

December 16, 1998

Administrator  
Health Care Financing Administration  
7500 Security Blvd.  
Baltimore, Maryland 21244

Attn: Family and Children's Health Programs Group  
Center for Medicaid and State Operations  
Mail Stop C4-14-16

To the Administrator:

The attached document represents proposed amendments to the Colorado Title XXI State Plan. Since the Plan was first submitted in October, 1997 and approval given earlier this year, we have begun enrolling children in our state CHIP program, the Children's Basic Health Plan, dba as Child Health Plan Plus (CHP+).

In addition to proposed amendments to reflect what has occurred operationally since the first children were enrolled on April 22, 1998, please note an amendment raising the maximum age for participation in CHP+ through the age of 18. This change represents a revision in state statute that had allowed coverage of children only until their 18<sup>th</sup> birthday. The Department of Health Care Policy and Financing requested and received this statutory change during the 1998 session in order to bring Colorado into compliance with federal requirements.

Questions about the proposed amendments to the Colorado State Plan may be directed to Barbara Ladon, Director of HCPF's Office of Program Development. She may be reached by phone at 303 866-3227 or by e-mail ([barbara.ladon@state.co.us](mailto:barbara.ladon@state.co.us)). Fax communications may be sent to 303 866-2803.

Sincerely,

Dean Woodward  
Deputy Director

cc: Dee Raisel

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**Section 1. General Description and Purpose of the State Child Health Plans (Section 2101)**

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1  Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**
- 1.2  Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**
- 1.3  A combination of both of the above.

**Introduction**

Colorado ~~submits~~ submitted its Title XXI State Plan to expand children's access to health coverage by implementing state legislation and building on the experience and infrastructure of the Colorado Child Health Plan, a program providing basic medical services to low-income children. The ~~Colorado Child Health Plan will adopt~~ **Children's Basic Health Plan adopted** an expanded benefits package and additional features ~~which will to~~ bring it into compliance with Title XXI. This Title XXI program ~~will be~~ **is** called the **Children's Basic Health Plan, but does business as the Child Health Plan Plus (CHP+)**.

The Colorado General Assembly passed several pieces of legislation during the FY **97-98** session that directly affect Colorado children's access to health care:

House Bill **97-1304**, sponsored by Representative Dave Owen and Senator Sally Hopper, **authorizes authorized** the establishment of the Children's Basic Health Plan, a subsidized health-insurance program for children ages 0 through 17 with family incomes at or below 185% of the federal poverty level. The legislation requires that the Children's Basic Health Plan benefits be based on the Standard Plan as defined in Colorado's small group insurance reform law (see Attachment 1 for Standard Plan benefits). **The legislation directs that services are to be** delivered through HMOs that are willing to contract with Medicaid. Premiums are ~~to be~~ set on a sliding fee scale. **Families above 185% of poverty can buy the Children's Basic Health Plan at full cost.** The Children's Basic Health Plan, **dba Child Health Plan Plus (CHP+)**, is not an entitlement. The General Assembly appropriates funds for the Children's Basic Health Plan each year, and enrollment will

be limited based on this funding.

House Bill 97-1304 also **authorizes authorized** the expansion of the existing Colorado Child Health Plan from age 0 through age 12 to age 0 through age 17, and from 54 Colorado counties to all 63 Colorado counties from July 1997 until the plan **sunsets sunset** on June 30, 1998. **During the 1998 legislative session, the Colorado General Assembly raised the age limit to cover children under the age of 19 (House Bill 98-1325).** The Colorado Child Health Plan **is was** a health care reimbursement plan for children in families with incomes below 185% of poverty. Covered services **are were** outpatient services including primary care, specialty care, and outpatient surgery with an emphasis on preventive care and early treatment for injury and acute and chronic illness. Children **currently** enrolled in the Colorado Child Health Plan **receive received** inpatient services through the Colorado Indigent Care Program. The Colorado Child Health Plan and Colorado Indigent Care Program were intended to together deliver a comprehensive package of services to children.

The provisions of House Bill 1304: the "Children's Basic Health Plan" **are provided** the framework for this State Plan. We **plan to initially implement implemented** the Children's Basic Health Plan under the name Child Health Plan Plus. **We continue to market the plan and do business as Child Health Plan Plus (CHP+).**

Senate Bill 97-5, sponsored by Senator Sally Hopper and Representative Dave Owen, requires that 75% of Medicaid clients be enrolled in managed care, either HMOs or the Primary Care Physician Program, by July 2000. The legislation establishes strong standards for managed care Organizations to ensure quality and access including provider network adequacy, client education, performance data reporting, complaint and grievance procedures, and continuity of care. The legislation encourages contracts between managed care organizations and essential community providers and establishes a grants program for essential community providers. An enrollment broker will serve as the single entry into HMO enrollment to ensure clients receive objective information to make informed health plan choices. Savings realized from the growth of Medicaid managed care enrollment subsequent to June 30, 1997 will partially fund the Children's Basic Health Plan, **dba Child Health Plan Plus.**

Senate Bill 97-101, sponsored by Senator Jim Rizzuto and Representative Tony Grampsas, **authorizes authorized** school districts to receive federal matching funds for money expended to provide health services through schools to children enrolled in Medicaid. Schools may use 30% of the federal funds to provide medical services to uninsured and underinsured students.

The implementation of House Bill 1304, the Children's Basic Health Plan **will be has been** a collaborative process. Six design teams **are currently working worked to:** (1) determine the

benefits and family cost sharing for the Children's Basic Health Plan; (2) develop a marketing and outreach campaign and materials; (3) determine the eligibility, enrollment, and management information systems and procedures; (4) determine the procedures for tracking the flow of funds to the Children's Basic Health Plan; (5) determine employers' role in the expanding children's health insurance coverage; and (6) determine the HMO contracting mechanism, rates, and performance measures. The Colorado Department of Health Care Policy and Financing **will administer administers the Children's Basic Health Plan, dba** Child Health Plan Plus, with subcontracts to the ~~Colorado Child Health Plan and the~~ Colorado Foundation for Families and Children.

This State Plan represents the first of a two-phase approach to implementing the Children's Basic Health Plan. This first phase **begins began April 22, 1998 January 1, 1998**. The first phase, called **Children's Basic Health Plan, dba** Child Health Plan Plus, entails expanding the ~~current~~ Colorado Child Health Plan from outpatient benefits to comprehensive benefits described in Section 6.2 of this plan delivered through HMOs. The ~~Colorado Child Health Plan~~ **Children's Basic Health Plan, dba Child Health Plan Plus** provider network **will** serves children who live in areas of the state without HMO coverage. This comprehensive benefits package called the Child Health Plan Plus is based on the benefits and cost sharing recommendations of a Benefits Design Team with broad-based constituency representatives (see Section 9.9 for a description of this public process). During this first phase, eligibility and enrollment systems and information management infrastructure **will be have been** built, marketing and outreach campaigns **will be have been** implemented, and identification of additional moneys for the state match will be attempted to plan for the implementation of phase two.

The second phase called the Children's Basic Health Plan, **dba as Child Health Plan Plus**, will include implementation of a rules-based eligibility system, a more sophisticated collections and HMO payment system, and an enhanced managed care quality oversight system. The second phase may also include a buy-in into family coverage. The overall program will be guided by the Children's Basic Health Plan Policy Board. Colorado will submit any necessary amendments or waivers to this State Plan to implement phase two of the Children's Basic Health Plan.

#### **Amendment to State Plan**

**This document contains proposed amendments to the Colorado State Plan that reflect changes occurring since submission of the State Plan on October 13, 1997. Most significant was the state legislation enacted in April 1998 that raised the maximum age of coverage through age 18.**

**That same legislation gave the Department the authority to begin covering Colorado children**

in April 1998. (The 1997 statute creating the Children's Basic Health Plan contained a beginning date of July 1, 1998. Initially, the Department had interpreted that provision of HB 97-1304 to mean that the July date was the last date upon which we could begin enrolling children. The Colorado Attorney General's office interpreted the statute differently and said that we did not have authority to begin coverage until that date.) HB 98-1325 allowed us to begin coverage upon signature of that bill.

House Bill 98-1325 also created a Policy Board and charged Board members with promulgating rules for the Children's Basic Health Plan. The Board composition and responsibilities are detailed later in this amended version of the State Plan.

The amended Plan also clarifies that the program is officially called the Children's Basic Health Plan but does business as Child Health Plan Plus or CHP+.

Section 2. General Background and Description of State Approach to Child Health Coverage (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1 Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).

See Attachment 2 for a description of children's insurance status by income and race and ethnicity.

2.2 Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2)

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance.)

Colorado currently has six public efforts underway to identify and enroll uncovered children who are eligible to participate in public health insurance programs or to receive public health services. These efforts are: 1) Medicaid; 2) the Colorado Child Health Plan; 3) the Health Care Program for Children with Special Needs; 4) the Colorado Indigent Care Program; 5) the Colorado Uninsurable Health Insurance Plan (CUHIP); and 6) direct health services delivered by community health centers, Title V, school-based health centers, voluntary practitioner programs, and WIC.

1. **Medicaid**, administered by the Colorado Department of Health Care Policy and Financing, provides health coverage to low-income, elderly and disabled Coloradans. Colorado takes the following steps to enroll children in Medicaid:

1. County social services departments determine a person's eligibility for TANF and Medicaid. Presumptive eligibility sites (Federally Qualified Health Centers and Planned Parenthood clinics), county nurses' offices, doctors' offices and Indian Health Centers determine Medicaid eligibility and enroll pregnant women. Infants up to twelve months old born to Medicaid-enrolled women are guaranteed Medicaid eligibility for twelve months.

2. Outstationed eligibility sites (FQHCs, Disproportionate Share Hospitals, and local county health departments) help people apply for Medicaid by collecting and sending their applications and paperwork to the county social services office for eligibility determination.

3. Posters, brochures, and a 1-800 number provide Medicaid information to potentially eligible families at several locations, including public assistance offices.

4. The **Children's Basic Health Plan, dba ~~Colorado~~ Child Health Plan** CHP+ refers applicants who are eligible for Medicaid to their county social services office.

2. **The Colorado Child Health Plan (CCHP)**, administered through the University of Colorado Health Sciences Center, is **was** legislatively established as a community-based health care reimbursement plan for low-income children under the age of eighteen. The plan **provides provided** outpatient medical care to children from families whose incomes place them at or below 185% of the Federal Poverty Level. Children eligible for Medicaid are not eligible for the Colorado Child Health Plan. Colorado Child Health Plan applicants who **appear-appeared** to be eligible for Medicaid, from income and asset data provided on the family's CCHP application, **receive received** a letter from CCHP referring them- to their county social services department to apply for Medicaid. Colorado Child Health Plan providers **must had to** accept their CCHP patient as a Colorado Medicaid patient if that child **switches switched** from CCHP to Medicaid during the contract year. (Please see Section 2.2.2 for more information on the Colorado Child Health Plan.)

3. **The Health Care Program for Children with Special Needs (HCP)** is a joint state/federal program administered by the Colorado Department of Public Health and Environment for children age 20 and under who have a physical disability that interferes with normal growth and development. HCP helps pay medical bills and provides follow-up for children diagnosed with a clinically qualifying handicapping condition. Children with conditions eligible for the program are identified through county nursing services, health care providers, Child Find coordinators in public schools, and local Early Childhood Connections staff. Currently, about 5,000 children are enrolled in HCP statewide.

Public health nurses and discipline coordinators in nutrition, speech, audiology, deafness,

occupation/physical therapy and social work also provide care coordination across agencies by assuring that services in the schools and through Community Centered Boards are not duplicative of those provided in medical settings. HCP coordinates benefits with public and private health insurance programs to assure coverage for needed services that are not covered under a particular plan. Through coordination of benefits between HCP and Medicaid, HCP pays only for covered services not paid by Medicaid. Through coordination of benefits between HCP and **CEHP CHP+**, HCP pays for services related to the disability, and **CEHP CHP+** pays for all other **CEHP CHP+**-covered health care.

Applicants deemed eligible for HCP are enrolled at regional HCP offices. Based on income data provided on their HCP application, those who appear to be eligible for Medicaid are required to go to their county social services office to apply for Medicaid, and to report back to HCP if qualified for Medicaid. HCP-enrolled children and their siblings who are not eligible for Medicaid are automatically eligible for the **Colorado Child Health Plan Children's Basic Health Plan, dba Child Health Plan Plus**, and can enroll on a short application form, through a facilitated application agreement between **CEHP CHP+** and HCP administrations. HCP coordinators and regional offices have **CEHP CHP+** short enrollment forms and help families enroll in **CEHP CHP+**.

4. The Colorado Indigent Care Program (CICP), administered by the Colorado Department of Health Care Policy and Financing, is a state and federally funded provider reimbursement program that discounts the cost of medical care at its participating health facilities for adults as well as children. If a person is eligible for Medicaid, he or she is ineligible for CICP. Covered services vary by participating hospitals or clinics, but generally include hospital costs such as inpatient stays, surgery, and prescription drugs. All children deemed eligible for the heretofore mentioned programs are directed toward them at CICP-participating providers. Colorado takes the following steps to enroll children in the Colorado Indigent Care Program (CICP):

CICP-contracted providers (primarily FQHCs, DSH hospitals, and participating clinics) screen children for CICP eligibility during their visit, assist with completing the application, and determine eligibility for the program.

The non-CICP community health centers and other safety net providers who determine Medicaid eligibility refer clients to a CICP provider if they determine that a client is not eligible for Medicaid, but may be eligible for CICP.

5. The Colorado Uninsurable Health Insurance Plan (CUHIP), established in 1990 by the

Colorado General Assembly as a quasi-governmental entity, provides health insurance to individuals, including children, who are denied health insurance by private carriers because of a pre-existing medical condition. People who are eligible for Medicaid or Medicare cannot enroll in this program. Only eight people, or one percent of those CUHIP members who disenrolled from the plan in 1996, did so because they became eligible for Medicaid.

6. **Direct health services** are provided by community health centers, county public health departments, school-based health centers and voluntary practitioner programs

7. **Community health centers** offer a wide range of health care to people who may need some financial assistance with their medical bills. Colorado has 15 community health centers with more than 50 clinic sites in medically under-served areas of the state. Community health centers provide comprehensive primary care services including care for acute and chronic illness, injuries, family planning and prenatal care, emergency care, diagnostics services and prescriptions.

Community Health Centers take the following steps to enroll children in Medicaid, the Colorado Indigent Care Program, the ~~Colorado Child Health Plan~~ **CHP+** or the health center's sliding fee scale plan:

1. Provide a financial screen for each new patient or family.
  2. Provide information on and explanation of the program(s) that the family members are eligible for.
  3. Assist with completing applications and collecting required documentation.
  4. Determine eligibility on-site or forward applications to the determining agency **and** communicate with family about eligibility status.
  5. Assist families when their financial situation and eligibility changes to switch to the appropriate program.

If a patient/family is not eligible for any program, the health center uses its sliding fee scale to determine the fee according to family size and income.

Maternal and Child Health Block Grant (Title V of the Social Security Act) funds in Colorado are "passed through" to local public health agencies and other qualified non-profit agencies where they are used to support a number of activities on behalf of women and children, particularly those of low income. State Title V staff provide

oversight, consultation and standards to assure appropriate utilization of these funds. When families are ineligible for any insurance plan, or when there is not another provider of free or reduced price health care (i.e. community or rural health centers) available or accessible, these public health agencies provide direct services to low income children. Services provided in local public health agencies are almost always provided by public health nurses. Services include comprehensive well child clinic services, including developmental and physical assessments, immunizations, and parent education. Families under 100% FPL pay nothing for these services. Others pay on a sliding fee scale.

Local public health agencies identify low income, uninsured children through referrals from a variety of sources including: WIC, child health and immunization clinics, other community health providers (including private physicians), community health and social services agencies and schools, Headstart centers, Early Childhood Connections (Part C), homeless shelters, and self-referrals. Public health staff will refer families to any available health care insurance source for which they appear to be eligible, including Medicaid and the ~~Colorado Child Health Plan~~ **CHP+** and will often work with local physicians to try and secure services on a reduced-fee basis. Many public health agency staff will assist families in completing application forms for Medicaid or the ~~ECHP~~ **CHP+**. In Colorado, Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) outreach workers and administrative case managers are a part of local public health agency staff who facilitate access to Medicaid and to Medicaid services for eligible children. Funding for local EPSDT outreach staff comes to the state Title V agency from the state Medicaid agency and is distributed locally through the Colorado Department of Public Health and Environment (CDPHE). CDHPE also oversees Title V funds going to those same agencies for public health and child health services.

~~School-based health centers~~ provide comprehensive primary care services including care for acute and chronic illness, injuries, family planning and prenatal care, some diagnostics services and prescriptions. SBHCs provide services at no charge. However, patients are asked whether they have health care coverage. The degree to which the SBHCs bill for reimbursement depends on the administrative capabilities of the center. SBHCs facilitate application to Medicaid, ~~ECHP~~ **CHP+** or CICP when documentation of family income and assets is obtainable without jeopardizing students' confidentiality.

The Special Nutritional Program for Women, Infants and Children (WIC) provides nutritious food to supplement the regular diet of pregnant women, breast-feeding

women, infants, and children under age five who meet state income standards. Women and children under five years old qualify if the combined family income is at or below 185% of the federal poverty level. WIC staff encourage pregnant women and parents and guardians of infants under 12 months of age to apply for Medicaid. At community health centers, these women and children qualify for presumptive eligibility in Medicaid and receive immediate care. WIC staff distribute application forms for the ~~Colorado Child Health Plan~~ **CHP+**. Children enrolled in WIC who are not eligible for Medicaid can enroll in ~~CHP~~ **CHP+** on a short enrollment form through an information sharing agreement between WIC and ~~CHP~~ **CHP+**.

~~The Commodity Supplemental Food Program (CSFP)~~ provides infant formula and nutritious foods to supplement the diet of pregnant and postpartum women and children under age 6. Women who live in Conejos, Costillo, Denver, Mesa, Rio Grande or Weld counties and who have a combined family income at or below 185% of the federal poverty level qualify for the program. CSFP distributes short application forms for the ~~Colorado Child Health Plan~~ **CHP+**.

**2.2.2.**

**The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:**

Colorado currently has three public efforts underway to identify and enroll uncovered children who are eligible to participate in health insurance programs or to receive health services that involve a public-private partnership. These efforts are: 1) the ~~Colorado Child Health Plan~~ **CHP+**, 2) the Kaiser School Connections Program, and 3) voluntary practitioner programs.

1. Colorado takes the following steps to enroll children in the ~~Colorado Child Health Plan~~ **Children's Basic Health Plan, dba Child Health Plan (CHP+)**:

Outreach and application assistance is available at contracted health care provider offices (including FQHCs, DSH hospitals, local county health departments, and private providers).

A primary vehicle for identification and enrollment of children is on-going cooperation with local school districts to market the program. Children eligible for the Free and Reduced Price Meals programs, the Special Nutritional Program for Women Infants and Children (WIC) program and the Health Care Program for Children with Special Needs

(HCP) have a shortened application form and facilitated application process. Children who are not already receiving public assistance through these particular programs can apply for ~~the CCHP~~ **CHP+** on a longer application form.

Outreach through posters, brochures, presentations, public service announcements, and television ads target audiences of potentially eligible families and children.

~~As mentioned above, the Colorado Child Health Plan (CCHP) is a health insurance program for children 17 and under with family income at or below 185% FPL. The CCHP covers outpatient services including preventive and primary care, specialty care, emergency care, diagnostics and prescriptions. The CCHP has been established through a broad community coalition including generous support from Blue Cross Blue Shield of Colorado and the University of Colorado Health Sciences Center, among others.~~

The outreach coordinator at ~~the Colorado Child Health Plan~~ **CHP+** works actively to recruit social service workers, county commissioners, physicians and physicians groups, hospital administrators, family resource centers, school nurses, public health nurses and school district representatives to hold community forums where information about ~~the CCHP~~ **CHP+** is widely distributed. ~~In 1997, eight such community forums were held throughout the state with widespread community participation. These representatives throughout the state act as advocates for children to enroll them into the program.~~ Families enroll their children on a mail-in application available by calling a toll-free telephone number. Furthermore, children who want to enroll ~~in the Colorado Child Health Plan~~ **CHP+** and are determined to be eligible for Medicaid (and therefore ineligible for ~~CCHP~~ **CHP+**), are redirected to their county social service agencies and are strongly encouraged to apply for Medicaid coverage.

2. Kaiser Permanente offers the School Connections program, a **new** health care plan for low-income uninsured school children, introduced in January 1997. School Connections is the first program in the nation to offer full comprehensive health care services in collaboration with school-based health centers. The program enables 1,300 children to receive full Kaiser Permanente benefits for \$3 a month. Preventive services are provided at the school-based health center and Kaiser Permanente provides the rest. Services include primary care, mental health, chemical dependency, laboratory, x-rays, emergency care, specialty care, and outpatient **and** inpatient hospital care.

~~School Connections is a collaborative two-year pilot program that is estimated to cost \$1 million annually. School Connections is available through twenty Denver, Adams County District 14 and Sheridan public schools. If a child is eligible for the Free and Reduced Price Meals Program, the child is eligible for School Connections. Children can enroll on a first-~~

~~come-first-served basis if they are attending one of the selected schools. The creation of the School Connections program has been the result of a public-private partnership with the Colorado Department of Public Health and Environment, the Colorado Department of Health Care Policy and Financing, school-based health centers and Kaiser Permanente. Enrollment for the program has been successfully achieved through cooperation between the participating school districts and Kaiser Permanente.~~

Kaiser Connections is a two year pilot program which will end on 12-31-98. The program serves three school districts in the Denver-metro area. Current enrollment is approximately 700 children with an enrollment cap of 1300. CHP+ and Kaiser Connections both service children from families with incomes below 185% of FPL. Until 12-31-98, children from eligible families will be able to choose which program they would prefer to participate in, although Kaiser Connections program may have reached its cap by the time that the **Children's Basic Health Plan dba Child Health Plan Plus** began enrollment. When the pilot is over, Kaiser will evaluate and decide how to continue the program that competes with the Children's Basic Health Plan. They may target a different population or coordinate their programs with CHP+.

