6.21% |
| CALHOUN | 627 | 639 | 621 | 619 | -1.28% |
| CARROLL | 3250 | 3315 | 3429 | 3505 | 7.85% |
| CHICOT | 2296 | 2293 | 2293 | 2283 | -0.57% |
| CLARK | 2587 | 2621 | 2640 | 2610 | 0.89% |
| CLAY | 4006 | 4100 | 4060 | 4308 | 7.54% |
| CLEBURNE | 2779 | 2893 | 2857 | 2934 | 5.58% |
| CLEVELAND | 1073 | 1063 | 1067 | 1096 | 2.14% |
| COLUMBIA | 3441 | 3483 | 3551 | 3618 | 5.14% |
| CONWAY | 2839 | 2924 | 2904 | 2984 | 5.11% |
| CRAIGHEAD | 12346 | 12571 | 12610 | 12984 | 5.17% |
| CRAWFORD | 7437 | 7690 | 8167 | 8381 | 12.69% |
| CRITTENDEN | 10192 | 10008 | 10288 | 10597 | 3.97% |
| CROSS | 2730 | 2760 | 2808 | 2869 | 5.09% |
| DALLAS | 1239 | 1249 | 1260 | 1324 | 6.86% |
| DESHA | 2536 | 2517 | 2542 | 2591 | 2.17% |
| DREW | 2636 | 2735 | 2675 | 2729 | 3.53% |
| FAULKNER | 10067 | 10405 | 10770 | 11109 | 10.35% |
| FRANKLIN | 2216 | 2252 | 2340 | 2380 | 7.40% |
| FULTON | 1468 | 1498 | 1526 | 1540 | 4.90% |
| GARLAND | 12400 | 12211 | 12270 | 12399 | -0.01% |
| GRANT | 1712 | 1768 | 1855 | 1930 | 12.73% |
| GREENE | 5405 | 5628 | 5882 | 6134 | 13.49% |
| HEMPSTEAD | 3720 | 3770 | 3814 | 3913 | 5.19% |
| HOT SPRING | 4232 | 4353 | 4366 | 4504 | 6.43% |
| HOWARD | 2038 | 2069 | 2171 | 2253 | 10.55% |
| INDEPENDENCE | 4692 | 4682 | 4791 | 4991 | 6.37% |
| IZARD | 1587 | 1614 | 1607 | 1657 | 4.41% |
| JACKSON | 2530 | 2550 | 2564 | 2621 | 3.60% |
| JEFFERSON | 12203 | 12324 | 12464 | 12599 | 3.25% |

| | | | | | |
|---|---|---|---|---|---|
| JOHNSON | 3818 | 3833 | 3921 | 3967 | 3.90% |
| LAFAYETTE | 1090 | 1111 | 1162 | 1194 | 9.54% |
| LAWRENCE | 2583 | 2561 | 2592 | 2624 | 1.59% |
| LEE | 1905 | 1823 | 1756 | 1701 | -10.71% |
| LINCOLN | 1659 | 1668 | 1714 | 1765 | 6.39% |
| LITTLE RIVER | 1519 | 1567 | 1607 | 1685 | 10.93% |
| LOGAN | 3116 | 3176 | 3332 | 3401 | 9.15% |
| LONOKE | 6868 | 7119 | 7251 | 7687 | 11.92% |
| MADISON | 2083 | 2120 | 2184 | 2232 | 7.15% |
| MARION | 1761 | 1866 | 1932 | 1969 | 11.81% |
| MILLER | 5664 | 5878 | 6088 | 6204 | 9.53% |
| MISSISSIPPI | 8728 | 8825 | 9014 | 9264 | 6.14% |
| MONROE | 1444 | 1444 | 1443 | 1365 | -5.47% |
| MONTGOMERY | 1241 | 1265 | 1325 | 1335 | 7.57% |
| NEVADA | 1328 | 1356 | 1415 | 1462 | 10.09% |
| NEWTON | 1132 | 1096 | 1115 | 1114 | -1.59% |
| OUACHITA | 3898 | 3896 | 3899 | 4006 | 2.77% |
| PERRY | 1277 | 1245 | 1343 | 1317 | 3.13% |
| PHILLIPS | 5436 | 5484 | 5384 | 5351 | -1.56% |
| PIKE | 1615 | 1597 | 1623 | 1660 | 2.79% |
| POINSETT | 4356 | 4378 | 4389 | 4488 | 3.03% |
| POLK | 3008 | 3056 | 3149 | 3171 | 5.42% |
| POPE | 7215 | 7413 | 7681 | 7894 | 9.41% |
| PRAIRIE | 1087 | 1073 | 1077 | 1122 | 3.22% |
| PULASKI | 48456 | 50159 | 53378 | 54942 | 13.39% |
| RANDOLPH | 2610 | 2651 | 2686 | 2671 | 2.34% |
| SALINE | 8617 | 9139 | 9458 | 9690 | 12.45% |
| SCOTT | 1774 | 1715 | 1751 | 1748 | -1.47% |
| SEARCY | 1233 | 1228 | 1210 | 1224 | -0.73% |
| SEBASTIAN | 15190 | 16050 | 16796 | 17182 | 13.11% |
| SEVIER | 2951 | 3114 | 3182 | 3318 | 12.44% |
| SHARP | 2475 | 2559 | 2565 | 2652 | 7.15% |
| ST. FRANCIS | 5195 | 5261 | 5287 | 5238 | 0.83% |
| STONE | 1691 | 1700 | 1697 | 1740 | 2.90% |
| UNION | 6332 | 6551 | 6500 | 6495 | 2.57% |
| VAN BUREN | 2087 | 2130 | 2254 | 2197 | 5.27% |
| WASHINGTON | 20212 | 21124 | 22762 | 24209 | 19.78% |
| WHITE | 9000 | 9236 | 9257 | 9559 | 6.21% |
| WOODRUFF | 1231 | 1201 | 1215 | 1270 | 3.17% |
| YELL | 3459 | 3498 | 3634 | 3715 | 7.40% |
| Total | 367559 | 376057 | 387926 | 398809 | 8.50% |
| | | | | | |