3. Voluntary practitioner programs include The Children's Clinic in Fort Collins, The Monfort Clinic in Greeley, Doctors Care in Littleton, Rocky Mountain Youth in Denver, and the Marillac Clinic in Grand Junction. Doctors Care operates a primary care clinic staffed by nurse practitioners. The program refers patients who need specialty care to members of the Arapahoe Independent Practice Association, who provide free care. Rocky Mountain Youth, a Denver not-for-profit, provides health care services to low-income and homeless children. The group also aids practitioners in understaffed rural communities and staffs a mobile health van. In 1996 the organization treated 10,000 children. Five doctors, three nurse practitioners and a social worker provide health care on a sliding fee scale with reimbursement from Medicaid, client cost sharing, and donations from the community. The Marillac Clinic in Grand Junction is staffed by volunteer physicians and nurses, and provides free care to individuals who have no coverage of any kind. These programs advertise through school districts, county health departments, doctors' offices, and hospitals.

~~In the current CHP program, voluntary practitioner programs are CHP providers and perform outreach functions for the CHP.~~ Under CHP+, these providers could subcontract with a **Children's Basic Health Plan, dba CHP+, contracted HMO**, or in a non-HMO county, continue to provide FFS services.

The Mental Health Capitation Program provides mental health services to Medicaid recipients in Colorado. Any savings from the capitation program, may be used for direct services. These funds, if available, supplement existing funds used to provide mental health and substance abuse

services to the indigent uninsured. These services would be available CHP+ enrollees. For non covered services--either services that are not covered under the benefits package or benefits that have been exhausted under the CHP+ plan. However, these services are not entitlement services, and availability varies by service, recipient, and geographic area.

**2.3 Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered: (Section 2102)(a)(3)**

1. ~~Current~~ Colorado Child Health Plan members ~~will have a had~~ the choice of staying in the outpatient CCHP or enrolling in **the Children's Basic Health Plan, dba** Child Health Plan Plus (CHP+) to receive a comprehensive benefits package. These members ~~will receive~~ **received** materials informing them of their choice and the process for enrolling in the CHP+. See Section 5 for a description of the outreach methods to ~~current~~ CCHP members. Children applying to the CHP+ on or after ~~January 1, 1998~~ **will April 22, 1998 did** not have the CCHP outpatient option and ~~must had to~~ choose the comprehensive CHP+ benefits package.

The ~~state plans to coordinate~~ Department has coordinated its program eligibility and HMO enrollment efforts for the **Children's Basic Health Plan, dba** CHP+ with community health centers, CACP providers, Medicaid, and public health outreach nurses. These providers ~~will~~ either help determine CHP+ eligibility (through a rules-based eligibility system available on an Internet Web site or through paper applications faxed or mailed to the **Children's Basic Health Plan, dba** CHP+, administrative offices) or ~~will~~ refer people to the CHP+ toll-free telephone line for eligibility determination. **The Children's Basic Health Plan, dba** CHP+, ~~has pursued~~ **will pursue** cooperative agreements with interested county social service offices to exchange CHP+ and Medicaid application information. Families who apply for Medicaid ~~will be~~ **are** informed about **the Children's Basic Health Plan, dba** CHP+, and families applying for CHP+ ~~will be~~ **are** informed about Medicaid. Medicaid applicants with children who do not qualify for Medicaid ~~will be~~ **are** asked to sign a release form permitting the information provided for their Medicaid application to be used to determine the children's eligibility for the **Children's Basic Health Plan, dba** CHP+. Likewise, CHP+ applicants found to be Medicaid eligible ~~will be~~ **are** asked to sign a release permitting the information provided for their CHP+ application to be used to determine the child's eligibility for Medicaid.

The **Children's Basic Health Plan, dba** as Child Health Plan Plus ~~will undertake~~ **is using** a two-phase approach to ensure that Medicaid-eligible children are enrolled in Medicaid. The first

phase ~~will entail~~ entails *summary* screening of CHP+ applicants for Medicaid eligibility and referral of children likely to be Medicaid-eligible to county social service offices, as well as utilization of Medicaid outstationed eligibility and presumptive eligibility providers to determine CHP+ and Medicaid eligibility. The second ~~phase will entail~~ entails implementation of an integrated eligibility system for medical assistance programs including the Children's Basic Health Plan, dba CHP+, and Medicaid.

**Phase One: The Child Health Plan Plus Eligibility System**

From the date of state plan implementation until June 2000 when the Colorado Benefits Management System (see Section 2.3) is operational, the **Children's Basic Health Plan, dba CHP+** will collect family income, family size, and family asset information that will enable the eligibility technician to determine if the applicant is likely to be eligible for Medicaid. If the child appears to be eligible for Medicaid, the family will receive a letter informing them to contact their county social services office and will be given a 1-800 number if they have further questions. Information may be shared between CHP+ and county social services offices as described above.

Families who apply for **the Children's Basic Health Plan, dba CHP+**, at community health centers and other safety net providers who are Medicaid outstationed eligibility and/or presumptive eligibility sites can either receive assistance in applying for Medicaid or be presumptively enrolled in Medicaid if they are pregnant women or infants under one born to women enrolled in Medicaid. These Medicaid outstationed eligibility providers and presumptive eligibility sites will serve as Satellite Eligibility Determination Sites (**SEDs**) for the CHP+. This will assure coordination of Medicaid and CHP+ eligibility determination by allowing the same entities to determine or assist in determining eligibility for both programs. A family who applies for Medicaid at the county social services office and is found ineligible will be able to apply for **the Children's Basic Health Plan, dba Child Health Plan Plus**.

**Phase Two: Colorado Benefits Management System (CBMS)**

The second phase of coordinated Medicaid and Child Health Plan Plus eligibility determination requires the development of an integrated eligibility system. This information system, the Colorado Benefits Management System (CBMS), is a joint development effort between the Colorado Department of Human Services and the Colorado Department of Health Care Policy and Financing. Beginning in July 2000, providers, families, and public agencies will be able to determine eligibility for a range of public medical assistance programs through the CBMS. The CBMS will allow families who apply for the CHP+ but are determined to be Medicaid eligible to

automatically enroll in Medicaid. The CHP+ will pilot this rules-based eligibility system during phase one. Systems and rules developed through this Children's Basic Health Plan, dba CHP+ eligibility system will be incorporated into the CBMS upon its implementation.

~~The state plans to use~~ As of November 1998, the state is using an enrollment broker for the Medicaid managed care program to enroll Medicaid clients into HMOs. The enrollment broker ~~will help~~ helps Medicaid clients who call to find a managed care option that works best for them. The Medicaid enrollment broker contract ~~is estimated to begin January 1998. The RFP for the enrollment broker asked bidders to include~~ includes an enrollment function for the CBHP CHP+, ~~as well as to estimate the additional cost of conducting eligibility~~

~~determination for the CHP+. An enrollment broker with responsibility for the Medicaid and CHP+ programs would help~~ The enrollment broker helps families select providers to ensure continuity of care if they move between ~~the two programs~~ Medicaid and CHP+, Children's Basic Health Plan, dba CHP+, applicants ~~will~~ either choose an HMO at the time of eligibility determination, or choose an HMO within 14 to 45 days. The latter group ~~will be~~ is referred to the enrollment broker for information on health plan choice and HMO enrollment services based on CHP+ enrollment protocols. ~~The state will continue to explore the possibility of using the Medicaid enrollment broker for the CHP+ based on consideration of bids submitted in October 1997.~~

2. Current HCFA policy does not permit the use of the Internet for the transmission of data subject to the Federal Privacy Act (which would include Medicaid and Title 21). Based on this policy, the State's proposal to transmit eligibility information using the Internet would not be allowed. However, this policy is currently under review, and we are working to develop criteria for systems design and procedures that would be necessary to satisfy Federal Privacy Act concerns. The State's proposed system would need to satisfy these criteria in order to be approved for use under Title 21 or Medicaid, and our approval of the Title 21 plan would be contingent on the State's satisfaction of those requirements.

We understand the importance of defining criteria and protocols regarding the use of the Internet for transferring data governed by the Federal Privacy Act. We agree to comply with HCFA criteria for systems design and procedures when they are published. The following information is submitted to help you understand our opinions regarding a technical security model for using the Internet. We believe that when layers of this model are combined, a secure means of transferring data ~~will be~~ is achieved.

A security model must include a clear policy and procedure set for governing the communication with users, for a testing strategy, and for auditing. These components ~~will be~~ are addressed

individually below.

Communication: All user institutions **will must** sign a statement of intent regarding the appropriate use of the **Children's Basic Health Plan, dba CHP+**, system. Each **institution will be expected to provide provides** an individual or department that assumes responsibility for the installation and configuration of client systems as well as the dissemination of user passwords. If the local administrator has reason to believe that the password has been revealed to an unauthorized user, he or she **will be expected is** to inform the CHP+ system administrator so that the password may be changed.

Testing: All new application components will be tested rigorously using a pre-designed set of procedures and/or rules. The purpose of this testing is to establish that only authorized users are able to access the system and that a user, once connected, may only gain access to those portions of the server required to run the application.

Auditing: Log files will be generated of all accesses made to the system. A procedure will be developed for the systematic review of those log files with the purpose of identifying potential unauthorized use of the system. Any identified infringements will result both in communication with the users and refinement of the security model and testing procedures as necessary to prevent further infringements of the same type.

From a technical perspective, Internet access is governed at four levels: physical, network, transport, and application. Below, is our proposal for how security will be implemented at each of the four levels.

Physical: The Internet server **would be is** physically controlled by housing it in a secure location under lock and key, similar to any other centralized computing resource. Access to this location **will be is** restricted to authorized CHP+ employees and their agents.

Network: Communication with the system via the network **will be is** controlled by restricting both the sources and the types of communication allowed. In order to restrict communication from unauthorized locations, access control lists **will be are** maintained at the web server, a designated firewall system and/or an intervening router. In addition, the types of communications protocols allowed to enter the system **will be are** carefully monitored and controlled. Only the protocols required to access the system **will be are** allowed. At this time our primary protocol for access is HTTP. Protocols and commands that will be stopped are Telnet, FTP, SMTP, Ping, Finger, Netstat, Echo, and remote login commands such as rsh, rlogin, and rdist.

Transport: To secure the transfer of data across the Internet, the system **will incorporate the use of uses** the Secure Sockets Layer (SSL) protocol for encryption and user identification. Because SSL generates a new encryption key for each session, a user who manages to break the SSL encryption of a message **will at most gain at most gains** access to the contents of a single transmission. The encryption algorithm **will use uses** a 128-bit key as a minimum. Password and/or encryption **will restrict restricts** access to the private key required at the server for the implementation of SSL. In addition, all users **will be are** required to install and transmit their own digital certificates from a designated certification agency.

Application: To assure user identification, a login ID and password **will be are** required to gain access to the system. The login ID and password **will be are** specified by our central administration staff. Criteria for formatting the login ID and password **will be are** strictly enforced by security software on the server operating system. Passwords **will be are** hanged regularly by the CHP+ administrator and disseminated via mail or phone to the local system administrator. In addition, server browsing **will be is** disabled so that users may only view and access those files and directories for which they have a valid address.

In order to access the system, a user **will need needs** a valid certificate from the appropriate certification agency, a valid user name and password combination, and **an** application capable of communicating through HTTP. Login ID's, passwords, **and** business data **will be are** encrypted. The communications protocols, source addresses, and destination addresses **will be** controlled. A policy governing appropriate design and use **will be is** enforced. With this multi-layer security approach, we believe that users **will** only achieve access to specifically designed applications.

Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4)

Delivery of health services to Children's Basic Health Plan, dba Child Health Plan Plus members ~~will be~~ is primarily through Health Maintenance Organizations (HMOs.) ~~The outpatient Colorado Child Health Plan currently maintains its own statewide provider network. This network will be~~ The statewide provider network established by the former Colorado Child Health Plan has been expanded to care for children who are eligible for CHP+ but who have not yet been enrolled in an HMO (HMOs generally initiate coverage on the first of the month only), or those children who live in areas where no HMO service is available.

**HMOs**

While over 20 HMOs are licensed to do business in Colorado, state legislation (House Bill 97-1304) requires that only plans willing to contract with Medicaid are eligible to serve CHP+ clients. This will insure that clients are not forced to change providers each time their financial situation changes the program for which they are eligible. Currently, seven HMOs contract with the Colorado Medicaid program: Kaiser Permanente, Rocky Mountain HMO, Colorado Access, ~~QualMed~~, Community Health Plan of the Rockies, United HealthCare, HMO Colorado. These plans vary in structure, service area and membership. For example, Kaiser Permanente operates in the Denver metropolitan area and has over 300,000 commercial members. Rocky Mountain HMO serves significant numbers of commercial and Medicaid clients statewide. Colorado Access serves exclusively Medicaid members in metropolitan areas throughout the state using community health centers and public hospitals for service delivery.

~~HMO contract standards and premiums will be developed in collaboration with the Children's Basic Health Plan design teams. (See Section 9.9 for a description of the process to involve the public in design of the plan.)~~ The Department has negotiated the HMO contract with six of the seven HMOs (the Rocky Mountain HMO contract has not been finalized. The next contract for the cycle (FY 99-00) will address the following areas: enrollment, marketing, benefits, premiums, provider network, utilization management, quality of care, access to care, member rights, and grievance procedures.

Contract standards will be based on a review of standards from the following sources: National Association of Insurance Commissioners (NAIC) Model Acts, National Committee for Quality Assurance (NCQA) Accreditation Standards, and Quality Improvement System for Managed Care (QISMC) standards, ~~and commercial HMO contracts in Colorado (if available) such as The Alliance (a small group purchasing cooperative) and The Colorado Business Group on Health (a large employer coalition). Final contract provisions will be were negotiated through the Contracting and Quality Assurance Team composed of consumers, plans, state agencies, and provider organizations.~~

~~A potential~~ CHP+ HMO ~~contractor will~~ contractors have to pass the examination of three entities: the Colorado Division of Insurance (DOI), the Department of Public Health and Environment (CDPHE) and the Colorado Department of Health Care Policy and Financing (HCPF). The DOI grants HMO licenses based on a review of financial stability, adequate provider subcontracts, access to care and quality of care. The DOI subcontracts the quality and access review to the CDPHE. When a licensed plan applies for a Medicaid contract, HCPF reviews several aspects of the plan's operation including provider network, utilization, management, access to care, quality improvement and grievance procedures. ~~HCPF will further review a Medicaid plan who applies to serve CHP+ clients.~~ HCPF reviews the Medicaid plans that apply to serve CHP+ clients. Where CHP+ contract standards vary from those of DOI and HCPF, the Department ~~will conduct~~ conducts additional reviews in coordination with the Medicaid, DOI, CDPHE, or other purchaser reviews. For example, an appropriate CHP+ network ~~would include~~ includes an adequate number of pediatricians and pediatric specialists within a reasonable distance of potential enrollees.

~~Project staff plan to have executed contracts with participating CHP+ HMOs on January 1, 1998.~~

~~Children's Basic Health Plan, dba Child Health Plan Plus, Provider Network~~

The ~~existing~~ former Colorado Child Health Plan ~~has~~ developed its own statewide provider network, with provider contracts held by the University of Colorado Health Sciences Center (UCHSC). UCHSC continues to hold those contracts through a memorandum of understanding with the Department. These physicians, hospitals and ancillary service providers ~~will deliver the~~ provide services covered by the Children's Basic Health Plan, dba Child Health Plan Plus comprehensive benefit package ~~described in Section 6.2~~ in areas where HMO services are not available, mainly rural areas. ~~The Department of Health Care Policy and Financing hopes that areas of the state without HMO coverage will be very few if any.~~ Although this network covers 40 of 63 counties in the state, only 15 percent of CHP+

eligibles live in those counties. In its provider network program, the CHP+ reimburses ~~its~~ primary care physicians ~~under~~ through capitation payments and ~~—~~ ~~reimburse its~~ reimburses specialty, inpatient, and pharmaceutical providers on a fee-for-service basis. ~~Blue Cross Blue Shield of Colorado will continue to donate the plan's fee-for-service claims processing services.~~ Pharmacies accepting the PCS Health Systems plan ~~will~~ continue to provide prescription benefits.

Essential Community Providers: As required by state legislation (House Bill 97-1304), the Child Health Plan Plus only contracts with HMOs that contract with the Colorado Medicaid program. To retain their Medicaid contracts, these HMOs must fulfill the statutory requirements of **SB 97-75** with regard to use of ECPs. Therefore, the CHP+ HMO network includea these providers. ECPs include community health centers, community mental health centers, public health agencies, school-based clinics, family planning clinics, and other indigent care providers.

Primary Care: ~~CBHP~~ CHP+ ~~will use~~ uses the former Colorado Child Health Plan physician network ~~that currently includes~~ of over 1,000 participating primary care providers to provide routine care and case management. Primary care providers receive a monthly capitation payment.

~~For members whose utilization of care is significantly greater than the norm, the CHP+ will, upon review by plan's medical director, either supplement the capitation with a case management fee, or pay the lesser of billed charges or the CHP+ maximum reimbursement minus the copayment instead of the normal monthly capitation.~~

Immunizations: ~~Like the Colorado Child Health Plan, the~~ The Children's Basic Health Plan, dba. CHP+, ~~will aggressively encourage~~ aggressively encourages appropriate immunizations for its members. ~~The Colorado Department of Public Health and Environment supplies CCHP providers with free vaccine under the Vaccines for Children Program. CCHP now pays its~~ CHP+ pays physician network providers for the cost of the vaccine plus a \$10 per dose ~~as an~~ administration fee.

Specialty Care: ~~As with the Colorado Child Health Plan, primary~~ Primary care providers ~~will~~ refer CHP+ members to any one of over 1,500 participating specialists for medically necessary specialty care.

Hospital Benefits: ~~As the Colorado Child Health Plan has done~~ ~~for non-inpatient hospital benefits, the CBHP will pay for all hospital benefits fee-for-service at the Colorado Medicaid rate.~~ CHP+ pays for all hospital benefits on a fee-for-service basis using the Colorado Medicaid rate. The plan has ~~already~~ signed contracts with 57 hospitals throughout the state. These contracts are being amended to include inpatient care.

**Pharmaceuticals:** ~~Like the Colorado Child Health Plan, the CBHP dba CHP+ pharmaceutical benefit will be~~ Pharmaceutical benefits are available to CHP+ members through the HMO PCS Colorado pharmacy network. This affiliation allows the plan to process claims through the online PCS Health Systems plan. All pharmacies contracted with PCS are able to accept ~~CHP- CHP+~~ CHP+ member prescriptions. The majority of Colorado's pharmacies belong to the PCS network.

~~For the purposes of procuring medical providers, the Colorado Child Health Plan maintains contractual agreements with primary care providers, specialists, ancillary care services, hospitals and provider networks throughout the State.~~

**3.2 Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)**

HMOs and providers who contract with the **Children's Basic Health Plan, dba Child Health Plan Plus (CHP+)**, program ~~will~~ primarily perform utilization management functions. Utilization management functions for the CHP+ provider network ~~will be~~ are split between contracting providers and the Child Health Plan Plus. Health maintenance organizations, on the other hand, ~~will~~ have a full delegation of all utilization management functions.

**The Children's Basic Health Plan, dba CHP+**, contract standards ~~will~~ require a participating HMO to have adequate utilization management staff and procedures to assure that services provided to enrollees are medically necessary and appropriate. The utilization management contract standards ~~will~~ address the contractors written program, procedures, staff, timelines, and denials. Project staff will review the NAIC, NCQA, and QISMC guidelines referenced in Section 3.1 for development of these standards, but will also ensure that the standards are consistent with Colorado Division of Insurance regulation requirements.

**HMO Utilization Controls**

Monitoring HMO compliance with utilization management contract standards will be accomplished in one of three ways: 1) the plan will show current NCQA accreditation (only two of the seven eligible plans now have this status); 2) CHP+ program staff will coordinate with Medicaid annual on-site review; or 3) the **Children's Basic Health Plan, dba CHP+**, will contract with an external review entity to evaluate plan contract compliance. Project staff will

evaluate the appropriate mechanism to review non-NCQA-accredited plans, based on factors such as effectiveness and cost.

### **Fee for Service Network Utilization Controls**

The **Children's Basic Health Plan dba** Child Health Plan Plus will use utilization control methods ~~currently~~ employed by the Colorado Child Health Plan: primary care providers, referrals, prior authorizations, and educational services.

### **Primary Care Providers (PCPs)**

The Colorado Child Health Plan depends upon its PCPs to tightly manage member care. The child's PCP is the first person the child sees when she is sick or needs preventive care (except when visiting a participating OB/GYN physician for an annual gynecological exam). The primary care provider's office should be easy for the child to travel to and easy to reach by telephone at all times.

The PCP performs all routine non-emergency care for the child and services that are usually done periodically within a specific time frame (e.g., immunizations or physical exams). Routine care is performed during the PCP's normal business hours. When the child visits his or her primary care provider, the child can see any of the participating health care professionals in that practice including MDs, DOs, nurse practitioners, child health associates, and physician's assistants.

The PCP makes all necessary arrangements for the child's care. The PCP will refer the child to a hospital or specialists when needed. A referral must be issued from the primary care provider before the child receives services from a specialty provider or facility. This referral must be entered into the plan's system and a referral number must be generated before the referred service claim will be reimbursed.

The child may change PCPs at the time of renewal and only once without cause during the enrollment year. Exceptions to this policy may be made for a change of residence and on appeal. The appeal must be documented explaining the reason for the change request.

### **Referrals**

The PCP will obtain a referral number from the plan's third party administrator by phone or will fax the referral information to the plan's third party administrator. ~~Blue Cross Blue Shield of Colorado for will continue to donate these third party administration services.~~ The plan will mail a confirmation referral form or a denial of the referral request to the member, the PCP, and the specialist. For in-network referrals, confirmation or denial will be given over the phone or within 24 hours by Fax.

The referral letter indicates the number of visits approved and the time period in which the member must receive care. If only one visit is authorized, a second visit will not be covered. The family is responsible to pay for all visits in excess of those authorized and for care received before or after the specified time period.

A referral is not required for a child to visit a participating OB/GYN provider for an annual routine gynecological exam. To visit an OB/GYN provider without a referral, the member must choose an OB/GYN provider within the plan network; otherwise, coverage will be denied. To visit an OB/GYN provider outside of the plan network, a referral to a non-participating provider must be obtained.

**P** \_\_\_\_\_

Prior authorizations from the plan are required before a member can receive certain services or services outside of the plan's network. The child's PCP is responsible for obtaining all necessary prior authorizations. Services requiring prior authorizations include, but are not limited to:

All outpatient therapies including physical therapy, speech therapy, and occupational therapy  
Services performed by a provider outside the plan's network  
Elective hospital admissions  
Hospice care  
Inpatient and outpatient surgery  
Durable medical equipment  
Some diagnostic tests  
Some prescriptions

A complete list of services requiring prior authorization is available to providers in the CHP+ Provider Manual

### **Educational Services**

The plan provides families, health care providers and human services workers with education about the plan and how to use the plan. This includes quarterly newsletters **about new policies, common problems and frequently asked questions; a Benefits Booklet; and a Provider Manual. Customer service representatives are available to answer questions.**

3. How will the State assure that children with special needs receive care from adequately experienced providers? Will these children be allowed to have specialists as their primary care providers?

As described in Section 7.2 of the State Plan, the provider networks of contracted HMOs will be evaluated for adequacy of pediatricians and pediatric specialists. A review of the numbers and types of pediatricians and pediatric specialists will be conducted jointly by the Division of Insurance and will be based on the Access Plan, which describes a plan's provider network including numbers, types, locations, referrals and accommodations for members with special needs.

Contracts with managed care plans **will** require that the plans have a process in place to permit special needs children to obtain a standing referral for specialty care. **The managed care contract will definit defines "special needs." If a child's primary care physician determines that the child has special needs, the physician will give the child a standing referral to the appropriate specialist. The standing referral can be renewed on an annual basis.**

The CHP+ HMO contract reads:

Special Health Care Needs: With respect to persons enrolled pursuant to this contract, shall mean ongoing health conditions that:

Have a biological, physiological or cognitive basis

Have lasted, or are virtually certain to last, for more than one year, **and**

Produce one or more of the following sequelae;

- a. significant limitation in areas of physical, cognitive or emotional function;
- b. dependency on medical or assistive devices to minimize limitation or function of activities;
- c. significant limitation in social growth or developmental function;
- d. need for psychological, education, medical or related services over and above the usual for a child's age; or
- e. special ongoing treatments such as medication, diets, interventions, or accommodations at home or school.

1. The Contractor agrees to have a mechanism to determine if a Member has Special Health Care Needs. The Contractor agrees to have a system in place to allow the Primary Care Physician (PCP) to provide standing referral for Members with Special Health Care Needs to a specialist. A standing referral will need to be renewed once a year.

2. The Contractor must have in place for Members with Special Health Care Needs an adequate network of pediatric providers and subspecialists and contractual relationships with tertiary institutions to meet their medical needs. All members with Special Health Care Needs must have timely access to:

- a. comprehensive evaluation for the condition
- b. pediatric subspecialty consultation and care appropriate to the condition, and
- c. rehabilitative services provided by professional with pediatric training.

The **next** HMO contracts ~~which will take effect~~ commenced on July **1, 1998, will specify specify** a working relationship between the Health Care Program for Special Needs and the MCOs, not only to provide case management for these children, but for the public agency to pay for treatments and durable medical equipment costs which exceed the basic benefit design

In addition, the **Children's Basic Health Plan, dba** CHP+, program ~~will build~~ **is building** on the five-year collaborative relationship of the ~~current former~~ CHP program with the Health Care Program for Special Needs (HCP), headquartered in the Department of Public Health and Environment. HCP has long been funded as a program targeting the high cost services and routine case management for children with special needs. Since HCP can pay only for treatments and services as they relate to the child's handicapping condition, HCP has depended upon the

**former CCHP to provide these children with primary and preventive care since the inception of the CCHP. ~~The CCHP application for HCP recipients is presented in Attachment One.~~**

Both the MCO health delivery system and the fee-for-service delivery system under CHP+ **will continue to work collaboratively with HCP. ~~The fee-for-service component of the CHP+ will continue to coordinate benefits with the HCP. In preliminary contract negotiations with HMOs hoping to serve the CHP+ enrollees, plan representative have been enthusiastic about the opportunity to contract with the HCP for assistance in case-managing special needs children. Many of these plans recognize that they do not have a great deal of experience working with special needs children and want to learn more about what HCP can offer.~~** The CHP+ staff **will work** works with staff at HCP to convey the needs of the managed care plans and assists the HCP in developing a case management product that is attractive to these plans.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section **2102(b)(1)(A)**)

4.1.1. Geographic area served by the Plan: The plan is available statewide, in all 63 Colorado counties.

4.1.2. Age: The plan is available to children 0 through ~~18~~ 17 years of age. This age criteria allows a family to apply for one full year's coverage up to the day before the child's 19th ~~18~~<sup>19</sup> birthday. That child will then receive 12 months coverage through the day before that child's ~~19~~<sup>19</sup> birthday. The family must prove the child's birth date by submitting a birth certificate, a hospital record or a baptismal record.

4.1.3. Income: Eligible children are from families whose incomes are at or below 185% of the federal poverty level. Children seeking coverage under the Child Health Plan Plus cannot be eligible for Medicaid. See Attachment 3 for a description of the family size and income criteria.

4.1.4. Resources (including any standards relating to spend downs and disposition of resources): The net asset value of family resources in excess of disallows in four categories is added to income when determining a family's financial eligibility. These asset values do not have to be documented. Technicians rely upon a family's self-reported net asset values. The value of assets in excess of the disallows are counted as income. There is no requirement that assets be less ~~than~~ a certain amount for a person to be eligible for CHP+. See Attachment 4 for a description of the Colorado Child Health Plan resource verification criteria ~~that will be~~ used by the CHP+. The plan will allow spend downs for medical bills, day care, and child support. These are detailed in Attachment 4.

4.1.5. Residency: Colorado residency is required. A resident is anyone who is: 1) a U.S. citizen; or 2) a documented immigrant; or 3) a Colorado resident; or 4) a migrant worker. See Attachment 5 for a description of the residency verification criteria.

The State ~~intends to comply~~ complies with immigration requirements established in Sections 403 and 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, and the

Balanced Budget Act of 1997.

CHP+ eligibility technicians will use the 1-551 Resident Alien Card to verify the month, day and year when the applicant child became a temporary resident. ~~This information is indicated on the card in a field labeled "TEMP RES ADJ DATE." If there is no date given, the applicant child did not received lawful permanent resident status. The temporary residency adjustment date will indicate the arrival of an immigrant before 8/22/96. Simple subtraction from the current eligibility date should indicate continuous residence for more than five years.~~

~~The CHP+ application will contain a question about the child's arrival date in the US as a further indication of residency status.~~

~~Plan administration will explore the use of the Systematic Alien Verification for Entitlements (SAVE) to further help verify an alien's immigration status through an INS computer database.~~

The supporting documentation contains references to the 1-551 form and will be updated to reflect that the date for permanent resident status should be drawn from the Date Adjusted to LPR status section.

The State uses the evidence provisions of State Medicaid Manual section 3212. The State also intends to use the SAVE system used by Medicaid to verify eligibility.

**4.1.6.** Disability Status (so long as any standard relating to disability status does not restrict eligibility): No child is denied eligibility based on disability status. If the child receives SSI and is eligible for Medicaid, the child will be denied coverage because she is eligible for Medicaid, not for reasons of disability status.

**4.1.7.** Access to or coverage under other health coverage: Both the application and the separate "Insurance Form" ask families questions about other insurance coverage. The plan administration seeks information about all other access to health care coverage, both public and private, on the application form before the child is enrolled in the plan and from providers once the child is enrolled in the plan. A child will be found ineligible if: 1) she is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; or 2) she is eligible for Medicaid; or 3) she is a member of a family that is eligible for health benefits coverage under a State health benefits plan based on a family members' employment with a public agency in the State; or 4) she has had coverage under an

employer plan with at least a 50% employer contribution during the past three months.

**4.1.8.** Duration of eligibility :Once a child has been accepted, he or she is continuously eligible for one year from the date of the application or HMO enrollment unless the child moves from the state or becomes enrolled in Medicaid.

**4.1.9.** Other standards (identify and describe):

**4.2.** The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section **2102)(b)(1)(B)**)

**4.2.1.** These standards do not discriminate on the basis of diagnosis.

**4.2.2.** Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

**4.2.3.** These standards do not deny eligibility based on a child having a pre-existing medical condition.

**4.3.3** Describe the methods of establishing eligibility and continuing enrollment. (Section **2102)(b)(2)**)

Both initial eligibility and annual renewal eligibility for the Child Health Plan Plus ~~will be~~ are determined either at the main office or at a decentralized eligibility site. All applications ~~will be~~ are received by mail or by Fax at the central office or during face-to-face interviews at the decentralized sites.

~~The CCHP administration uses Children's Basic Health Plan, dba CHP+, uses one of four methods for determining an applicant's income to establish current financial status. The following Colorado Child Health Plan methods of establishing eligibility and continuing enrollment will be applied to the Child Health Plan Plus. The methods are:~~

- Method I: Current employment income and cash from other sources reported on a ull application is used to qualify families with employment or retirement income.
- Method II: The current monthly expenses method is used for self-employed and unemployed applicants. These monthly expenses are reported on a full application.

Method III: For unemployed applicants who cannot document monthly expenses, and or seasonal workers who have indicated uneven employment in the "Income Exceptions" portion of the application, the plan administration uses the most recently filed income tax return. The income **tax** return is enclosed with the family's full application.

Method IV: For children whose families are enrolled in any one of six other state assistance programs CHP+ will enroll these Medicaid-ineligible children in the plan using "easy enrollment" procedures. Application for the CHP+ thus can be made on one of three short applications. Verification of income reported on short forms is obtained directly from the plan's sister agencies. This income verification determines both program eligibility and family cost-sharing requirements.

1. The yellow short form is made available to families who have enrolled in the Colorado Indigent Care Program (CICP) through one of the state's "safety net" providers. Since the eligibility guidelines for CHP+ are identical to those used by the CICP, children enrolled using this short application immediately receive the same letter rating as that assigned to the family at the decentralized eligibility site for the CICP.
2. The green short form is made available to families with at least one child enrolled in the state's Free and Reduced-Price Meals Program. Children who receive Reduced-Price Meals are automatically eligible for CHP+ because their families' income is, by definition, between 130% and 185% of the Federal Poverty Level. Children who receive Free Meals are screened for Medicaid eligibility before they are enrolled in **the Children's Basic Health Plan, dba CHP+**.
3. The purple short form is made available to families with at least one family member enrolled in either the Commodity Supplemental Foods Program, the Special Nutritional Program for Women, Infants and Children, or the Health Care Program for Children With Special Needs. Each of these programs has a family income ceiling of 185% of the Federal Poverty Level. In each case, applying children are screened for Medicaid eligibility before they are enrolled in the CHP+.

Application and member tracking within the CHP+ information system includes five major functions: the determination of patient-file status, application processing, eligibility determination, enrollment, and the storage of enrollment data for active patients. The majority of applicant data is stored in five primary tables: file tracking, application, family information and patient information, and enrollment.

These five tables are linked by a family identifier assigned at the time of entry into the tracking system and by the patient's social security number and unique state Medicaid identification number.

An additional table is used to provide the patient-provider link that is the basis of the capitation system.

#### Application Tracking

File folders are assembled with the last name of the parent, the postmark date of the application, an application tracking record, and all application documentation for each application received. Families are sent a letter requesting additional or missing information if necessary. When payment has been included in the application, the check, cash, or money order is removed and deposited in the plan's bank account.

Application information is entered into the data system and a unique family ID is generated at the time of entry for the purpose of linking related records within the system. The application tracking record for each application is maintained and updated throughout the processing of the application.

#### Application Processing

Processing procedures differ slightly for each of the four different types of applications. The full application allows the CHP+ eligibility technicians to use all income and resource information to assign families a "rating" or a letter assignment of financial condition. The processing of each of the three short "easy enrollment" applications follows slightly different verification procedures depending upon which other state program qualifies the family for "easy enrollment" in the **Children's Basic Health Plan, dba CHP+**.

*Processing the Full Application*

Upon receipt of a full application, the postmark is cut from the envelope and attached to the application before it is placed in a file folder labeled with a tracking sheet. There is a checkpoint on the tracking sheet for each piece of information which technicians must include before they can proceed with eligibility determination. Each checkpoint also represents a piece of data which is captured in the plan's information system.

Once the application is complete and plan eligibility technicians have received all necessary information, the next step is the entry of the family's application data into the information system.

Method I

The data entry form is modeled after the CCHP full application. This form stores work income, pay-period type, non-work income, previous year's income, expenses, assets, income exceptions, and other miscellaneous fields required for eligibility determination. All family size, income and/or expense, resource, and spend down criteria listed in Section 4.1 are used to determine the family's eligibility using the CCHP rules-based information system. The current year's total income is calculated as the sum of the work and the total non-work income fields.

The family income used for determining eligibility and family cost sharing is the sum of the gross income, adjusted home equity, adjusted business equity, and adjusted personal assets less the family deduction, any other liabilities, and the sum of all extraordinary (spend down) expenses. The applicant is then screened for Medicaid as described in Section 4.4.1.

Method II

When eligibility is determined using the monthly expenses method, annualized monthly expenses are used to determine the family's gross income. The family's cost sharing responsibilities and the child's eligibility for Medicaid is determined using the algorithm described under Method I above.

Method III

Where expenses are not available and/or the family has indicated an "Income

Exception," partial income information is then compared to the income reported on the most recently filed income tax return. If an income exception is noted, the smaller of the two years' incomes is used. Otherwise the larger of the two years' incomes is used. Again, the family's cost sharing responsibilities and the child's eligibility for Medicaid is determined using the algorithm described under Method I above.

***Processing the Short Form Applications and Creating the Patient Record***

Upon receipt of a short form application, the postmark is cut from the envelope and attached to a copy of the application before it is placed in a file folder labeled with a tracking sheet.

In the case of each of the short form applications, verification of income is received from the plan's sister agencies. This income verification allows the plan to determine the amount of cost sharing (premiums and copayments) for which the family is responsible. Once the child is screened for Medicaid eligibility, all children registered through the short form application are determined eligible.

**Decentralized Eligibility and the WER Site**

The Colorado Child Health Plan successfully piloted one fully operational decentralized eligibility site, The Resource Center in Grand Junction on the Western Slope. **This is now a site for the Children's Basic Health Plan, dba CHP+.** This site uses a duplicate of the ~~CCHP~~ CHP+ database and performs the same functions locally as those which occur at the plan's Denver offices. Data is sent from The Resource Center to **the CCHP** CHP+ central database at least weekly via the Internet and is matched and integrated into the plan's central database.

To replicate this decentralized eligibility site system, the plan **has** opted to develop a Web site data submission form. This can be viewed at [www.uchsc.cchp.edu](http://www.uchsc.cchp.edu). The plan has received requests to perform decentralized Web site eligibility from **six** organizations located throughout the state. The next site to become operational ~~will be~~ **was** the Denver Health and Hospitals system of eight neighborhood clinics, several school-based health centers and the city's major trauma hospital located in Denver County. Training for Web site submission was completed October 1, **1997**.

Other decentralized eligibility sites include a community health center network in south central rural Colorado, a provider's office in Pueblo, a health department in Fort Collins and another Resource Center located just west of Colorado Springs.

#### Enrollment in Health Plans

Parents who live in areas served by HMOs must select an HMO for their children to enroll in the **Children's Basic Health Plan, dba CHP+**. A family can select an HMO by: 1) indicating their HMO choice on the application form when they apply to the CHP+; or 2) selecting an HMO when they apply for the CHP+ at the time of service at a provider site. Families who live in an area without access to an HMO will receive care through the CHP+ provider network (expanded from the **current former CCHP** outpatient network to provide comprehensive benefits).

CHP+ applications **will** include information on health plan service area and, when **it is** available, quality indicators. Parents **will be are** instructed to select an HMO for their child(ren) and offered a 1-800 number to answer questions they may have. A parent who seeks care for their child at a provider's office and applies for the **Children's Basic Health Plan, dba CHP+** at the time of the visit can receive outpatient services through the CHP+ provider network on a fee-for-service basis until their HMO enrollment is effective. The child can receive outpatient fee-for-service care through the CHP+ for a period of 14 to 45 days until the effective date of HMO coverage. If the family selects an HMO at the time of treatment, they will have 30 days after the initial selection to change health plans. (Future health plan changes can be made under rare circumstances for good cause.)

#### Redetermination of Eligibility

Children enrolled in the **Children's Basic Health Plan, dba CHP+** will be guaranteed eligibility for twelve months. A renewal packet will be mailed to families 45 days before the day their CHP+ coverage will end without renewal. A reminder card to re-apply to CHP+ will be mailed 30 days before the end-of-coverage date. Families **will be are** given a 30-day grace period of continued coverage in month 13 with a financial penalty for failing to renew on time.

The family **will also receive** also receives a 30-day grace period beyond the child's expiration date. This grace period **will allow allows** the family time to complete a renewal application before the child's coverage is interrupted.

The "financial penalty" for failing to renew on time is that of interrupted

coverage. Plan administration understands that a family may fail to renew on time for a variety of reasons, among them attaining employer-based insurance which they may later lose, a move which disrupts the family's financial management, a shift to Medicaid coverage which may be of a few months' duration, or a change in custody or living arrangements for the child.

A newly eligible family will receive a guaranteed twelve months of continuous coverage. At the time of the child's annual renewal, the family will receive two notices of time to renew before the child's expiration date - one 45 days prior to the expiration date and one 30 days prior to the expiration date.

If the family does fail to renew with a complete application by the end of the 30-day grace period, ~~the family can still renew the child's eligibility. the child's eligibility may still be renewed.~~ The only penalty ~~imposed at that time will be an interruption in coverage.~~ **is interrupted coverage.** During the 30-day grace period, if the family does submit a renewal application, the **child will receive receives** continuous coverage through the thirteenth month. If the family does not submit a complete application before the end of the grace period, the child's eligibility **will end ends** on the child's official expiration date.

If the family fails to make premium payments, ~~the family will~~ receive two monthly past due notices and one, third and final disenrollment notice. Premiums ~~will be are~~ determined past due at the time of billing for the next monthly premium. If the child is disenrolled for her family's failure to make monthly premium payments, the plan will impose a lockout period.

~~There are two questions remaining before the Eligibility, Enrollment and Management Information Systems Design Team - the length of the lockout period and the liability of the family for payments in arrears. Even in this case, the lockout will carry no financial penalty other than, perhaps, requesting premium payments that remain in arrears.~~

~~The annual renewal process will require~~ Annual renewal requires the same financial, residency, and age documentation that is required at the time of the family's first application. The only document that **will does** not have to be submitted a second time, at the time of renewal, is the child's birth certificate. The family will be fully processed for eligibility at each renewal period.

**4.4. Describe the procedures that assure:**

**4.4.1. Through intake and follow-up screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))**

**Medicaid Screening**

Legislation for the original Colorado Child Health Plan **denies denied** coverage to any child who is eligible for Medicaid. The method described below is **now was used by the CCHP and will be is** used by **Children's Basic Health Plan, dba CHP+**.

Because Colorado's Medicaid eligibility depends on age and income, each child in a family must be separately screened for possible Medicaid eligibility. The plan's rules-based rating system applies the Medicaid rules by the child's age and the family's calculated income. Then, if one child of several in a family is found to be eligible for Medicaid, the plan's information system will allow technicians to enroll only those children not eligible for Medicaid in the plan's patient registration system.

Screening for Medicaid eligibility occurs at the time of enrollment. For each child listed on the application, the system displays whether or not she is eligible for Medicaid based on the algorithm described below. The operator may elect to enroll the child if the child is determined in fact not to be eligible based on some criteria not recognized by the system such as provision of a Medicaid denial.

For the purposes of the system, Medicaid eligibility is determined from a combination of the gross income determined above, the family size, the family's personal assets, and the equity in the family's vehicles. If the total personal assets less deductions is greater than \$1,000 or if the sum of the vehicle equity and the personal assets less deductions is greater than \$2,500, the family is deemed not eligible for Medicaid. Otherwise, if the age of the child is less than 6 and the family's total income is less than 133% of the federal poverty level, or if the child is less than 14 (born after September 30, 1983), and the family's total income is less than 100% of the federal poverty level, then the user is advised that the child may be eligible for Medicaid and must deliberately override the determination in order to enroll the child.

Until July 2000, the family of a child found to be eligible for Medicaid will receive a letter indicating that the child cannot be insured by the plan because he/she appears to be eligible for Medicaid. The family will be instructed to make application for Medicaid at the appropriate

county social services office and will be given a 1-800 phone number to call with further questions. The family will be notified that the application will be reconsidered if parents have applied for and been denied Medicaid within the last six months if they send a copy of the Medicaid denial to the **Children's Basic Health Plan, dba CHP+**.

CHP+ ~~will pursue~~ pursues cooperative agreements with interested county social service offices to exchange information collected for CHP+ and Medicaid applications. Families who apply for Medicaid ~~will be~~ informed about the **Children's Basic Health Plan, dba CHP+**, and families applying for **CHP+ will be** are informed about Medicaid. Medicaid applicants with children who do not qualify for that program ~~will be~~ are asked to sign a release form permitting the information provided for their Medicaid application to be used to determine the children's eligibility for the CHP+. Likewise CHP+ applicants found to be Medicaid eligible ~~will be~~ are asked to sign a release permitting the information provided for the CHP+ application to be used to determine the child's eligibility for Medicaid.

By July 1998, the CHP+ ~~should have had~~ an operationalized rules-based engine **designed by an interagency task force comprised of members of the State's Medicaid financing agency, the Department of Health Care Policy and Financing and the Department of Public Health and Environment, the Department of Human Services, the staff of the Children's Basic Health Plan dba Child Health Plan +, and the State's Indigent Care Program.**

Prior to the full implementation of the rule-based system, the eligibility staff ~~will screen~~ screened types of income manually and ~~make made~~ a determination of the appropriateness of the exclusion of reparation payments prior to entering the total income reported by the family under "non-work income." The specific exclusion of reparation payments is contained in the CHP+ Policies and Procedures Manual.

Even and appropriate treatment of reparations payments will be simple under the rules based system. Though income data will be collected for all income types, for the purposes of eligibility determination, income which is excluded by federal statutes will not be included in the determination of the total family income. Reparation payments, specifically, are not included in the determination of total family income.