Source: Monthly snapshot data from ADHS Division of County Operations.

# Endnotes

1 Kaiser Family Foundation State Health Facts (2010). Arkansas: Projected Federal CHIP Allotments, Under Current Law and Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA 2009) (dollars in millions), FY2009. Available http://www.statehealthfacts.org/profileind.jsp?ind=660&cat=4&rgn=5

2 Georgetown Center for Children and Families (2010). CHIP Allotments: What's been spent and what remains? Washington DC: Georgetown University. Available at http://ccf.georgetown.edu/index/cms-filesystem-action?file=regional%20meetings/southern/southern%20unspent%20allotments.pdf

3 Georgetown Center for Children and Families (2009). CHIP Tips: Medicaid Performance Bonus '5 of 8' Requirements, Washington DC: Georgetown University. Available at http://ccf.georgetown.edu/index/chip-tips-medicaid-performance-bonus-5-of-8-requirements

4 For CHIP, or ARKids First B, the match rate is increased by 5% to roughly 86%. Under Medicaid, or ARKids First A and other categories, the rate increases to 75% from the normal 50% administrative match. See Center for Children and Families (2009). The Children's Health Insurance Reauthorization Act of 2009. Washington, DC: Georgetown University, p. 11. Available http://ccf.georgetown.edu

5 For more information, see Kaiser Commission on Medicaid and the Uninsured (2010) and Center for Children and Families (2010). Children's Oral Health Benefits. Washington, DC: Kaiser Family Foundation. Available at http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf%20publications/federal%20schip%20policy/dental.pdf

6 Income eligibility for ARKids First A is 133% for families with children under 6 (or $24,352 for a family of three); income eligibility is lower at 100% of the federal poverty level (or $18,310 for a family of three) for families with children ages 6 through 18.

7 Center for Children and Families (2010). President Obama's Health Care Reform Proposal
Key Medicaid, CHIP, and Low-Income Provisions (February 22, 2010). Available at http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf%20publications/health%20reform/president%20health%20proposal.pdf

8 AACF (2010). Scoring Health Reform in Congress (UPDATED 1/11/10): Children and Families Need Action, Affordability and Accountability. Little Rock, Arkansas: AACF. Available at http://aradvocates.org/health-reform-side-by-side-analysis-of-senate-and-house-bills/

9 Kaiser Family Foundation ranks State Health Facts ranks Arkansas in the top 20 lowest rates of uninsured children (8 – 9 percent depending on the data run). Note that date represent a two-year rolling average, while the runs used by AACF use a three-year rolling average, giving a slightly higher percentage. http://www.statehealthfacts.org/

10 See Arkansas Advocates for Children and Families (2009). Crossing the Finish Line 2009: How Arkansas can Cover all Children. Available at http://www.aradvocates.org/assets/PDFs/AACF-health-insurance-2009-SMALL.pdf and Health Insurance for Children: the Arkansas Success Story, 1997 – 2005 by Arkansas Advocates for Children & Families (2006). Available at http://arkadold.aristotle.net/_images/pdfs/Outreach.pdf

11 If expanded eligibility were to go into effect today, 80% of the states uninsured children would qualify for ARKids First.

12 See page 7, Arkansas Advocates for Children and Families (2009). Crossing the Finish Line 2009: How Arkansas can Cover all Children. Available at http://www.aradvocates.org/assets/PDFs/AACF-health-insurance-2009-SMALL.pdf

13 Data on children denied ARKids First show similar patterns but smaller percentages. Roughly 1 out of 4 applicants is denied ARKids First for paperwork reasons. See upcoming brief on simplifying enrollment and renewal, which will be available at www.aradvocates.org.

14 Closure Codes 58 and 100, for example, compiled from data provided by DHS Division of County Operations

15 Sommers, B.D. (2005). From Medicaid to Uninsured: Drop-Out among Children in Public Insurance Programs. Health Services Research 40(1), pp.59 -68. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361126/

16 https://access.arkansas.gov

17 For more information on medical homes, visit http://www.medicalhomeinfo.org/ or http://afmc.org/HTML/consumer/medicaid/

med_home.aspx

18 Note: Data reflect a point-in-time snapshot from September 2009

19 Kaiser Health News (2009). "Physician Shortage Limits Even Insured Patients' Access To Care" Available at http://www.kaiserhealthnews.org/daily-reports/2009/august/19/primary-care.aspx?referrer=search

20 Association of American Medical Colleges (2009). "Medical School Enrollment Continues to Rise to Meet Physician Need, But Future Graduates Could Face Shortage of Residency Training Slots." Available at http://www.aamc.org/newsroom/pressrel/2009/091020.htm

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