Cash gifts, intangible income, reparation payments, per capita American Indian/Alaska Native payments, and other commonly reported income are included as non-work income. These payments are usually documented by submission of the applicant's award letter. In the absence of such documentation, the CHP+ asks the family to complete a "cash-gift form" that must be signed by the donor and the recipient.

During the transitional period, CHP+ will strengthen its Medicaid eligibility flags **to** encompass more Medicaid rules that would signal a referral to Medicaid. This process includes the following:

1. Recording of identifying information for all members counted as part of the ~~CCHP~~ **CHP+** family unit along with their relationships to the applicants. This will allow **an** accurate assessment of the Medicaid Budget Unit as distinguished from the CHP+ family.
2. The addition of itemized income and asset listing along with categorical descriptors to the database so that a correct assessment can be made of Medicaid income and assets.
3. Linking the asset in income records to the family members so that a correct determination can be made of the income and assets for the Medicaid Budget Unit.

The combination **of** the three revisions should allow a correct determination of the eligibility based on income and family size. Additional flags will also be added to the entry system to highlight cases where a child may be eligible for Medicaid due to their health status or some other factor.

Using the rules set, a precise determination of income for the Medicaid Budget Unit, including applicable income disregards, is being included to the initial screening for Medicaid eligibility. A series of questions will also be added to the application to flag cases where Medicaid eligibility may be conferred by health and other factors not discernible from the application data. Those cases will then be referred to Social Services for a full assessment of Medicaid eligibility status.

Medicaid eligibility personnel, Colorado Indigent Care Program personnel, and the CHP+ eligibility personnel ~~are working closely to define~~ **have designed** a common rules based eligibility system that ~~would~~ will be accessible through eligibility sites throughout the state.

The task force ~~is also working toward~~ **has developed** a shared application for both Medicaid families and CHP+. This shared application ~~will be distributed by the summer of 1998~~ **has been distributed**. ~~Until this application is operational, the CHP+ and Medicaid eligibility systems will work cooperatively, with follow-up, to make sure that families that are referred to Medicaid and complete the Medicaid application process.~~ A family denied CHP+ because the child appears to be eligible for Medicaid would have its financial, age and residency information forwarded directly to the appropriate county social service agency. Similarly, children denied Medicaid would have information sent directly from that Medicaid eligibility site to the CHP+ site.

In counties that have access to ~~both the Medicaid system and the CHP+ eligibility system~~ **systems**, the same technician will be able to accomplish eligibility determination and enrollment

for both programs.

**Other Creditable Coverage Screening**

The CHP+ application, like the **current former** Colorado Child Health Plan's application, **will ask asks** the applicant to report any health insurance coverage. If the family reports creditable coverage (most group health plans and health insurance coverage), the child will be found ineligible. Providers contracting with the **Children's Basic Health Plan, dba CHP+** will be required contractually to notify the plan whenever they have reason to believe a member has coverage other than CHP+. CHP+ will then verify coverage with the insurance carrier and notify the family that they will be disenrolled if the family continues to carry other coverage.

**4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))**

**The Children's Basic Health Plan, dba Child Health Plan Plus will ~~undertake~~ undertakes** a two-phase approach to ensure that Medicaid-eligible children are enrolled in Medicaid. The first phase **will be is** a screening of CHP+ applicants for Medicaid eligibility. Medicaid-eligible children **will be are** referred to county social service offices and application information **will be is** shared between Medicaid and CHP+ if the county social service agency and family agrees to do so. CHP+ eligibility staff **will follow follows** up on these referrals with clients and **will notify notifies** county eligibility staff that they have made a referral. Children who appear to be Medicaid eligible **will only be are only** enrolled in the **Children's Basic Health Plan, dba CHP+** after they have received a denial letter from a county office.

The second phase of coordinated Medicaid and **Children's Basic Health Plan, dba CHP+** eligibility determination will be based on the development of the Colorado Benefits Management System, an integrated eligibility system. Providers, families, and public agencies will be able to determine eligibility for a range of public medical assistance by July 2000 with the establishment of the Colorado Benefits Management System (CBMS). The CBMS will allow families who apply for the CHP+ but are determined to be Medicaid eligible to automatically enroll in Medicaid without requiring the family to go to the appropriate county social services office. The CHP+ will pilot this rules-based eligibility system that will later be incorporated into the CBMS upon its implementation.

**4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))**

The CHP+ application **will asks** whether the applicant has been covered under an employer

health benefits plan with at least a 50% employer contribution during the three months prior to application. A person will be ineligible for the **Children's Basic Health Plan, dba CHP+**, if they have had such coverage in the noted time period. The **Children's Basic Health Plan** application **will ask also asks** whether the applicant currently has group or individual coverage and will deem the child ineligible if he/she has such coverage. CHP+ eligibility technicians **will** verify this information with the families' employers if necessary.

**4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D))**

The **current former** Colorado Child Health Plan **has had** contracts with Indian Health Services in all areas of the state to allow tribal clinics to deliver health care to Native Americans. **The Children's Basic Health Plan, dba CHP+**, will amend and continue these contracts. Because the federal legislation governing the Indian Health Services has regulations against the use of managed care, CHP+ will pay these facilities fee-for-service. These primary care contracts, will continue to allow Native Americans full access to specialty providers through a managed care environment (though still paid fee-for-service.) This access to specialty care was previously unavailable.

**The Children's Basic Health Plan, dba CHP+** will work directly with the Indian Health Resource Center to reach out to Native Americans living in the Denver metro area, home to nearly half of Colorado's Native Americans. CHP+ will conduct outreach to Native Americans living in the remainder of the state, much of which is rural, through local public health nurses and case workers. In Southwestern Colorado, case workers at the San Juan Basin Health Department in Durango will provide outreach at two Indian Health Centers at the Ute Mountain Ute Indian Reservation near Towaoc and Southern Ute Indian Reservation in Ignacio.

**4.4.5.** Through coordination with sites that are capable of determining eligibility for a variety of other public and private programs (FQHCs, DSH hospitals, local health departments, and family planning clinics) the state will ensure that eligible individuals are enrolled in the appropriate program through a one-stop shopping approach. Please see Section 2.2 for a discussion of the **Children's Basic Health Plan, dba Child Health Plan Plus'** coordination with other public and private programs providing creditable coverage for low-income children. The CHP+ will continue the Colorado Child Health Plan's coordination of benefits procedures for public health services. **The Children's Basic Health Plan, dba CHP+, will act acts as** a "wrap-around" to other state programs providing direct services (not insurance) – especially the Health Care Program for Children with Special Needs (HCP) and clinical activities of the state's health departments and nursing services. This **will entail entails** coordination of benefits and CHP+

provider communications with the HCP program.

Easy enrollment procedures and collaborative outreach efforts, described in detail in Section 5.1 further the plan's goal to coordinate with other public and private programs.

**Section 5. Outreach and Coordination (Section 2102(c))**

**Describe the procedures used by the state to accomplish:**

**5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))**

Outreach ~~will be~~ is conducted using methods proven successful by the Colorado Child Health Plan and Medicaid, and through state programs, county agencies, and providers. At the state level, the Colorado departments of Health Care Policy and Financing; Human Services; Public Health and Environment; and Labor and Employment are working together to make available one-stop access to public assistance for low-income families where possible. **The Children's Basic Health Plan, dba CHP+, will work works** at state and county levels to encourage "one-stop" access to CHP+ information and enrollment. CHP+ outreach ~~will be~~ is conducted through established cooperative arrangements with agencies, programs and providers, using methods described below.

Two types of outreach ~~will be~~ are conducted.

First, children enrolled in the ~~current~~ **former** (outpatient benefits-only) Colorado Child Health Plan (CCHP) ~~will were~~ automatically ~~be~~ eligible for the new, full coverage **Children's Basic Health Plan dba Child Health Plan Plus**. Through direct mail, these ~~families will receive~~ **received** information ~~to enroll about enrolling~~ in the new program. ~~HMOs will be encour~~ **are encouraged** to include CCHP network primary care providers (PCPs), including essential community provides (ECPs) in their networks to assure continuity of care and continuous coverage.

The second type of outreach ~~will be~~ **was** to families with children likely to be eligible for the CHP+, but who ~~are were~~ not ~~currently~~ **enrolled** in the ~~former~~ Colorado Child Health Plan. This outreach ~~will occur~~ **occurred** at locations and through agencies where families access public assistance and/or health care services.

Outreach and application assistance ~~will target~~ **targets** eligible families through:

- Medicaid outstation and eligibility sites and presumptive eligibility sites at FQHCs, DSH hospitals, community health centers, and family planning clinics;
- Family resource centers;

Locations of contracted providers (private physicians' offices, hospitals, and others)  
Medicaid and TANF eligibility determination sites at county social service agencies;  
Job training centers and employment offices;  
Eligibility verification agreements with other state programs including: Public Schools' Free and Reduced-Price Meals Program (FRM); the Health Care Program for Children with Special Needs (HCP); the Special Nutritional Program for Women, Infants, and Children (WIC); Commodity Supplemental Foods Program (CSFP); and the Colorado Indigent Care Program (CICP). Children eligible for these programs, after screening for Medicaid, can automatically enroll in the CHP+.

County public health departments and nursing services.

~~Colorado Child Health Plan~~ CHP+ Satellite Eligibility Determination sites (SEDs). SED sites are established at agencies and providers submitting qualifying proposals. CHP+ ~~will continue~~ **continues** CCHP's solicitation of proposals from safety net providers, public health services, county social service departments, school districts, hospital districts, family resource centers, and others. ~~The Children's Basic Health Plan, dba~~ CHP+ ~~will reimburse~~ **reimburses** these sites to provide application assistance and/or eligibility determination. SED sites may do so on paper via mail or Fax, or electronically via the CHP+ Web site.

Public schools through distribution of materials to families in school mailings, newsletters, and at back-to-school nights.

Outreach and application assistance ~~will target~~ **targets**:

Families of migrant workers at community/migrant health centers. ~~The Children's Basic Health Plan, dba~~ CHP+ ~~will work~~ **works** with the Colorado Migrant Health Program to develop specific outreach activities for migrants statewide.

Homeless children at homeless health centers and other service agencies for the homeless.

Children in rural and frontier areas. CHP+ ~~will work~~ **works**, as CCHP ~~has did~~, with public health nurses, school enrollment campaigns, community/migrant health centers and private physicians and hospitals that are located throughout the state. ~~The Colorado Child Health Plan Plus~~ **currently** has contracted providers in all **63** counties.

Through the CHP+'s Website on the Internet, agencies and individuals can access all information about the ~~Children's Basic Health Plan, dba~~ Child Health Plan Plus, complete an application on line, and down-load completed applications and patient enrollment records to the CHP+ administrative offices.

#### Outreach and Coordination Methods

The ~~Children's Basic Health Plan, dba~~ Child Health Plan Plus, ~~will be~~ **is** marketed statewide as

a full benefit health plan, following seven primary strategies: 1) direct appeal to eligible families through press releases, public service announcements, and video; 2) outreach through school districts 3) outreach through employers; 4) outreach through collaboration with local county agencies; 5) outreach through regional health and social service agencies; 6) outreach through other state programs; and 7) outreach through collaboration with the Colorado Foundation for

Families and Children. All **CHP+** materials ~~will be~~ **are** designed for easy reading and ~~will be~~ **are** printed in English and Spanish.

Assumptions about the target population for **the Children's Basic Health Plan, dba CHP+** ~~used in the State Plan submitted in October 1997~~ **were** based on the experience of the former Colorado Child Health Plan. For an audience consisting of families with a variety of financial needs, ~~the plan must~~ **the Department felt that the plan had to appeal** to both the chronically needy who have regular interaction with human service agencies, and to the working poor who have traditionally avoided government programs. Outreach efforts for the **Children's Basic Health Plan, dba** Child Health Plan Plus, therefore, ~~will use~~ **have used** the Colorado Child Health Plan's technique of portraying itself as a low-cost health plan supported by state government rather than as a government program.

The **Children's Basic Health Plan, dba** Child Health Plan Plus, ~~will be~~ **has been** marketed in phases by geographic region in **1998** following the four outreach strategies described above. ~~As the Child Health Plan Plus contracts~~ **The Children's Basic Health Plan, dba CHP+, has contracted** with HMOs. Colorado Child Health Plan families living in a region covered by those HMOs ~~will be~~ **were** offered the option of upgrading their children's coverage to comprehensive coverage. These full **benefits will be** ~~have been~~ **made** available to families either through a participating HMO or directly through the ~~CCHP-~~ **CHP+** network of providers if they live in an area without HMO coverage.

Beginning in November **1997**, parents of CCHP members in areas of the state with HMOs ~~will receive~~ **received** letters offering the opportunity to upgrade their children's coverage. The packet ~~will contain~~ **contained** a letter, a chart, a booklet, and a response form. The letter ~~will describe~~ **described** two options: (1) continue with CCHP outpatient coverage with no change; or (2) change to the **Children's Basic Health Plan, dba** CHP+ HMO full-service plan and pay a monthly premium if their family income is ~~was~~ **greater than 62% FPL**. A chart ~~will describe~~ **described** coverage options, the plans ~~they can~~ **from which they could** choose, the sliding scale of monthly premiums, based on income and family size. (See Attachment **6** for family cost sharing requirements.) A booklet designed specifically for a lower-income audience ~~will describe~~ **described** how managed care plans work, and how to make a good choice for one's

children. New applicants on or after ~~January 1, 1998~~ *April 22, 1998* ~~will~~ did not have the option to enroll in the CCHP outpatient package. ~~These applicants will only be able to~~ **After that date applicants were able only** to enroll in **the Children's Basic Health Plan, dba CHP+** comprehensive package.

Parents of CCHP members in areas of the state ~~that do not have~~ **without** HMO penetration ~~will receive~~ **received** a letter describing two options: (1) continue with CCHP outpatient coverage with no change; or (2) upgrade their CCHP coverage with inpatient and mental health services through the ~~CCHP~~ **CHP+** provider network for an additional monthly premium.

CHP+ customer service personnel ~~will staff the staff a~~ Toll-Free telephone line. A recorded telephone message ~~will include~~ **provides** options for callers to hear about the expanded coverage and about choosing a managed care plan.

The main outreach methods are:

Direct Appeal to Eligible Families through Press Releases, Public Service Announcements, and Video.

Radio and television public service announcements ~~will be~~ **were** aired to support mailings of materials to community human service agencies. A toll free number to call for more information ~~will be~~ **is** featured in the public service announcements, printed materials, **and** press releases. Frequent news releases ~~will be~~ **are** sent to the press about the increased coverage available. Radio stations, TV and cable stations, all Colorado daily and weekly newspapers, and specialty publications and newsletters for professional associations in the areas of children's health care, parenting, day care, and education ~~will~~ receive the press releases.

Outreach methods other than written materials ~~will be~~ **are** employed whenever possible. A video loop ~~current under development will explain the health plan and will be~~ **explaining the Children's Basic Health Plan, dba CHP+** is shown in waiting rooms of providers' offices and eligibility determination sites. All outreach materials ~~will~~ prominently feature the 1-800 telephone number. Callers to the toll-free number ~~will~~ hear a recorded message about the plan, speak to a customer service representative, or leave their name and address to receive ~~an~~ application. Spanish-speaking callers ~~will~~ speak with a Spanish-speaking ~~operator at the~~ **operator at the CDPHE Family Health Center staff.** **CHP+ staff person.**

Outreach through School Districts

**CHP+ will collaborate** collaborates with the Department of Education to conduct Back-to-School Enrollment Campaigns in school districts statewide, and to develop School-Based Enrollment Projects in selected communities. School districts will verify CHP+ eligibility when applicants are qualified for the meal program. Children who qualify for Reduced-Price Meals **will be are** automatically eligible for the **Children's Basic Health Plan, dba CHP+**, and those who qualify for the free meals **will be are** screened for Medicaid eligibility during the eligibility determination process. Back-to-school enrollment campaigns also reach out to eligible families who have not applied for the school meal program. Applications and enrollment forms **will be are** available to all eligible families through school employees who are most likely to speak with eligible families: the health aid, assistant principal, principal, school secretary, PTA contact, social worker, English as a Second Language coordinator, Child Find coordinator, physical education instructor, coach, and that teacher who has particularly close rapport with students and parents. Enrollment kits with flyers, enrollment pamphlets and applications **will be are** mailed to schools identified by the district as interested in helping to conduct **CHP+** outreach. Fliers **will also be are** sent home to each family with the school's newsletter.

#### Outreach through Employers

To encourage employers to provide information to employees with uninsured children, the **Children's Basic Health Plan dba**, Child Health Plan Plus will include employers in regional planning meetings, make presentations to chambers of commerce and business organizations, send press releases to trade publications, and contact employers through direct mail. **The feasibility of initiating an employer buy-in program is being studied.**

#### Outreach through Collaboration with Local County Agencies

In order to involve concerned citizens at the community level, **the Children's Basic Health Plan, dba** CHP+, will invite county health departments to host annual regional planning meetings for health care providers, human service agencies, school districts, and community leaders to discuss the health care needs of underserved children in their community and to learn how CHP+ can help.

Outreach and training sessions on CHP+ eligibility will be conducted for the staff of county public health departments, county social services, WIC coordinators, Medicaid case workers, family resource centers, school nurses, providers, the Health Care Program for Children with Special Needs, Community-Centered Boards, Early Childhood Connections, and Child Find.

#### Outreach through Regional Health and Social Service Agencies

The **Children's Basic Health Plan dba** Child Health Plan Plus will continue the Colorado Child Health Plan's relationships with providers, social services agencies, and public health nurses to

conduct outreach and application assistance. CHP+ eligibility ~~will~~ **can** be determined at community-based health care providers including Federally Qualified Health Centers (FQHCs), Disproportionate Share Hospitals (DSHs), community health centers, family planning clinics, rural health centers, school based health centers, and Residency Program family medicine centers. Outreach materials ~~will be~~ **are** distributed at physician's offices where staff ~~will~~ **members** assist families with CHP+ applications.

Outreach through Other State Programs

Through collaboration with the administration of six other state programs the **Children's Basic Health Plan, dba** CHP+ ~~will offer~~ **offers** an enrollment shortcut to children of families in which at least one family member is enrolled in the school Free and Reduced-Price Meal Program (FRM); Special Nutrition Program for Women, Infants, and Children (WIC); Commodity Supplemental Foods Program (CSFP); the Health Care Program for Children with Special Needs (HCP); and the Colorado Indigent Care Program (CICP). With the cooperation of the county

level staff for these five programs, all children in such a family who are age ~~17~~ **18** and under and ineligible for Medicaid can enroll in CHP+ on one short enrollment form.

Outreach for the **CBHP dba** CHP+ and Medicaid ~~will continue~~ **continues** to be conducted through the Governor-sponsored Bright Beginnings Program, a home visitation program for newborns. Home visitors give new parents CHP+ and Medicaid program brochures and answer questions of new parents. Visitors call parents at times coinciding with the child's immunization schedule to remind parents to have their children immunized and to inform them ~~of~~ the availability of free or reduced price immunizations and health care coverage.

Outreach through Collaboration with the Colorado Foundation for Families and Children

The Foundation for Families and Children, a private partner to state government to promote and sustain the health, education, and well being of children and families in Colorado communities, will reach out to eligible families through several foundation-sponsored coalitions:

The Colorado Connection for Healthy Kids is a collaboration of four state agencies and ten state organizations dedicated to promoting comprehensive school health.

The Rural County Project is a local development project designed to support to 29 rural counties.

The transitions from School to Work Program helps families find day care, transportation,

health care, and job training.

The Family Preservation and Family Support Program provides training for family advocates, home visitation nurses, and counseling specialists.

The Colorado Family Resource Network is an association of 150 family support agencies and community-based organizations, supported by grants from the Colorado Department of Human Services.

**5.2. Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))**

The **Children's Basic Health Plan, dba** CHP+, outreach efforts described above **will be are** coordinated as often as possible with Medicaid and other children's health coverage or direct services.

Children can enroll or receive assistance in enrolling in Medicaid or CHP+ at Medicaid outstationed eligibility sites and presumptive eligibility sites located at FQHCs, family planning clinics, and DSH hospitals. County social service departments **will** inform families who have been denied Medicaid eligibility of CHP+ and will share information collected in the eligibility determination process with ~~CBHP~~ CHP+ if the county and family agrees to do *so*. **The Children's Basic Health Plan, dba**-CHP+ **will refer** refers applicants who appear to be Medicaid eligible to county social service offices and **will conduct** conducts follow up of these children. CHP+ **will conduct** conducts eligibility training for county social services and **give** gives these offices **CHP+** brochures and applications for children who are not eligible for Medicaid but may be eligible for CHP+.

CHP+ outreach and application assistance **will be are** available at state agencies where families apply for job training and placement, food assistance, and services for children with special needs. Application assistance, eligibility determination, and application submission **will also be are** available through CHP+ Satellite Eligibility Sites (SEDs). CHP+ SEDs **will** include community-based health providers such as school-based health centers and FQHCs, public health service providers, WIC providers, Health Care Program for Children with Special Needs offices, county departments of social services, school districts, and family resource centers.

Please see Sections 2.2.1, 2.2.2, 4.4.2 and 5.1 for a description of how children who are determined to be eligible for Medicaid or other children's health insurance or services **will be are** referred to and enrolled in those programs.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.)

Benchmark coverage; (Section 2103(a)(1))

6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)

6.1.1.2. State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2.  Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. See attached actuarial report that meets the requirements specified in Section 2103(c)(4).

6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage."

6.1.4. Secretary-Approved Coverage. (Section 2103(a)(4))

6.2 The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any

**exclusions or limitations) (Section 2110(a))**

**BENEFITS IN COUNTIES WHERE HMOS ARE AVAILABLE**

**6.2.1. [X] Inpatient services (Section 2110(a)(1))**

Inpatient services includes all physician, surgical and other services delivered during a hospital stay. Inpatient services covered in full with no copayments.

**6.2.2 [X] Outpatient services (Section 2110(a)(2))**

Outpatient services include outpatient surgery -- covered in full with no copayments. Clinic services and other ambulatory health care services have **no** co-pay for below 150% FPL and **no** copayment for above 150% FPL.

**6.2.3. [X] Physician services (Section 2110(a)(3))**

Physician services include medical office visits with a physician, mid-level practitioner or specialist. Covered in full with \$2 copayment for **patients between 101% and 150%** FPL and \$5 copayment above 150% FPL. Preventive care and immunizations covered in full with no copayment.

**6.2.4. [X] Surgical services (Section 2110(a)(4))**

Covered in full. See **6.2.1 Attachment B:** for outpatient surgical services and for inpatient surgical services.

**6.2.5. [X] Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))**

See section **6.2.2 Attachment B**

**6.2.6 [X] Prescription drugs (Section 2110(a)(6))**

Covered for outpatient prescription drugs with \$1 co-payment below 150% FPL and \$3 generic prescription copayment for above 150% FPL and \$5 copayment for brand name

prescription above 150% FPL.

6.2.7 [ ] Over-the-counter medications (Section 2110(a)(7))

6.2.8 [X] Laboratory and radiological services (Section 2110(a)(8))

Covered in full with no co-payment for physician-ordered services.

6.2.9 [X] Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

Prenatal maternity care covered in full with no copayment

6.2.10 [X] Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

45 days of inpatient mental health services covered with an exception clause to review cases for children needing longer hospital stays. No copayments.

6.2.11 [X] Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))

Outpatient mental health services covered with a 20 visit limit. \$2 copayment for ~~below~~ **150%** patients between 101% and **150%** FPL and \$5 for above 150% FPL.

6.2.12 [X] Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

2,000 maximum per year paid by plan. Coverage for lesser of purchase price or rental price for medically necessary durable medical equipment, including home administered oxygen. No copayments.

6.2.13 [ ] Disposable medical supplies (Section 2110(a)(13))

6.2.14 [X] Home and community-based health care services (See instructions) (Section

2110(a)(14))

Home health care covered in full with no copayments.

6.2.15  Nursing care services (See instructions) (Section 2110(a)(15))

6.2.15 6  Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))

6.2.17  Dental services (Section 2110(a)(17))

Coverage in connection with treatment of the teeth or periodontium is excluded unless such treatment is performed by a physician or legally licensed dentist, is begun within 72 hours after an accidental injury to sound natural teeth. Also not excluded (state mandate) is orthodontic and prosthodontic treatment for cleft lip or cleft palate for newborns.

**Coverage for preventive dental services and emergency assessments with \$2 copayment for below 150% FPL and \$5 copayment for above 150% FPL.**

6.2.18  Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

6.2.19  Outpatient substance abuse treatment services (Section 2110(a)(19))

Limited Coverage. 20 visit limit. Inpatient is not covered.

6.2.20  Case management services (Section 2110(a)(20))

Covered when Medically Necessary with no copayment.

6.2.21  Care coordination services (Section 2110(a)(21))

6.2.22.  Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

**30** visits per diagnosis covered per year. \$2 copayment for **below 150% FPL** individuals

between 101% and 150% FPL and \$5 copayment for above 150% FPL.

6.2.23  Hospice care (Section 2110(a)(23))

Covered in full with no co-payment.

6.2.24.  Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))

6.2.25  Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.26  Medical transportation (Section 2110(a)(26))

Hospital and emergency room transport covered. **\$15 copayment for all below 185% FPL. Copayments will be waived with admission into hospital from ER.**

6.2.27.  Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))

6.2.28.  Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

Neurobiologically-based mental illnesses will be required to be treated as any other illness or condition under Colorado state law. Illnesses in this category include schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder and panic disorder. There will be a \$2 copayment for **below 150% FPL** patients between 101% and 150% FPL and a \$5 copayment for above 150% FPL for all office visits and no copayments for admissions.

Organ transplant coverage will include liver, heart, heart/lung, cornea, kidney, and bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk state II and state III breast cancer, and Wiskott Aldrich Syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. Transplants will be covered only if they are medically necessary and the facility meets clinical standards for the procedure. No copayments.

Vision Services: Vision screenings are covered as age appropriate preventive care. Referral is required for refraction services. There is a \$50 annual benefit for eyeglasses. Vision therapy is covered. Copayments are \$2 for below 150% FPL and **\$5** for above 150% FPL.

Audiological services: Hospitals are mandated to cover newborn hearing screenings. Coverage will include assessment and diagnosis. Hearing aides are covered for congenital and traumatic injury with a maximum payment of \$800 per year paid by plan. No copayments.

Intractable pain treatment will be included as a benefit with \$2 co-payment for below 150% FPL and \$5 copayment for above 150% FPL.

Autism coverage will be included with \$2 co-payment for below 150% FPL and **\$5** copayment for above 150% FPL.

Skilled nursing facility covered in full with no co-payments. Care must follow a hospital confinement and the skilled nursing facility confinement must be the result of an injury or sickness that was the cause of the hospital confinement. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

Diagnosis and referral services, as defined by Guidelines for Adolescent Preventive Services (GAPS) for alcohol and substance abuse is covered in full with no co-payments. Alcohol and substance abuse treatment not included.

The following is a list of services to be provided through the Children's Basic Health Plan, dba Child Health Plan Plus (CHP+) provider network and the family co-payments for these services. The benefits in the HMO package that are **not** included in the provider network package are: 1) dental services; 2) hospice care; 3) medical transport; **4) autism;** and **5) skilled nursing facility.** The family cost sharing for the HMO package and provider network package are slightly different, as described in this section and in Attachment 7.

## BENEFITS IN COUNTIES WHERE HMOS ARE NOT AVAILABLE

### 6.2.1. [X] Inpatient services (Section 2110(a)(1))

I

Inpatient services includes all physician, surgical and other services delivered during a hospital stay. Inpatient services covered in full with no copayments

**6.2.2. [X] Outpatient services (Section 2110(a)(2))**

Outpatient services include outpatient surgery -- covered in full with no copayments. Clinic services and other ambulatory health care services have a \$2 co-payment for all families.

**6.2.3. [X] Physician services (Section 2110(a)(3))**

Physician services include medical office visits with a physician, mid-level practitioner or specialist. Covered in full with \$2 copayment for all families. Preventive care and immunizations covered in full with no copayment

**6.2.4. [X] Surgical services (Section 2110(a)(4))**

Covered in full. See 6.2.1 for outpatient surgical services and 6.2.2 for inpatient surgical services.

**6.2.5. [X] Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))**

See section 6.2.2.

**6.2.6. [X] Prescription drugs (Section 2110(a)(6))**

Covered for outpatient prescription drugs with \$2 copayment for generic or name-brand drugs for all families.

**6.2.7. [ ] Over-the-counter medications (Section 2110(a)(7))**

**6.2.8. [X] Laboratory and radiological services (Section 2110(a)(8))**

Covered in full with no co-payment for physician-ordered services.

**6.2.9. [X] Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))**

Prenatal maternity care covered in full with no copayment.

6.2.10. **[X]** Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

45 days of inpatient mental health services covered with **an** exception clause to review cases for children needing longer hospital stays. No copayments.

6.2.11. **[X]** Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))

Outpatient mental health services covered with a 20 visit limit. **\$2** copayment for all families.

6.2.12. **[X]** Durable medical equipment and other medically-related or remedial devices (such **as** prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

\$2,000 maximum per year paid by plan. Coverage for lesser of purchase price or rental price for medically necessary durable medical equipment, including home administered oxygen. No copayments.

6.2.13. **[ ]** Disposable medical supplies (Section 2110(a)(13))

6.2.14. **[X]** Home and community-based health care services (See instructions) (Section 2110(a)(14))

Home health care covered in full with no copayments.

6.2.15. **[ ]** Nursing care services (See instructions) (Section 2110(a)(15))

6.2.16. **[X]** Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))

6.2.17. **[ ]** Dental services (Section 2110(a)(17))

6.2.18. **[ ]** Inpatient substance abuse treatment services and residential substance abuse

treatment services (Section **2110(a)(18)**)

**6.2.19.** [ ] Outpatient substance abuse treatment services (Section **2110(a)(19)**)

**6.2.20.** [ ] Case management services (Section **2110(a)(20)**)

**6.2.21.** [ ] Care coordination services (Section **2110(a)(21)**)

**6.2.22.** [X] Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section **2110(a)(22)**)

30 visits per diagnosis covered per year. \$2 copayment.

**6.2.23.** [ ] Hospice care (Section **2110(a)(23)**)

**6.2.24.** [ ] Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section **2110(a)(24)**)

**6.2.25.** [ ] Premiums for private health care insurance coverage (Section **2110(a)(25)**)

**6.2.26.** [ ] Medical transportation (Section **2110(a)(26)**)

**6.2.27.** [ ] Enabling services (such as transportation, translation, and outreach services (See instructions) (Section **2110(a)(27)**)

**6.2.28.** [X] Any other health care services or items specified by the Secretary and not included under this section (Section **2110(a)(28)**)

Neurobiologically-based mental illnesses will be required to be treated as any other illness or condition under Colorado state law. Illnesses in this category include schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder and panic disorder. There will be a \$2 co-payment for all office visits and no co-pays for admissions.

Vision Services: Vision screenings are covered as age appropriate preventive care. Referral is required for refraction services. There is a \$50 annual benefit for eyeglasses. Vision therapy is covered. Copayments are \$2.

Audiological services: Hospitals are mandated to cover newborn hearing screenings. Coverage will include assessment and diagnosis. Hearing aides are covered for congenital and traumatic injury with a maximum payment of \$800 per year paid by plan. No copayments.

Intractable pain treatment will be included as a benefit with \$2 co-payment.

Diagnosis and referral services, as defined by Guidelines for Adolescent Preventive Services (GAPS) for alcohol and substance abuse is covered in full with no co-pays. Alcohol and substance abuse treatment not included.

6.3. Waivers - Additional Purchase Options. If the state wishes to provide services Under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: (Section 2105(c)(2) and(3))

6.3.1. [ ] Cost Effective Alternatives. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

6.3.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i))

6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii))

6.3.1.3. The coverage must be provided through the use of a

community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section **1886(d)(5)(F)** or 1923 of the Social Security Act. Describe the community based delivery system. (Section **2105(c)(2)(B)(iii)**)

6.3.2. [ ] Purchase of Family Coverage. Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section **2105(c)(3)**)

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children. (Section **2105(c)(3)(A)**)

6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section **2105(c)(3)(B)**)

Section 7. Quality and Appropriateness of Care

Check here if the state elects to use funds provided under Title **XXI** only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

**7.1** Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A))

Will the state utilize any of the following tools to assure quality?

(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1.  Quality standards
- 7.1.2.  Performance measurement
- 7.1.3.  Information strategies
- 7.1.4.  Quality improvement strategies

The Children's Basic Health Plan, dba, Child Health Plan Plus (CHP+) will use quality standards, performance measures, information strategies, and quality improvement studies to assure high-quality care for CHP+ enrollees. The CHP+ program will use quality assurance methods and tools such as NCQA accreditation standards, National Association of Insurance Commissioners (NAIC) standards, Quality Improvement System for Managed Care (QISMC), Healthplan Employer Data and Information Set (HEDIS), Consumer Assessment of Health Plans Survey (CAHPS) data, standard Division of Insurance reports and quality improvement study data. The CHP+ will use standards, performance measures, consumer information, and quality improvement methods for HMOs and for the CHP+ provider network.

**Quality Assurance for Care Delivered through HMOs and through the Children's Basic Health Plan, dba CHP+ Provider Network to CHP+ Members**

As discussed in Section 3.1, the Contracting and Quality Assurance design team will determine quality standards. Standards developed by the team will be based on a review of national quality assurance models such as the NAIC model act, NCQA accreditation standards, and the new QISMC developed by HCFA. These quality standards will address issues such as quality management and improvement, provider credentialing, preventive health and medical records. The Contracting and Quality Assurance design team will evaluate which standards will be used for contracting HMOs and which will be used for the CHP+ provider network.

Different agencies will monitor quality assurance standards for contracting HMOs and the

CHP+ provider network. Plan compliance with these standards are currently reviewed by several different entities including the Division of Insurance (through its licensing regulations), the Department of Public Health and Environment (through its licensing and examinations), the National Committee for Quality Assurance (for those plans that are accredited), and the Department of Health Care Policy and Financing (through its Medicaid contracting activities). The Department of Health Care Policy and Financing will review health plans for compliance with CHP+ standards that are not reviewed by another entity. While it is yet to be determined which entities will evaluate each quality standard, the CHP+ program (alone or in collaboration with regulators or purchasers) will conduct regular, on-site review of each contracting health plan to assure that it is operating in compliance with the **Children's Basic Health Plan, dba** CHP+, contract. CHP+ staff will review the performance of the CHP+ provider network.

The contract with the health plans will require them to collect and report HEDIS, CAHPS and complaint data. While NCQA has not yet determined whether health plans will be required to report this data separately for **the Children's Basic Health Plan, dba**, CHP+ enrollees or aggregated with Medicaid data, health plans will be required to report the measures that reflect the quality of children's health care in their plan. If it has an adequate quantity of children with continuous enrollment the CHP+ will produce these measures for its provider network either directly or through a contractor. The following is a draft list of required measures:

**HEDIS 3.0**

- Children's access to primary care providers
- Childhood immunization rate
- Adolescent immunization rate
- Well-child visits in the first 15 months of life
- Well-child visits in the third, fourth, ~~fifth~~, and sixth years of life
- Adolescent well care
- Availability of language interpretation services
- Pediatric physician specialists
- Pediatric mental health services

**CAHPS categories**

- Ease of identifying a provider
- Waiting time for an appointment
- Phone waiting time for medical advice
- Access to assessment, tests, treatment and specialists

Emergency room use  
Ease of referral to specialists  
Follow-up reminders

The **Children's Basic Health Plan, dba, CHP+ HMO** contract will require plans to report their grievance data to the Division of Insurance as required by state law. CHP+ staff will record and process complaints about the CHP+ provider network.

The **Children's Basic Health Plan, dba, CHP+** will use these performance measures —HEDIS, CAHPS and grievance data—to annually evaluate a health plan's performance and to assist enrollees in choosing a plan. While these measures will be an important component of the CHP+ quality program, the data will not be available until **1999-2000**, after a full year of plan operation. Until then, the program will rely on quality standard reviews and reported complaints to monitor quality of care.

Consumer education tools will be developed to ensure that CHP+ enrollees have adequate information to negotiate managed care enrollment. A primary tool for consumer choice will be a report card provided to every member at open enrollment. This report card, first available in **1999-2000**, will communicate the results of each CHP+ plan on key performance measures in HEDIS, CAHPS and complaint data. The second tool, the plan member handbook, will be developed by **Children's Basic Health Plan, dba CHP+** in conjunction with the plans to assure that benefit, provider network, and grievance procedures are communicated effectively. Other consumer education materials will be developed as part of CHP+'s quality assurance program and will be based on the results of performance measures.

**7.2 Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))**

**Access Assurance for Care Delivered through HMOs and the Children's Basic Health Plan, dba CHP+, Provider Network**

In addition to setting affordable cost-sharing requirements described in Section 8, access to services will be assured by evaluating and monitoring the adequacy of provider networks and by analyzing the results of complaint data, performance measures, and client satisfaction surveys. Provider network analysis will look at the number and types of pediatricians, pediatric specialists and other providers available, their locations, and their hours. For HMOs, the primary data

source for this evaluation will be the plan's access plan. The access plan is a document required by the Colorado Division of Insurance that describes elements of its provider network including numbers, types, locations, referrals, and accommodation of members with special needs, e.g. language interpretation services and physically accessible facilities. Although the **Children's Basic Health Plan, dba** CHP+ provider network will not be required to produce this access plan, staff will evaluate this network on similar criteria. CHP+, staff will also annually evaluate access-related performance measures such as access-related complaints, ease of identifying a provider (CAHPS), phone waiting time for medical advice (CAHPS), and access to primary care physicians (HEDIS).

Adequate access to emergency services is assured for all Colorado managed care enrollees by a new Division of Insurance regulation which took effect on July 1, 1997. This regulation (4-2-17) specifies that a managed care organization cannot deny an emergency claim if a "prudent lay person would have believed that an emergency medical condition or life or limb threatening emergency existed." The regulation also restricts the use of prior authorizations for emergency care and the denial of emergency care provided by non-network providers.

Section 8. Cost Sharing and Payment (Section 2103(e))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

**8.1** Is cost-sharing imposed on any of the children covered under the plan?

**8.1.1**  Yes

**8.1.2**  No, skip to question 8.5.

**8.2** Describe the amount of cost-sharing and any sliding scale based on income: (Section 2103(e)(1)(A))

**8.2.1** Premiums See Attachment 6

**8.2.2** Deductibles None

**8.2.3** Coinsurance

No coinsurance. Copayments depending on service. See Sections 6.2.1-6.2.28 or Section 7 for copayments by service provided.

American Indian/Alaska Natives are not exempt from co-payment and premium requirements except that co-pays will not be required when services are received at an Indian Health Service facility.

Please see attached revised copayment structure regarding medical transportation.

**8.2.4** Other

**8.3.** Describe how the public will be notified of this cost-sharing and any differences based on income:

Parents of ~~current~~ Colorado Child Health Plan who live in an area with an HMO option ~~will receive~~ received a letter offering them the opportunity to upgrade their children's coverage to the Child Health Plan Plus. The letter ~~will describe~~ described two options: (1) continue with

CCHP outpatient coverage with no change through the end of their current single year of guaranteed eligibility; or (2) upgrade their CCHP coverage to the comprehensive benefits of the CHP+ delivered by a HMO for a monthly premium if their family income is at or above **63%** FPL.

All enrollees are subject to the same premium amounts, with the **Children's Basic Health Plan, dba CHP+**, annual enrollment fee counted toward the person's CHP+ premium. The half price premiums for CCHP enrollees has been eliminated. **Please see revised premium schedules.**

Parents of children in areas without HMO penetration ~~will have~~ **were given** the following two options: 1) continue with CCHP outpatient coverage with no change; or 2) upgrade their CCHP coverage to the comprehensive benefits of the CHP+ delivered by the CHP+ provider network for a monthly premium if their family income is above **62%** FPL.

Families ~~who make application on or after January 1, 1998 will only applying after April 22, 1998 only~~ have the CHP+ comprehensive benefits option, which ~~will be~~ **is** delivered through ~~an~~ HMO or through the **Children's Basic Health Plan, dba CHP+** provider network if they live in ~~an~~ area without HMO coverage.

For children ~~currently~~ enrolled in the CCHP who enroll in the CHP+ (HMO or the provider network) above 150% FPL, the benefit expansion will entail a higher premium. For some CCHP families who enroll in the **Children's Basic Health Plan, dba CHP+**, (HMO or the provider network) below 150% FPL, the enriched benefit package will cost less than the CCHP outpatient package.

A chart ~~will describe~~ **describes** coverage options, the cost sharing requirements for enrollment (premiums) and specific services (copayments) based on income and family size, and the plans they can choose. A booklet designed specifically for a lower-income audience ~~will describe~~ **describes** how managed care plans work, and how to make a good choice for one's children. CCHP customer service will be expanded to staff additional extensions for the CHP+, toll-free telephone line in English and Spanish. The recorded message ~~will include~~ **includes** two additional options for callers to hear about the expanded CHP+, coverage offer, and about choosing a managed care plan.

**8.4 The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: (Section 2103(e))**

**8.4.1 [X] Cost sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))**

**8.4.2 [X] No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))**

The following procedures will be considered well-baby and well-child care: CPT-4 codes:

Preventive medicine codes 99381-New patient under one year; 99382-New Patient age 1-4 years; 99383-New patient ages 5-11 years; 99384- New patient ages 12 through 17 years; 99391-Established patient under one year; 99392-Established patient ages 1-4 years; 99393-Established patient ages 5 through 11 years; 99431- Newborn care (history and examination); 99432-Normal newborn care.

Evaluation and Management Codes: 99201-99205-New patient; 99211-99215-Established patient.

ICD-9-CM codes: V20-V20.2-Health supervision of infant and child; V70.0-General medical examination (routine); V70.3-V70.9-General medical examination.

All infants and children should be seen by a Primary Care Provider regularly for immunizations (shots) and check-ups. The **Children's Basic Health Plan, dba** Child Health Plan Plus follows the well-child visits schedule recommended by the American Academy of Pediatrics. The American Academy of Pediatric recommends that children receive well-child visits at the following ages: 1 week, 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 11 years, 12 years, and 13 years.

Appropriate well-baby and well-child visits are one of the performance goals of the CHP+ program and will be assessed using HEDIS measures.

**8.4.3. [X] No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).**

8.4.4 [X] No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))

8.4.5 [X] No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))

8.4.6 [X] No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A))

8.4.7 [X] Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1))

8.4.8 [X] No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B))

8.4.9 [X] No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A))

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved: (Section 2103(e)(3)(B))

Premiums for families through 100% FPL will be waived. For families between 101% and 150% with one child, premiums will be \$9/child/month, and for families with two or more children, \$15/family/month. Between 151% and 169% FPL, families with one child will pay \$15/child/month, and families with two or more children will pay \$25/family/month. For families between 170% and 185% FPL with one child, they will pay \$20/child/month and families with two or more children will pay \$30/family/month. For families above 185% FPL there will be no subsidy.

The state has set family premium cost sharing for families, with incomes at or above 150% FPL using the following steps:

1. Determine annual income at 150% FPL and 185% FPL for varying family sizes.

2. Set family monthly premium cost sharing at 1.5% of a family's income at 150% FPL.
3. Estimate the average family co-payment expenditure as \$50 per child per year and add this to the value of the family monthly premium
4. Add the \$50 average family cost-sharing to the family premium cost-sharing to verify the likelihood that the monthly combined premium and co-payment do not exceed 5% of family income.

The prices listed in the aforementioned steps ~~will take effect~~ were effective July 1, 1998. Families ~~will have~~ a "half-price enrollment sale" from ~~January 1~~ April 22, 1998 to June 30, 1998 so that ~~current~~ CCHP families who ~~pay~~ paid a \$25 yearly enrollment fee ~~will incur~~ incurred a more gradual increase in their cost-sharing responsibilities and CHP+ staff ~~will have~~ had time to explain the validity of an increased family cost for an increased benefit.

The following sample family illustrates that the vast majority of families ~~who pay~~ paying the premiums and co-payments at the higher level beginning July 1, 1998 ~~will~~ contribute well below 5% of their family's annual income on their children's health care expenditures. A single parent family with two children at 150% FPL earns \$19,995 in annual income. Five percent of \$19,995 is \$999.75. The family's \$25 monthly premium ~~would come~~ comes to \$300 per year. Taking this \$300 premium expense from the five percent of the family's income (\$999.75) leaves the family with \$699.75 to spend up to five percent of their family's income on their children's health care. Paying the \$699.75 in co-payments at \$5 per doctor's visit or brand-name and prescription drug, the family could make 140 visits per year or 70 visits per child per year without their children's health care costs exceeding 5% of their family income.

In the circumstance that a child should spend greater than 5% of his/her family's annual income due to his/her high use of medical services, the child's family will be reimbursed for such expenditures. Nevertheless, in setting the premium subsidy and co-payment rates, the State expects such circumstances to be highly unlikely. It remains the responsibility of the family to detail their expenditures and request reimbursement if costs exceed the 5% limit. Please see the actuarial report for further detail.

**How will the State make families aware of the aggregate limit on cost-sharing? The application states that responsibility rests with the family to request reimbursement for expenditures that surpass the 5 percent limit (page 57). How will this process work?**

State planners feel that few families will reach their 5% limit. **An** analysis of the State's proposed premium schedule suggest that premium payments will rarely exceed 1% of the family's adjusted gross income. **However**, CHP+ administrative personnel **will** make families aware of the aggregate limit on cost-sharing through a number of information and educational sources.

Through direct communication with families, the CHP+ marketing and outreach efforts **will** often discuss the aggregate limit on cost-sharing. The first direct written communication with CHP+ families, sent December 10, 1997, **instructs instructed** parents that the expenditures on their child(ren)'s health care through CHP+ should not exceed 5% of family income. Through contracts with Managed Care Organizations, the CHP+ administration will ensure that the plans make their enrollees aware of the aggregate limit on cost-sharing by including information regarding the cost-sharing limit in their member handbooks.

The State **will adopt has adopted** the "shoe box" approach to reimburse families who exceed the 5% limit. Families **will be are asked required** to track expenditures **based on he calculation of family income provided by the state and to** submit receipts for all expenditures in excess of the 5% limit. **Since the eligibility process will determine an "eligibility income" for each family, that family will receive notification of the exact dollar figure that will represent 5% of the family's adjusted gross income.**

Once they submit evidence that they have exceeded the 5% cap, the state will issue them a "co-pay exempt" sticker to be placed on their membership card. Providers and plans will be informed that enrollees with this sticker are not be charged a co-pay for any service. The 5% limit will be calculated on the family's income at the time of eligibility determination. The cap will be recalculated if a family applies for a redetermination before the year is complete.

This approach may seem onerous, however, through numerous conversations with a number of other state officials, the "shoe box" approach seems to be the most immediate practical solution. In addition, recipients of the Colorado Indigent Care Program have had experience with this approach. Recipients of services under the CICIP are instructed to track expenditures and file reimbursement for all expenditures that exceed 10% of the family's adjusted gross income. When the family receives notification of CICIP eligibility, the eligibility technician notifies the family of the cap.

**8.6 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:**

8.6.1.  The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

8.6.2.  The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe:

**Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)**

**9.1 Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2))**

Strategic objectives are to:

1. Improve health status of children in Colorado with a focus on preventive, and early primary treatment.
2. Decrease the proportion of children in Colorado who are uninsured and reduce the financial barriers to affordable health care coverage.
3. Do not "crowd out" employer coverage.
4. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children
5. Acquire contracts to provide statewide HMO coverage.

**Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3))**

1. Improve health status of children in Colorado with a focus on preventive, and early primary treatment  
Performance Goals:
  - Ninety percent (90%) of children under two receive the basic immunization series
  - Ninety percent (90%) of 13 year olds receive required immunizations
  - Seventy-five percent (75%) of children under 15 months receive recommended number of well child visits
  - Seventy-five percent (75%) of three, four, five, and six-year-olds receive at least one well-child visit during the year.
  - Seventy-five percent (75%) of children 12 through 17 receive at least one well-care visit during the year.

2. Decrease the proportion of children in Colorado who are uninsured and reduce the financial barriers to affordable health care coverage.  
Performance Goals:
  - Decrease in the proportion of children  $\leq$  185% of federal poverty who are uninsured by 50%.
  - Increase the percentage of uninsured children enrolled **into the in the Children's Basic Health Plan, dba Child Health Plan Plus (CHP+)** as compared to **current** market penetration for the Colorado Child Health Plan.
3. Do not "crowd out" employer coverage.  
Performance Goals:
  - Maintain the proportion of children  $\leq$  185% of federal poverty who are covered under an employer-based plan taking into account decreases due to increasing health care costs or a downturn in the economy.
4. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children.  
Performance Goals:
  - Enroll **66%** of children currently receiving benefits through the outpatient Colorado Child Health Plan into the comprehensive Child Health Plan Plus by July 1, 1998.
  - Enroll 50% of children who previously received services through the Colorado Indigent Care Program into the Child Health Plan Plus by July 1, 1999.
  - Maintain that **50%** of referrals from CHP+ to Medicaid enroll in Medicaid.
5. Acquire contracts to provide statewide HMO coverage.  
Performance Goals:
  - Secure HMO coverage by one or more HMOs in each of the **63** Colorado counties.

**Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops: (Section 2107(a)(4)(A),(B))**

**Objective 1: Improve health status of children in Colorado with a focus on preventive, and early primary treatment.** Plans will be required to submit independently audited HEDIS data. If possible based on the number of continuously enrolled children, HCPF will produce these measures for the CHP+ provider network, either directly or through contract. HCPF will use these data to measure the success of the plans in reaching the performance goals regarding immunization and well-child care.

**Objective 2: Decrease the proportion of children in Colorado who are uninsured and reduce the financial barriers to affordable health care.** Performance goals under this objective will be measured based on the decrease in the proportion of children in families with incomes ■ 185% of the federal poverty level who are uninsured compared to the proportion that were uninsured prior to the effective date of this state plan. Baseline numbers of uninsured children will be calculated from a three year average of the 1995, 1996, and 1997 March supplement to the Current Population Survey produced by the Bureau of the Census. New estimates of uninsured children will be calculated as more current data become available and will be used to compare trends from year to year. CHP+ enrollment numbers will be compared to previous years and to the first year of implementation of the state plan. Clients who disenroll before their 12 months of eligibility have expired will be asked for a reason. Responses to that query will be tracked and used to evaluate the extent that the CHP+ has reduced financial barriers to affordable health care coverage.

**Objective 3: Do not "crowd out" employer coverage** Performance goals under this objective will be measured based on the proportion of children ■ 185% of federal poverty who are covered under an employer-based plan taking into account decreases due to increasing health care costs or a downturn in the economy. The proportion of children covered under an employer-based plan will be evaluated, and analysis will be conducted to test for evidence of "crowding out." The baseline for comparison will be obtained from a 3-year average of the 1995, 1996, 1997 March supplement to the Current Population Survey.

In addition, the eligibility determination process **will include includes** several questions

**Objective 4:** To coordinate and consolidate with other health care programs providing services to children to create a seamless system for low-income children in need of health care. Performance goals under this objective will be based on enrollment from children previously receiving care through the Colorado Child Health Plan or the Colorado Indigent Care Program. Clients who enroll in either the Child Health Plan Plus or the Colorado Indigent Care Program will be tracked in an eligibility determination module that will interface with the Medicaid Management Information System allowing for coordination within the programs and with Medicaid. The Child Health Plan Plus eligibility system ~~will also conduct~~ conducts Medicaid screening and ~~will allow~~ allows the state to track the number of children who were referred to Medicaid through the eligibility determination process. ~~The Child Health Plan Plus will ask the~~ Department of Health Care Policy and Financing ~~to~~ will query Medicaid enrollment data to determine how many children referred from CHP+ to Medicaid have enrolled.

**Objective 5:** Acquire contracts to provide statewide HMO coverage. Performance goals under this objective will be measured by assessing whether at least one HMO provides coverage for CHP+ in each of the 63 Colorado counties. We will also assess whether HMOs are serving CHP+ members in the entirety of each HMO's licensed service area.

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

- 9.3.1.  The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2.  The reduction in the percentage of uninsured children.
- 9.3.3.  The increase in the percentage of children with a usual source of care.
- 9.3.4.  The extent to which outcome measures show progress on one or more of the health problems identified by the state.

- 9.3.5.  HEDIS Measurement Set relevant to children and adolescents younger than **19**.
- 9.3.6.  Other child appropriate measurement set. List or describe the set used.
- 9.3.7.  If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
  - 9.3.7.1  Immunizations
  - 9.3.7.2  Well child care
  - 9.3.7.3  Adolescent well visits
  - 9.3.7.4  Satisfaction with care
  - 9.3.7.5  Mental health
  - 9.3.7.6  Dentalcare
  - 9.3.7.7  Other, please list: \_\_\_\_\_
  - 9.3.7.8  Performance measures for special targeted populations.
- The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section **2107(b)(1)**)
- The state assures it will comply with the annual assessment and evaluation required under Section **10.1.** and **10.2.** (See Section **10**) Briefly describe the state's plan for these annual assessments and reports. (Section **2107(b)(2)**)

The Colorado Department of Health Care Policy and Financing will perform the annual assessments and evaluations required in Section 2108(a). The Annual Report will include an assessment of the operation of the Child Health Plan Plus, its progress toward meeting its strategic objectives, and performance goals. The baseline number of uninsured children will be calculated from an average of the 1995, 1996, and 1997 March supplements to the Current Population Survey produced by the Bureau of the Census.

By March 31, 2000 the state will submit an evaluation that includes the following elements as specified in Section 2108(b).

- A. An assessment of the effectiveness of the CHP+ in increasing the number of children with creditable health coverage. One of the plan's strategic objectives is to decrease the proportion of low-income children in Colorado who are uninsured. The effectiveness of the plan in meeting this goal will be evaluated by examining the proportion of children in families with incomes  $\geq$  185% of the federal poverty level who are uninsured and the percentage of children who are income and asset eligible for Medicaid, who are enrolled in Medicaid. In addition, an estimate of the change in the proportion of children with incomes  $\geq$  185% who are covered under an employment-based plan to evaluate the extent that coverage provided under the plan does not substitute for coverage that would have been provided through an employer.
- B. A description and analysis of the effectiveness of the elements of this plan that will include, but are not limited to:
  - A. **Demographics.** The assessment will evaluate the characteristics of children covered under the CHP+ including age, family income, ethnicity, employment status of the child's parents, and access to other health insurance coverage, such as employment-based coverage, prior to enrolling in the CHP+.
  - B. **Quality** As described in section 7.1, quality will be measured through tools such as HEDIS, CAHPS, complaint data and quality improvement studies. HMOs and CHP+ contractors will use data from enrollment, claims and medical records to evaluate the effectiveness of care in the program. Effectiveness will be determined by the extent to which performance goals are met (see the five objectives under strategic objective one) and comparisons of CHP performance measures against benchmark standards (Medicaid and commercial performance) and community goals (Healthy People 2000).

- C. ***Subsidies and Cost-sharing.*** Another strategic objective is to provide access to appropriate medical care to children in low-income families by reducing the financial barriers to affordable health care coverage. Therefore, the state will report the amount of subsidies paid out of state and federal funds, the amount of cost-sharing paid in by enrollees, and the percentage of children who disenroll for financial reasons. This measure will also allow plan administration to determine families' compliance with cost sharing strictures.
  - D. ***Service area.*** The analysis will include a description of the service area of the CHP+, and will address the ability of the state to acquire contracts to provide statewide HMO coverage.
  - E. ***Time limits.*** CHP+ enrollees ~~will be~~ **are** guaranteed 12 months of eligibility, given that they meet their cost-sharing responsibilities. The evaluation will analyze how many children receive coverage for the full 12 months, and if not, will evaluate why coverage was dropped.
  - F. ***Benefits Covered and other Methods Used to Provide Health Assistance.*** The analysis will include a description of the benefits covered and other methods (if any) that the state used to provide health assistance.
  - G. ***Sources of Non-Federal Funding.*** The assessment will describe and detail sources of state and private funding used to cover the costs of the CHP+.
- C. **An** assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.
- D. **A** review and assessment of State activities to coordinate the **Children's Basic Health Plan, dba** CHP+, with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services. **A** strategic objective of the plan is to coordinate and consolidate health care programs providing services to children. This assessment will evaluate the ability of the CHP+ to coordinate with Medicaid, the Colorado Indigent Care Program, ~~the Colorado Child Health Plan~~ and other private programs.

E. An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children. Trends that will be examined include changes in health care cost indexes, changes in state demographics and income, changes in the work status of parents and the level of unemployment, the level of HMO penetration across the state, and any new state legislation enacted subsequent to this plan that will affect children's health care.

The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3))

The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e))

9.8.1.  Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2.  Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3.  Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4.  Section 1115 (relating to waiver authority)

9.8.5.  Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI

9.8.6.  Section 1124 (relating to disclosure of ownership and related information)

9.8.7.  Section 1126 (relating to disclosure of information about certain convicted individuals)

- 9.8.8.     Section 1128A (relating to civil monetary penalties)
- 9.8.9.     Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10    Section 1132 (relating to periods within which claims must be filed)

**Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement.**  
(Section 2107(e))

Six working teams ~~have been were~~ created to design the core elements of the Children’s Basic Health Plan (CBHP) and to promote ongoing public input into the plan. The CBHP teams’ recommended benefits and cost sharing ~~have been were~~ applied to the CHP+ proposed in this Title XXI State Plan. The six teams are: 1) benefits design and pricing; 2) eligibility, enrollment, and management information system design; 3) financing; 4) marketing and outreach; 5) employer advisory group; and 6) contracting and quality assurance. These teams **will** continue to make recommendations to the Department of Health Care Policy and Financing concerning the design of the Children’s Basic Health Plan. A Policy Board will review team recommendations and give strategic direction to the Department of Health Care Policy and Financing. The individuals who are members of these working teams ~~have had~~ the opportunity to provide input into the development of the CBHP, **dba CHP+**, from the early stages **of** the decision-making process up to and beyond implementation. These working teams are staffed and led by individuals representing the Department, the business community, the insurance industry, providers, children’s advocates, schools, employers, and other public and private programs providing services to children (See Attachment 8 for ~~an~~ implementation structure and Attachment 9 ~~for~~ team membership lists.)

**Benefits Design and Pricing.** This team is responsible for designing the benefit package and developing cost-sharing and subsidy structures. This team will develop price estimates for the benefit package under different cost sharing and subsidy structures scenarios. This team will recommend to the Department the benefit package and the subsidy level that will ensure an affordable product for low-income working families. Members of this team represent advocates for low-income families, the Colorado Division **of** Insurance, mental health providers, EPSDT outreach workers, providers of care to handicapped children, pediatricians, community health centers, and managed care organizations.

**Marketing and Outreach.** This team is responsible for developing a marketing plan and outreach strategy for partnering with schools, doctors' offices, employers, social service providers, and public health entities throughout the state. This team will recommend to the Department the most effective outreach plan, materials design, and marketing strategy to ensure that eligible families are notified that this product is available and how they can apply. The team is developing a long term, phased plan for outreach and marketing of the CBHP, **dba CHP+**. Not only **will** school systems **be** tapped, but team members, through their varied work in the community **will be** are natural advocates and **can also** enlist volunteers who can advocate for the CBHP, **dba CHP+**, throughout the state. This team **will recommend** recommends to the Department, the most effective outreach plan, materials design, and marketing strategy to ensure that eligible families are notified that this product is available and how to apply. Members of this team represent schools, day care centers, managed care organizations, providers, children's advocacy groups, and the Colorado Child Health Plan (CCHP).

**Eligibility, Enrollment, and Management Information Systems Design.** This team is responsible for developing **an** eligibility and enrollment system that is flexible, simple to administer, and meets the long-term needs of the Children's Basic Health Plan. This team will also be responsible for developing recommendations for the rules by which a child is deemed to be eligible for the program. Members of this team include representatives from managed care organizations, the Medicaid program in the Department of Health Care Policy and Financing, the Program for Children with Special Health Care Needs, Indian tribes, community health centers, the Colorado Child Health Plan, philanthropic provider clinics, and other providers.

**Financing.** This team is responsible for identifying funding streams available to finance the program, preparing budget projections, developing estimates of the number of children that will enroll, and creating mechanisms to ensure that the Children's Basic Health Plan, **dba CHP+**, will be fiscally sound. Members of this team include representatives from community health centers, the Colorado Indigent Care Program, the Office of State Planning and Budgeting, the Colorado Child Health Plan, and the Department of Health Care Policy and Financing's budget and accounting offices.

**Employer Advisory Group.** This team will present recommendations to the Department regarding mechanisms to ensure that the Children's Basic Health Plan does not become a substitute for employer-based coverage. This group will establish a means for the Department and employers **to** coordinate coverage for children eligible for the program, create incentives for employers to assist the Department with outreach and eligibility determination, and present recommendations **as** to how

the subsidy can be structured to ensure that employees do not drop employer-based coverage. Membership of this team represents a broad base of employers and business organizations such as US West, Kodak, and Mile Hi Child Care Centers.

**Contracting and Quality Assurance:** This team is responsible for developing purchasing strategies and contract standards for the CHP+ program. The team will decide how HMO contracts will be awarded, how HMO premiums will be determined, what requirements will be in the HMO contract and what quality information will be reported by the CHP+ plans. The team will review options for purchasing, pricing and quality assurance from Medicaid and commercial models. The team membership is currently being developed. Members of the team will include health plans, physicians, hospitals, clinics, consumers and state agency staff.

**Policy Board:** The initial Department-appointed Policy Board ~~will review~~ reviewed key team recommendations and ~~give~~ gave strategic guidance to the Department of Health Care Policy and Financing in the design and implementation of the Children's Basic Health Plan. This group ~~comprises was~~ comprised of high-level private sector business managers, hospitals, providers, children's advocates, the insurance industry, the General Assembly, the Colorado Department of Public Health and Environment, and the Colorado Division of Insurance. ~~This group will convene on a monthly basis to review the progress of the Working Teams and to address any issues brought forward by the Working Teams. Once the second phase of the State Plan is developed, the Policy Board will be responsible for reviewing the plan and briefing stakeholders, constituents, and other members of the community on the intent and content of the proposal.~~

The Department-appointed Policy Board disbanded after the passage of House Bill 98-1325, which became law on April 21, 1998. A provision of that legislation created an 11-member Policy Board charged with promulgating rules for the Children's Basic Health Plan, dba as CHP+.

By statute, four members of the Policy Board are the executive directors of the departments of Public Health and Environment, Health Care Policy and Financing, Education, and Human Services. The other seven members of the Board are appointed by the Governor, with the consent of the Senate, according to a proscribed structure: two must represent small business or other businesses, three must represent the health care industry (including one who is a managed care expert not affiliated with a MCO under contract to provider services under the Children's Basic Health Plan), one must represent an essential community provider, and one member must be a consumer.

The rule-making Policy Board provides a public forum for discussion of major policy issues, offers policy direction to the Department, sets programmatic rules on a number of key areas, and reports regularly to the General Assembly's Joint Budget Committee on program impact and effectiveness.

The Department of Health Care Policy and Financing is committed to allowing the public **as** many opportunities **as** possible to provide input into the development of this program. In addition to the methods described above, Department staff responsible for developing the state plan **will** have ongoing meetings to solicit input from stakeholders on the design of the Children's Basic Health Plan. ~~Staff will continue to have ad hoc meetings with a variety of interested parties and to mail updates of the planning process in a newsletter mailed to 5,000 Coloradoans who have expressed an interest in state health care policy issues.~~ Staff continues to identify people and share information with people who are interested in knowing more about the Children's Basic Health Plan.

Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

#### CHILDREN'S BASIC HEALTH PLAN BUDGET SFY 1999 AND 2000

The Colorado General Assembly chose to establish a non-entitlement, substantially privatized child health program rather than a Medicaid expansion. The legislative direction in House Bill **97-1304** and House Bill **98-1325** is to privatize marketing, eligibility determination and enrollment for the program. The Department has been working with different entities to implement the program operations necessary to enroll the eligible population and to operate the financing and delivery systems. At present, the Department has a short-term sole source contract (through December **31,1998**) with **a** private foundation for eligibility determination, application processing, marketing and outreach, and customer service. A Request for Proposal for these services has been issued and a new contractor will be selected to begin work in January **1999**.

Health care services are purchased through managed care organizations wherever possible, and a fee-for-service network in counties where managed care is not available. It is the Department's goal, with direction from the Children's Basic Health **Plan** Policy Board, to expand capitated service delivery statewide.

The current legislation specifies that CBHP be funded through a combination of Medicaid managed care savings, other savings achieved through health care reforms, consolidation and streamlining, state funds, private foundation donations, and federal matching funds.

Funding from savings is statutorily defined as savings and efficiencies realized from administrative and programmatic cost reductions in health care programs, other than caseload reductions. State law indicates that savings achieved through reforms, consolidations and streamlining may be appropriated to the Children's Basic Health Plan Trust Fund. **26-19-105 (3) CRS.** The statute further specifies that savings realized specifically from the consolidation of the children's portion of the Colorado Indigent Care Program into the Children's Basic Health plan will be deposited into the Trust Fund. **26-19-106 (5) CRS.** The Department of Health Care Policy and Financing submitted the **1998 Annual Savings Report** to the General Assembly October **1, 1998.** The report identifies General Fund savings in FY **2000** of **\$6,560,506** from Medicaid managed care and **\$2,368,026** from the consolidation of the children's portion of the CICP into the Children's Basic Health Plan.

The following assumptions and calculations are based upon the FY **1999** budget for the Children's Basic Health Plan and the FY 2000 funding request submitted to the state legislature November **1, 1998.**

## **Assumptions and Calculations**

### **Administrative Costs (\$4,324,670 FY 99-00; \$4,749,288 FY 00-01)**

Administrative costs include contract administration and state operating expenses. It does not include funding for state.

### **Contract Operations and Administration (\$2,850,213 FY 99-00; \$2,929,719 FY 00-01).**

At present, the Department has a short-term sole source contract (through December **31, 1998**) with a private foundation for eligibility determination, application processing, marketing and outreach, and customer service. A Request for Proposal for these services has been issued and a new contractor will be selected to begin work in January, **1999**.

Contractor staff will be responsible for the following functions:

Eligibility determination, application processing, and referring of children to a county Medicaid office when the children have been identified as likely eligible for Medicaid.

Operating eligibility system architecture, developing the production system, managing the implementation of the production system, and conducting ongoing systems support including backup and recovery of data, login ID support, application/rules changes, etc.

Conducting marketing and outreach for the plan, and offering technical assistance to schools, providers, and employers interested in helping market the program.

Printing, handling, and distributing enrollment and marketing materials, including but not limited to application forms, brochures, provider information, etc.

Maintaining a **1(800)** customer service line to answer questions about the plan and assist families with the application form.

Resource development, including soliciting donations and recruiting community partners for outreach, marketing and enrollment.

**Estimated Costs for Administrative Services Contract**

	<b>FY 98-99</b>	<b>FY 99-00</b>	<b>FY 00-01</b>
Eligibility Determination	214,108	<b>150,000</b>	154,500
Systems Administration	119,772	<b>227,758</b>	234,591
Marketing and Outreach	217,505	<b>125,000</b>	128,750
Customer Service	173,030	<b>359,705</b>	370,496
General Administration	312,463	<b>250,000</b>	257,500
Subtotal Personal Services	1,036,878	1,112,463	1,145,837
Advertising/Publicity	56,309	500,000	515,000
Contractual Services	26,400	300,000	309,000
Copy Machine Expense	2,507	46,970	48,379
Data Processing Hardware	38,833	38,833	39,998
Data Processing Software	28,202	28,202	29,048
Equipment Maintenance/Repair	13,200	13,200	13,596
Equipment Rental	13,200	13,200	13,596
Training	11,880	11,880	12,236
Info Systems Consultant	55,000	55,000	56,650
Office Supplies	63,360	15,000	15,450
Postage/Shipping/Courier	60,000	103,000	106,090
Printing	112,000	200,000	206,000
Space Rental	40,444	74,223	76,450
Telecom Equipment	10,049	10,049	10,350
Telephone Maintenance	1,100	1,100	1,133
Telephone Service	94,593	94,593	97,431
Travel	10,367	27,500	28,325
Other	<b>8,000</b>	<b>5,000</b>	5,150
Subtotal Operations	642,444	1,537,750	1,583,883
Overhead and Indirect	150,000	200,000	<b>200,000</b>
Total Operations	792,444	1,737,750	1,783,883
Total Operations and Personal Services	1,829,322	2,850,213	2,929,719

**2. Enrollment Broker (\$411,440 FY 99-00; \$499,129 FY 00-01).**

The Department is contracting with the Medicaid enrollment broker to inform clients of their managed care choices, and facilitate enrollment of clients into HMOs. The enrollment broker services will be billed on a per family basis. It is estimated it will cost \$35.30 per family for these services.

**Estimated Cost of Annual Enrollments**

	Avg. Member	Number of	Transaction	Total
FY 99-00	20,601	10,843	\$35.30	\$382,745
FY 99-01	24,991	13,153	\$35.30	\$464,306

**Estimated Cost of Disenrollment and Switching**

	Avg. Member	15% of Families	Transaction Costs	Total
FY 99-00	20,601	1,626	\$17.65	\$28,699
FY 99-01	24,991	1,973	\$17.65	\$34,823

Assumptions:

1. **Number of new enrollees is in counties that offer HMO choice. These**
  2. **On average, each family contains 1.9 children.**
  3. **Based on historical rate of switching HMOs in Medicaid, it is estimated that**
  4. **It is assumed that switching costs are one half the cost of a new enrollment.**
- 3. Premium Collection and Capitation Payments (\$805,517 FY 99-00; \$1,062,940 FY 00-01).**

The Department is contracting with Consultec, the Department's MMIS administrator, for premium collection and capitation payment to HMOs. Consultec will generate, mail, and process these payments for CBHP clients, and in turn, bill the Department for capitation payments net of premiums collected. Premiums will be billed, and capitation paid, on a per-child basis. It is estimated that it will cost **\$3.58** per child per year for these services.

Estimated Costs for Premium Collection Services

FY 99-00	% FPL	Distribution by Income	Avg. Monthly	Number of Families	Transactions Cost of	Months	Total
	under	40.1%	13,271	6,985	0	12	0
	100-150	38.5%	12,761	6,716	3.74	12	572,702
	151-170	9.3%	3,080	1,621	3.74	12	138,233
	171-185	12.1%	4,004	2,107	3.74	12	94,581
	Total	100%	33,119	17,429			805,517
FY 00-01	under	40.1%	17,512	9,217	0	12	0
	100-150	38.5%	16,839	8,863	3.74	12	755,724
	151-170	9.3%	4,064	2,139	3.74	12	182,409
	171-185	12.1%	5,284	2,781	3.74	12	124,806
	Total	99.99%	43,703	22,999			1,062,940

Assumptions:

1. Distribution by income is based on three months CBHP, dba CHP+ enrollment.
2. On average, each family contains 1.9 children.
3. Transactions cost for collecting premiums and paying capitations to plans is calculated based on the
4. **Other Administration** (\$235,000 in FY 99-00; \$257,500 in FY 00-01).

Other administrative costs that will be incurred by the Department include the following:

- \$25,000 to support the Policy Board, including meeting expenses, printing and postage and travel for out-of-metro area members;
- \$20,000 for legal services to support routine contractual functions, rule making and potential subscriber related issues;
- \$10,000 for auditing services;
- \$25,000 for actuarial services mandated under Title XXI;
- \$150,000 for evaluation consultation which is a mandated requirement under HB 1325; and
- \$5,000 for other consultation for addressing several key issues such as the impact of the premium structure.

**Health Care Costs (\$28,375,885 FY 99-00 ; \$38,943,267 FY 00-01)**

The estimated **HMO** capitation rate for FY 2000 is \$71.39. This estimate was arrived at through actuarial calculations and incorporates the impact of medical and pharmacy trends, adverse selection, revised immunization costs, and a revised methodology for calculating the impact of co-pays and benefit limits. The estimate does not incorporate any additional costs associated with implementing a managed care service delivery system statewide.

**Medical and Pharmacy Cost Trends:** This rate assumes a **7.5%** increase in medical and pharmacy costs over FY 1999.

**Adverse Selection:** The FY 1999 rate calculation assumed that **utilization** in the CBHP, dba CHP+, would mirror commercial insurance. Due to the economic level of CHP+ enrollees, premium requirements, and a relatively short **lock-out** period, the department believes that CHP+ enrollees under 100% FPL will have utilization patterns more like the Medicaid population than commercial populations. The rate estimate for FY **2000** increases the 100% FPL population utilization by **30%** to reflect these adverse selection issues.

## **Estimated Health Care Costs**

FY 99-00		Estimated	Projected	Per Capita =	Total
	under 2	4.86%	1,610	\$857	\$1,378,930
	6-Feb	31.05%	10,283	\$857	\$8,809,831
	7+	64.10%	21,229	\$857	\$18,187,123
	<b>TOTAL</b>	<b>100.01%</b>	<b>33,119</b>		<b>\$28,375,885</b>

FY 00-01	Age	Estimated Distribution	Projected Average	Per Capita = 74.2 per	Total
	under 2	4.86%	2,124	\$891	\$1,892,454
	6-Feb	31.05%	13,570	\$891	\$12,090,675
	7+	64.10%	28,014	\$891	\$24,960,138
	<b>TOTAL</b>	<b>100.01%</b>	<b>43,703</b>		<b>\$38,943,267</b>

Assumptions:

1. Enrollment projections are based on Colorado Child Health Plan growth
2. Age distribution is based on three months CBHP enrollment
3. Assumes 4% inflationary rate adjustment from FY 00 to FY 01

**Premiums Collected (\$2,785,737 FY 99-00; \$3,675,989 FY 00-01)**

House Bill 97-1304 requires that the program charge periodic premiums based on a sliding fee scale. The premium structure is as follows:

- Federal Poverty Level Number of Children
- One Child Two Children
- Under 100% FPL Waived Waived
- 101-149% \$9/child/month \$15/family/month
- 150-169% \$15/child/month \$25/family/month
- 170%-185% \$20/child/month \$30/family/month

Premiums will be collected by Consultec, the Department's MMIS administrator.

**Estimated Premium Collection**

	% FPL	Distribution	Number of	Number	Cost	Months	Total	Estimated
FY 99-00	under	40.1%	13,271	6,985	0	12	0	0
	100-150	38.5%	12,761	6,716	15	12	2,296,935	1,607,855
	151-170	9.3%	3,080	1,621	25	12	924,020	646,814
	171-185	12.1%	4,004	2,107	30	12	758,669	531,068
	<b>Total</b>	<b>100%</b>		<b>33,119</b>	<b>17,429</b>			<b>3,979,624</b>
FY 00-01	under	40.1%	17,512	9,217	0	12	0	0
	100-150	38.5%	16,839	8,863	15	12	3,030,978	2,121,685
	151-170	9.3%	4,064	2,139	25	12	1,219,314	853,520

171-185	12.1%	5,284	2,781	30	12	1,001,121	700,785
Total	100%	43,703	22,999			5,251,412	3,675,989

**Assumptions:**

- 1. On average, each family contains 1.9 children. Cost sharing is then taken from the premium schedule for families with 2 or more children.**
- 2. Distribution of income is based on three months CBHP enrollment.**
- 3. Assumes 70% collection rate**

**Summary of Costs (\$30,006,369 FY 99-00; \$40,130,617 FY 00-01)**

The Department of Health Care Policy and Financing has requested an additional **\$4,070,806** million General Fund in FY **99-00** for the Colorado Children's Basic Health Plan, dba CHP+. State statute provides that the primary mechanism for the program is savings achieved through reforms, consolidations and streamling, and through efficiencies realized from administrative and programmatic cost reductions, not including caseload reductions. **26-19-102 (3)(b)** and **26-19-105 (3)** C.R.S. The **1998** Savings Report, submitted to the General Assembly on October **1, 1998** pursuant to **26-4-113 (7)** and **26-19-106 (1)** C.R.S. identifies these savings. The report identifies General Fund savings of **\$17,973,594** in **FY 1999** and **\$8,928,532** in **FY 2000**. The sources of savings in **FY 2000** are **\$6,560,506** from Medicaid managed care and **\$2,368,026** from the consolidation of the children's portion of the Colorado Indigent Care program into the Children's Basic Health Plan. The weighted enhanced match rate for expenditures under Title **XXI** for **FY 98-99** is **34.89%** state and **65.11%**. Federal financial participation for administrative costs are restricted to **10%** of program costs net premiums.

**Budget Summary**

FY 99-00 Item	Total	General	Cash Fund	Federal	FY 00-01 Total	General	Cash Fund	Federal
Contract Operations	2,850,213	0	1,184,038	1,666,175	2,929,719		637,346	\$2,292,373
Enrollment Premium Collection	411,440 805,517	0 0	411,440 805,517	0 0	499,129 1,062,940		499,129 1,062,940	0
Other	235,000		235,000	0	257,500		257,500	0
Subtotal of	4,302,170	0	2,635,995	1,666,175	4,749,288	0	2,456,915	2,292,373
Health Care Premiums	28,375,885 2,785,737	9,900,346 971,943	0 0	18,475,539 1,813,793	38,943,267 3,675,989	13,630,143 1,286,596	0 0	25,313,123 2,389,393
CCHP Total	0 25,590,148	0 8,928,403	0 0	0 16,661,746	0 35,267,278	0 12,343,547	0 0	0 22,923,730
ECP grant Total	114,051 30,006,369	0 8,928,403	114,051 2,750,046	0 18,327,921	114,051 40,130,617	0 12,343,547	114,051 2,570,966	0 25,216,103

\* Federal financial participation may be distributed among any of the administrative lines. It is shown here

**Decision Item Request By Line Item**

	<b>Fund Source</b>	<b>Request Year FY 99-00</b>	<b>Following Year FY 00-01</b>
<b>Progradsub-Program</b>	TF	\$ 544,643	\$10,303,326
<b>Other Medical Services</b>	GF	\$4,070,806	\$3,415,144
<b>Children's Basic Health Plan</b>	CF		
CFE	(\$1,700,000)		
FF	(\$1,826,163)	\$6,888,182	
FTE			

**Comparison to the Base**

		<b>Prior FY 97-98</b>	<b>Current FY 98-99</b>	<b>Request</b>	
<b>Fund</b>	<b>Actual</b>	<b>Estimate</b>	<b>FY 99-00 Base</b>	<b>FY</b>	
<b>99-00</b>					
<b>Program/Sub-Program</b>					
<b>Other Medical Services</b>	TF	N/A	\$30,361,681	\$30,906,324	\$544,643)
<b>Children's Basic Health Plan</b>	GF	N/A	\$4,857,597	\$8,928,403	\$4,070,806
CF	N/A				
CFE	N/A	\$5,350,000	\$3,650,000	(\$1,700,000)	
FF	N/A	\$20,154,084	\$18,327,921	(\$1,826,163)	
FTE					

**Section 10. Annual Reports and Evaluations (Section 2108)**

- 10.1.** Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2))
- 10.1.1.**  The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and
  - 10.1.2.**  Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.
- 10.2.**  State Evaluations. The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: (Section 2108(b)(A)-(H))
- 10.2.1.**  An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.
  - 10.2.2.**  A description and analysis of the effectiveness of elements of the state plan, including:
    - 10.2.2.1.**  The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;
    - 10.2.2.2.**  The quality of health coverage provided including the types of benefits provided;

- 10.2.2.3.  The amount and level (including payment of part or all of any premium) of assistance provided by the state;
- 10.2.2.4.  The service area of the state plan;
- 10.2.2.5.  The time limits for coverage of a child under the state plan;
- 10.2.2.6.  The state's choice of health benefits coverage and other methods used for providing child health assistance, and
- 10.2.2.7.  The sources of non-Federal funding used in the state plan.
  
- 10.2.3.  An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.
  
- 10.2.4.  A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
  
- 10.2.5.  An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
  
- 10.2.6.  A description of any plans the state has for improving the availability of health insurance and health care for children.
  
- 10.2.7.  Recommendations for improving the program under this Title.

- 10.28.      Any other matters the state and the Secretary consider appropriate.**
  
- 10.3.      The state assures it will comply with future reporting requirements as they are developed.**
  
- 10.4.      The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.**

## Glossary

### Child Health Plan Plus (CHP+)

Child Health Plan Plus (CHP+), **the name by which the Children's Basic Health Plan is being marketed**, is the subsidized health insurance program delivering comprehensive benefits through HMOs to children age 0 through ~~17~~ **18** in families with incomes at or below 185% FPL. The Child Health Plan Plus ~~will be~~ **was** implemented ~~January 1,~~ **April 22,** 1998 as the first phase of Colorado's Title XXI program.

### Children's Basic Health Plan (CBHP)

The Children's Basic Health Plan (CBHP) is the subsidized health insurance program authorized by House Bill 97-1304 for children ages 0 through 17 in families with incomes at or below 185% FPL. **Subsequent state legislation (House Bill 98-1325) extend the program to children through the age of 18.** The Children's Basic Health Plan ~~will include~~ **includes** implementation of a rules-based eligibility system, a more sophisticated collections and HMO payment system, and an enhanced managed care quality oversight system as compared to ~~the Child Health Plan Plus Colorado Child Health Plan.~~ The overall program is guided by the Children's Basic Health Plan Policy Board, **a rule-making Type 1 transfer Board created in House Bill 98-1325.** ~~The CBHP is the second phase of Colorado's Title XXI program. Colorado will submit the necessary amendments or waivers to this State Plan to implement phase two of the Children's Basic Health Plan.~~

### Colorado Child Health Plan (CCHP)

The Colorado Child Health Plan (CCHP), administered through the University of Colorado Health Sciences Center, is ~~was~~ **legislatively established** as a community-based health care reimbursement plan for low-income children under the age of eighteen. The plan ~~provided~~ **provides** outpatient medical care to children from families whose incomes ~~place~~ **placed** them at or below 185% of the Federal Poverty Level. Children eligible for Medicaid ~~are~~ **were** not eligible for the Colorado Child Health Plan. As of June 30, 1997, the Colorado Child Health Plan had enrolled 7,003 children under 13 from 54 Colorado counties. By virtue of the passage of Colorado House Bill 97-1304, the plan became available to children 0 through 17 in all 63 Colorado counties. As of August 31, 1997, the plan had enrolled 9,482 children including members from all 63 counties up to age 18. **CCHP's statutory authority was not extended by the General Assembly and the program sunset on June 30, 1998.**

### The Health Care Program for Children with Special Needs (HCP)

The Health Care Program for Children with Special Needs (HCP) is a joint state/federal program administered by the Colorado Department of Public Health and Environment for children age 20

and under who have a physical disability that interferes with normal growth and development. HCP helps pay medical bills and provides follow-up for children diagnosed with a clinically qualifying handicapping condition. Examples of covered conditions include cerebral palsy, cystic fibrosis, seizures, heart defects, hearing loss, and cleft lip and palate. The program also provides diagnostic services for all financially qualified children suspected of having a disability or chronic heart condition. Children with conditions eligible for the program are identified through county nursing services, health care providers, Child Find coordinators in public schools, and local Early Childhood Connections staff. Currently, about 5,000 children are enrolled in HCP statewide.

**Colorado Benefits Management System (CBMS)**

An integrated eligibility determination system for medical assistance programs including Medicaid and the Children's Basic Health Plan. The project, co-managed by the Department of Human Services and the Department of Health Care Policy and Financing, will be implemented July, 2000.

**Colorado Indigent Care Program (CICP)**

The Colorado Indigent Care Program (CICP), administered by the Colorado Department of Health Care Policy and Financing, is a state and federally funded provider reimbursement program that discounts the cost of medical care at its participating health facilities for adults as well as children. If a person is eligible for Medicaid, he or she is ineligible for CICP. Covered services vary by participating hospitals or clinics, but generally include hospital costs such as inpatient stays, surgery, and prescription drugs. All children deemed eligible for the heretofore mentioned programs are directed towards them immediately at CICP-participating providers.

**Colorado Uninsurable Health Insurance Plan (CUHIP)**

Colorado Uninsurable Health Insurance Plan (CUHIP) was established in 1990 by the Colorado General Assembly as a quasi-governmental entity to provide health insurance to individuals, including children, who are denied health insurance by private carriers because of a pre-existing medical condition. People who are eligible for Medicaid or Medicare cannot enroll in this program. Only eight people, or one percent of those CUHIP members who disenrolled from the plan in 1996, did so because they became eligible for Medicaid. The plan is financed with funds from the state Business Association Unclaimed Property Fund. CUHIP provides an important source of insurance to children who are considered uninsurable. However, CUHIP rates (currently 130% of standard plan) are often out of reach for low-income families. CUHIP conducts an ongoing multi-media public awareness campaign to reach out to underserved markets across the state. Priority audiences include potential referral sources such as physicians, clinical social workers, financial planners, insurance agents and brokers.

### **Commodity Supplemental Food Program (CSFP)**

The Commodity Supplemental Food Program distributes United States Department of Agriculture food commodities to eligible low-income residents of Conejos, Costilla, Denver, Mesa, Rio Grande and Weld counties in Colorado. The program provides infant formula and nutritious foods to supplement the diet of pregnant and postpartum women (up to 12 months after delivery) and children under age six.

### **Community Health Centers**

Community health centers offer a wide range of health care to people who may need some financial assistance with their medical bills. Colorado has 15 community health centers with more than 50 clinic sites in medically underserved areas of the state. Community health centers provide comprehensive primary care services including care for acute and chronic illness, injuries, family planning and prenatal care, emergency care, diagnostics services and prescriptions.

### **Maternal and Child Health or Title V of the Social Security Act**

Maternal and Child Health or Title V of the Social Security Act funds in Colorado are "passed through" to local public health agencies and other qualified non-profit agencies where they are used to support a number of activities on behalf of women and children, particularly those of low income. State Title V staff provide oversight, consultation and standards to assure appropriate utilization of these funds. When families are ineligible for any insurance plan, or when there is not another provider of free or reduced price health care (i.e. community or rural health centers) available or accessible, these public health agencies often serve as the "safety net" provider for low income children, particularly those under 185% of FPL. Services provided in local public health agencies are almost always provided by public health nurses. Services include comprehensive well child clinic services, including developmental and physical assessments, immunizations, and parent education. Families under 100% FPL pay nothing for these services. Others pay on a sliding fee scale.

### **Plan**

The Plan refers to **the Children's Basic Health Plan, dba Child Health Plan Plus (CHP+)**.

### **School-Based Health Centers (SBHCs)**

School-based health centers provide comprehensive primary care services including care for acute and chronic illness, injuries, family planning and prenatal care, some diagnostics services and prescriptions. SBHCs provide services at no charge. However, patients are asked about coverage they may have. The degree to which the SBHCs bill for reimbursement depends on the

administrative capabilities of the center. SBHCs facilitate application to Medicaid, CCHP or CICP when documentation of family income and assets is obtainable without jeopardizing students' confidentiality.

**The Special Nutritional Program for Women, Infants and Children (WIC)**

The Special Nutritional Program for Women, Infants and Children (WIC) provides nutritious food to supplement the regular diet of pregnant women, breast-feeding women, infants, and children under age five who meet state income standards. Children under five years old qualify if the combined family income is at or below 185% of the federal poverty level.

**Safety Net Providers**

A safety net provider is a health care provider that has historically served medically needy or medically indigent patients who make up a significant portion of its patient population and waives charges for services on a sliding scale based on income and does not restrict access or services because of a client's financial limitations. Examples of safety net providers include Federally Qualified Health Centers (FQHCs), Disproportionate Share Hospitals (DSH), family planning clinics, and school-based health centers.

Section 17 Attachment 6  
**MONTHLY PREMIUMS**  
**CHILDREN'S BASIC HEALTH PLAN**  
 dba CHILD HEALTH PLAN PLUS (CHP+)

Payment amounts are based on annual income and family *size*.

<b>Family Size:</b>		<b>3 people</b>	<b>4 people</b>	<b>5 people</b>	<b>6 people</b>	<b>7 people</b>	<b>8 people</b>	<b>Monthly payment for:</b>		<b>Copayment</b>
<b>2 people</b>								<b>One Child</b>	<b>2 or more children</b>	
<b>Annual Income:</b>										
Up through \$10,850	Up through \$13,650	Up through \$16,450	Up through \$19,250	Up through \$22,050	Up through \$24,850	Up through \$27,650		No payment	No payment	<b>For each office visit</b>
						\$27,651-	\$41,476-	\$9 per family	\$15 per family	No copay
\$16,276-\$18,445	\$20,476-\$23,205	\$24,676-\$27,965	\$28,876-\$32,725	\$33,076-\$37,485	\$37,275-\$42,245	\$47,705				\$2 per visit
						\$47,706-		\$20 per	\$30 per	<b>\$5 per visit</b>

**Please see Section 18. Attachment 7 -- Child Health Plan Plus Benefits and Copayments**

**Attachment 1:**

**Colorado Standard Plan Benefit Package**

**The Colorado Standard Health Plan, deemed as the general standard benefit package in Colorado, as approved by the Colorado Department of Regulatory Agencies Division of Insurance covers the following items:**

<b>Benefit</b>		<b>Copayments</b>
1.	Hospital and Emergency Room Transport	\$50 copay/visit (including emergency transportation) <sup>1</sup>
2.	Inpatient	\$100 copay/admission <sup>2</sup>
3.	Outpatient/ Ambulatory Surgery	\$10 copay/visit
4.	Medical Office Visit (including physician, mid-level practitioner, & specialist visits)	\$10 copay/visit
5.	Laboratory & X-ray Services	No copay for physician-ordered services <sup>3</sup>
6.	Preventative Care	\$10 copay/visit
7.	Maternity Care  Prenatal  Delivery & inpatient well baby care	\$10/office visit; no copay for procedures, tests ordered by physician  \$100 copay/admission <sup>4</sup>
8.	Neurobiologically-Based Mental Illnesses (effective 1/98) <sup>5</sup>	Treated the same as any other condition (\$10/office visit; \$100 copay/admission)
9.	All Other Mental Health  Institutional care  (Maximum 45 inpatient or 90 partial days/year)  Outpatient care	  50% <sup>6</sup>  20 visits or \$1,500/year maximum <sup>7</sup>
10.	Alcohol & Substance Abuse	Diagnosis, medical treatment, & referral services. Covered 50% <sup>8</sup>
11.	Physical, Occupational, and Speech Therapy	\$10/visit <sup>9</sup>
12.	Durable Medical Equipment	50%. Maximum \$800/year paid by plan. Includes home oxygen. <sup>10</sup>

13.	Organ Transplants	\$100/admission copay <sup>11</sup>
14.	Home Health Care	Covered in full.
15.	Hospice Care	Covered in full.
16.	Outpatient Prescription Drugs	\$5 copay generic; \$10 copay brand name
17.	Skilled Nursing Facility Care	\$50 copay/day <sup>12</sup>
18.	Exclusions	Cosmetic care, war, care not medically necessary; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws <sup>13</sup> , non-fault auto, or employers liability laws, marital or social counseling, educational training problems, learning disorders, transplants except those listed, dental care except accidents, TMJ (except that TMJ that has a medical basis is covered), experimental/investigational procedures, infertility treatment and counseling except as specifically otherwise covered in the policy requirements of this plan, hearing aids and fitting, eye glasses and contact lenses, nursing home care except as specifically otherwise covered in this plan, and custodial care.

**There are no limitations for pre-existing conditions. A pre-existing condition is defined as an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within six months immediately preceding the effective date of coverage.**

**There is no coverage for dentistry, vision services and audiology. There is no lifetime maximum and no annual deductible.**

<sup>11</sup>Pursuant to Colorado Insurance Regulation 4-2-17, a carrier cannot deny a claim for emergency services necessary to screen and stabilize a covered person on the grounds that an emergency medical condition did not actually exist if a prudent layperson having an average knowledge of health services and medicine acting responsibly would have believed that an emergency medical condition or life or limb threatening condition existed. Non-emergency care delivered in an emergency room and ambulance service for non-emergency care are covered only if the covered person receiving such care was referred by the carrier or their primary care physician to the emergency room for care or was authorized by the carrier or their primary care physician to order an ambulance. If emergency rooms are used by the plan as a medical office/clinic, then office/clinic copays apply.

<sup>2</sup> ~~Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.~~

<sup>3</sup> ~~Includes low dose mammography screening not otherwise covered under the list of preventive care services, as mandated by Colorado law, Section 10-16-104 (4), C.R.S.~~

<sup>4</sup> ~~Well-baby care includes an in-hospital newborn pediatric visit.~~

<sup>5</sup> ~~Requires the following to be treated as any other illness or condition: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder. Applies to all group health benefit plans.~~

<sup>6</sup> ~~Pursuant to section 10-8-606 (2), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989; and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to section 10-3-903.5, C.R.S., that did not include mental health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provision of 10-16-105(2), C.R.S., relating to such an exclusion.~~

<sup>7</sup> ~~The per day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.~~

<sup>8</sup> ~~Carriers shall also offer alcoholism coverage pursuant to Section 10-16-104(9), C.R.S., as may be amended. HMOs shall comply with the alcohol and drug abuse benefit for federally qualified HMOs pursuant to 42 C.F.R., Section 417.101(a)(5).~~

<sup>9</sup> ~~Coverage for medically necessary therapeutic treatment only. Benefits will not be paid for maintenance therapy after maximum medical improvement is achieved.~~

<sup>10</sup> ~~Coverage for lesser of purchase price or rental price for medically necessary durable medical equipment, including home administered oxygen.~~

<sup>11</sup> ~~Covered transplants include liver, heart, heart/lung, cornea, kidney, and bone marrow for aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. Transplants will be covered only if the are medically necessary and the facility meets clinical standards for the procedure.~~

<sup>12</sup> ~~Care must follow a hospital confinement and the skilled nursing facility confinement must be the result of an injury or sickness that was the cause of the hospital confinement. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.~~

<sup>13</sup> ~~Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. In addition, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage if such proof is required on the HMO's other small employee plans.~~

Attachment 9:  
Children's Basic Health Plan Policy Board and Working Teams

CBHP POLICY BOARD

Function: The mission of the Policy Board is to provide strategic direction for the CBHP and to review major issues in its design and implementation. The Policy Board will seek to work by consensus to the extend possible.

Board Members

Lua Blankenship  
President  
The Children's Hospital

Thom Williams  
Vice President  
TIAA-CREF

Patricia Cahill  
President and CEO  
Catholic Health Initiatives

Dr. Albert C. Yates  
President  
Colorado State University

C. David Kikumoto  
President and CEO  
Blue Cross and Blue Shield

Paul Melinkovich, M.D.  
Denver Health Medical Center

*Ex Officio Members*

Barbara O'Brien  
President  
Colorado Children's Campaign

Steve Berman, M.D.  
Director of Health Policy  
University of Colorado Health Sciences  
Center

Kate Paul  
CEO  
Kaiser Permanente of Colorado

Bernie Buescher  
Executive Director  
Colorado Department of Health Care Policy  
and Financing

David Price, M.D.  
Past President  
Colorado Academy of Family Physicians

Jack Ehnes  
Commissioner of Insurance  
Colorado Department of Regulatory Agencies

Col. Michael Quinlan  
Regional Senior Vice President  
USAA – Mountain States Region

State Senator Sally Hopper  
Colorado State Senate

Marguerite Salazar  
President and CEO  
Valley-Wide Health Services

State Representative David Owen  
Colorado House of Representatives

David S. Shanks  
Bright Beginnings

Michael Rothman  
Director  
Office of Public & Private Initiatives  
Colorado Department of Health Care Policy  
& Financing

George Sparks  
General Manager  
Hewlett-Packard Company  
Solutions Services Division

Patti Shwayder  
Executive Director  
Colorado Department of Public Health &  
Environment

Thomas Stokes  
President  
Gates Capital Management  
Mel Takaki, DDS  
Takaki Dental Center

Michael J. Weber  
Executive Director  
Rocky Mountain HMO

Attachment 9:  
Children's Basic Health Plan Policy Board and Working Teams

***CHILDREN'S BASIC HEALTH PLAN POLICY BOARD***

House Bill 98-1325, which became law on April 21, 1998, created an 11-member Policy Board within the Department of Health Care Policy and Financing. The Board is statutorily charged with promulgating rules to govern the Children's Basic Health Plan, dba Child Health Plan Plus (CHP+).

By statute, four members of the Policy Board are the executive directors of the departments of Public Health and Environment, Health Care Policy and Financing, Education, and Human Services. The other seven members of the Board are appointed by the Governor, with the consent of the Senate, according to a proscribed structure: two must represent small business or other businesses, three must represent the health care industry (including one who is a managed care expert not affiliated with a MCO under contract to provider services under the Children's Basic Health Plan), one must represent an essential community provider, and one member must be a consumer.

The rule-making Policy Board provides a public forum for discussion of major policy issues, offers policy direction to the Department, sets programmatic rules on a number of key areas, and reports regularly to the General Assembly's Joint Budget Committee on program impact and effectiveness.

The first members of the Policy Board were appointed in June 1998 by Governor Romer. A roster of members follows. Please note that a consumer is not listed, as the Governor's appointee resigned in September 1998 for personal reasons.

## Children's Basic Health Plan Policy Board

Member Name and Title	Member's Organization and Address	Member's Phone, Fax, and e-mail
<b>Stephen Berman, M.D.</b> Professor of Pediatrics Director of Health Policy  (Health Industry Representative)	<b>The Children's Hospital - B032</b> <b>1056 E. 19<sup>th</sup> Avenue-</b> <b>Denver, CO 80218</b>	<b>(office) (303) 837-2771</b> <b>(pager) (303) 266-4895</b> <b>(fax) (303) 764-8072</b>
Term Expires: <b>6/30/02</b> <b>C. David Kikumoto</b> President and CEO  (Health Care Industry Representative)	<b>Blue Cross and Blue Shield</b> <b>700 Broadway, Suite 990</b> <b>Denver, CO 80273</b>	<b>(office) (303) 831-3234 (Jean)</b> <b>(fax) (303) 830-0887</b>  email: <b>cdkikum@bluemail.com</b>
Term Expires: <b>6/30/01</b> <b>William (Bill) Lindsay"</b>  (Health Care Industry Representative)	<b>President, Benefit Management and Design, Inc.</b> <b>1720 So. Bellaire, Suite 250</b> <b>Denver, CO 80222-4304</b>	<b>(office) (303) 691-0335 (Mary)</b> <b>(Fax) (303) 691-2245</b> <b>(Voice Mail) (303) 637-4078</b>  email: <b>benmgtdgn@aol.com</b>
Term Expires: <b>6/30/02</b>  <b>Kate Paul</b> CEO  (Business Representative)	<b>Kaiser Permanente</b> <b>10350 E. Dakota Ave.</b> <b>Denver, CO 80231</b>	<b>(office) (303) 344-7250 (Kevin)</b> <b>(fax) (303) 344-7682</b>
Term Expires: <b>6/30/01</b> <b>Marguerite Salazar</b> President and CEO  (Essential Community Provider Representative)	<b>Valley-Wide Health Services</b> <b>204 Carson Avenue</b> <b>Alamosa, CO 81101</b>	<b>(office) (719) 589-5161 (Jackie)</b> <b>(fax) (719) 589-5722</b>  email: <b>Ceo@VWHS.org</b>
Term Expires: <b>6/30/02</b> <b>Thomas (Thom) Williams</b> Vice President  (Business Representative)	<b>TIAA-CREF</b> <b>Republic Plaza, Suite 200</b> <b>370 Seventeenth Street</b> <b>Denver, CO 80202</b>	<b>(office) (303) 607-2002 (Lorraine)</b>  <b>(office direct) (303) 607-2000</b> <b>(fax) (303) 592-9418</b>
Term Expires: <b>6/30/02</b>		

**Proposed Effective Date: 1/1/98**

**CBHP Policy Board State Agency Members – page 2**

<b>Member Name and Title</b>	<b>Member's Organization and Address</b>	<b>Member's Phone, Fax, and e-mail</b>
<b>Barbara McDonn</b> ** Acting Executive Director	<b>Department of Health Care Policy &amp; Financing 1575 Sherman Street Denver, CO 80203</b>	(office) (303) 856-5096 (Luanna) (fax) (303) 866-2828  email: <b>Barbara.mcdonnell@state.co.us</b>
Executive Director	Department of Human Services 1575 Sherman Street Denver, CO 80203	
Patti Shwayder Executive Director	Department of Public Health & Environment 4300 Cherry Creek Drive S. Denver, CO 80246	(office) (303) 692-2012 (Pat Ennis) (fax) (303) 691-7702  email: <b>patti.shwayder@state.co.us</b>
David Smith Director Prevention Initiative	Colorado Department of Education 201 E. Colfax Ave., Room 405 Denver, CO 80203	(office) (303) 866-6683 (fax) (303) 866-6785  email: <b>Smith_d@cde.state.co.us</b>

\* Chair  
\*\* Vice Chair

9/30/98

**Working Team #1: Benefits Design and Pricing**

**Function:** To design and price the benefit package and to design the premium subsidy structure.

**Members**

Johnathan Asher  
Executive Director  
Legal Aid Society

Jennifer Laman  
Colorado Community Health Network

Buffy Boesen  
All Families Deserve A Chance Coalition

Virgilio Licona, M.D.  
Medical Director  
Colorado Access

Rick Bowles  
Medicaid Program Manager  
United Health Care of Colorado

Michelle Laisure  
Manager  
Colorado Medically Indigent Program  
Colorado Department of Health Care Policy  
& Financing

Diane Covington  
Director, Oral Health  
Colorado Department of Public Health and  
Environment

Charline Mann  
Secretary, Board of Directors  
Colorado Alliance for the Mentally Ill

Joan Haid  
EPSDT Team Leader  
Boulder County Health Department

Barry Martin, M.D  
Director of Clinical Services  
Metropolitan Denver Provider Network

Natalie Herlends  
Senior Counsel  
Community Health Plan of the Rockies

Myrle Myers  
Director of State Government Affairs  
Johnson & Johnson

David Herr, M.D.  
Associate Medical Director  
Rocky Mountain HMO

Shirley Ney  
HCFA Region VIII Office

Kathy Nichols  
Services Manager  
Planned Parenthood of the Rocky Mountains

Jim Johnston  
Foundation Health and  
QualMed Health Plan

M. Douglas Jones, M.D.  
Pediatrician-in-Chief (TCH)  
Professor and Chair  
Department of Pediatrics  
The Children's Hospital

Chris Pon  
Executive Director  
Colorado Uninsurable Health Insurance  
Program

Peggy Sandbak  
President  
Sandbak & Company

Don Schiff, M.D.  
Professor of Pediatrics  
The Children's Hospital

Linda Therrien  
Director  
Community Health Programs

Lisa Olson  
Service Coordinator  
Colorado Child Health Plan

Michele Patarino  
Blue Cross and Blue Shield

Courtney Thomas  
Director  
Child Health Services  
Colorado Department of Public Health &  
Environment

Laura Tollen  
Office of Public & Private Initiatives  
Colorado Department of Health Care Policy  
& Financing

Cathy Waters  
Handicapped Children's Program  
Department of Public Health & Environment

Carole Workman-Allen  
Office of Medical Assistance  
Division of Managed Care Contracting  
Colorado Department of Health Care Policy  
& Financing

Barbara Yondorf  
Director of Policy & Research  
Division of Insurance  
Colorado Department of Regulatory Agencies

## Working Team #2: Marketing

**Function:** To develop and implement a marketing plan to expand the Child Health Plan during SFY 1997-1998 and the transition to the Children's Basic Health Plan in SFY 98-99.

### Members

Cheryl Barnes  
Office of Medical Assistance  
Eligibility & Enrollment Section  
Colorado Department of Health Care Policy  
& Financing

Vatsala Kapur  
Office of Public & Private Initiatives  
Colorado Department of Health Care Policy  
& Financing

Steve Blatt  
Synapse, Inc. Strategic Marketing

Jennifer Laman  
Colorado Community Health Network

Karen Connell  
Colorado Department of Education

Rosemary Marshall  
Director of Public Relations  
Colorado Department of Labor and  
Employment

Jane Cotler  
Child Health Services  
Colorado Department of Public Health and  
Environment

Sally Maxey  
Family Voices

Diane DiGiacomo Peck  
Communications Officer  
Piton Foundation

Shirley Ney/Dee Raisl  
HCFA Region VIII Office

Edie Dulacki  
Johnston & Wells

Betty Pepin  
Administrator Director  
Commerce City Community Health Services

Beth Elland  
Community Partnerships  
St. Anthony Health Services

Gary Redabaugh  
Blue Cross and Blue Shield

Jane Gerberding  
Larimer County Department of Public Health

John Romero Campbell  
LA RASA

Tracy D'Angelo  
The Alliance

Ronnie Rosenbaum  
Director  
Shared Beginnings  
Centura/St. Anthony's Hospital

Paula Hudson  
Health Care Program for Children with  
Special Needs  
Colorado Department of Public Health &  
Environment

Karen Shields  
Connections Coordinator  
Kaiser Permanente

Rhonda Johnston  
Executive Director  
School-based Wellness Centers

Troy Sinar  
Marketing Manager  
SALUD Family Health Centers

Neil Kesselman, M.D.  
President  
Colorado Chapter of the American Academy  
of Pediatrics

Lucy Trujillo  
Colorado Foundation for Families and  
Children

Susan Tyler  
Outreach Coordinator  
Child Health Plan

### **Working Team #3: Eligibility, Enrollment and Management Information System Design**

Function: To design the eligibility, enrollment, and management information systems for the Children's Basic Health Plan.

#### **Members**

Dixie Anderson  
Colorado Department of Human Services

Annette Kowal  
Colorado Community Health Network

Colleen Bryan  
Project Manager  
Colorado Benefit Management System  
Department of Health Care Policy and

Kate Lutz  
EPSDT Manager  
Office of Medical Assistance  
Colorado Department of Health Care Policy

Chrystal Burrell  
Office of Medical Assistance  
Colorado Department of Health Care Policy  
& Financing  
Ned Calonge, M.D.  
Kaiser Permanente

Jessie Gray  
Denver Health and Hospitals

Jennifer Mauldin  
Handicapped Children's Program  
Colorado Department of Public Health &  
Environment

Charlotte Corrales  
Ignacio Indian Health Clinic

Patsy McAteer  
Handicapped Children's Program  
Colorado Department of Public Health &  
Environment

Diane Dunn  
Office of Medical Assistance  
Colorado Department of Health Care Policy  
& Financing

Brian Montague  
Colorado Child Health Plan

Norma Edelman  
EPSDT Administrative Service Trainer  
Colorado Department of Public Health &  
Environment

Connie Eldridge  
Blue Cross and Blue Shield

Sally Harmon  
Office of Medical Assistance  
Eligibility & Enrollment Section  
Colorado Department of Health Care Policy  
& Financing

Barbara Hinson  
Executive Director  
Children's Clinic

Ha Hoang  
Manager of Eligibility and Enrollment  
Colorado Child Health Plan

Beth Neva  
Office of Information Technology  
Colorado Department of Health Care Policy  
& Financing

Bonnie Sherman  
Executive Director  
Colorado Child Health Plan

Ann Taylor  
Executive Director  
Doctors Care

Cathy Van Doren  
Director  
The Alliance

Kim Walkenhorst  
EPSDT Case Manager  
Larimer County Health Dept.

Rebecca Weiss  
Health Policy Analyst  
Office of Public & Private Initiatives  
Colorado Department of Health Care Policy  
& Financing

Danielle Urban  
Market Development Planner  
Kaiser Permanente

## Working Team #4: Financing

**Function:** To ensure the Children's Basic Health Plan complies with state and federal financing regulations, to secure the proper flow of funds, and to conduct the analyses necessary to ensure sound financial management.

### Members

Cindy Baouchi  
Budget Analyst  
Colorado Department of Health Care Policy  
& Financing

Charla Low  
Director of Finance and Operations  
Child Health Plan

Ray Coffey  
Budget Analyst  
Colorado Department of Health Care Policy  
& Financing

Peggy Hill  
Research Associate  
Prevention Research Center for Family and  
Child Health

Lisa Fox  
Manager, Colorado Indigent Care Program  
Colorado Department of Health Care Policy  
& Financing

Melanie Melcher  
Budget Analyst  
Office of State Planning & Budgeting

Joe Keebaugh  
Office of Accounting & Purchasing  
Colorado Department of Health Care Policy  
& Financing

Cammie Muller  
Statistical Analyst  
Office of Public and Private Initiatives  
Colorado Department of Health Care Policy  
& Financing

Michelle Laisure  
Colorado Indigent Care Program  
Colorado Department of Health Care Policy  
& Financing

Pam McManus  
Chief Financial Officer  
Community Health Center, Inc.

Jennifer Laman  
Colorado Community Health Network

**Working Team #5: Employer Advisory Group**

**Function:** To design the employer buy-in components of the Children's Basic Health Plan.

**Members**

Melinda Anderson  
Business Financial Manager  
Mile Hi Child Care Centers

Cammie Muller  
Statistical Analyst  
Office of Public and Private Initiatives  
Colorado Department of Health Care Policy  
& Financing

Annmarie Castro  
Health Plan Manager  
US West, Inc.

Jim Palmer, Vice President  
Colorado Springs Chamber of Commerce

Ron Chatterton  
Human Resources  
Eastman Kodak Company

Joy Pickar  
Assistant Director, Government Relations  
State Farm Insurance Companies

Annemarie Chenoweth  
President  
Neoplan

Gerald Renteria  
Manager, Human Resources  
Graphic Packaging Corporation

Gayle Collins  
Cleo Wallace Center

Carla Rowland  
Colorado Child Health Plan

Jay Derks  
Mile Hi Child Care Centers

Walt Speckman  
Executive Director  
Weld County Human Services Department

Jennifer Laman  
Colorado Community Health Network

Laura Tollen  
Health Policy Analyst  
Office of Public and Private Initiatives  
Colorado Department of Health Care Policy  
& Financing

Liz Leif  
Leif Associates, Inc.

Bill Lindsay  
President  
Benefit Management and Design

Dorothy Marshall  
David A. Marshall Associates

Cathy Van Doren  
Director of Managed Care  
The Alliance

Peggy Morrison  
Chief Financial Officer  
Clinica Campesina  
Lafayette Clinic

Danielle Urban  
Market Development Planner  
Kaiser Permanente

John Moyski  
President  
Ponderosa Industries, Inc.

### Ad-Hoc Members

Loretta Archuleta  
Executive Director  
Rehabilitation & Performance Medicine  
Specialists

Judy Glazner  
University of Colorado Health Sciences  
Center

Jean Barker  
Director, Planning/Management Engineering  
Kaiser Permanente

Mike McArdle, Director  
Colorado Assn. Of Commerce and Industry

Kathy Bartilotta  
Principal  
KB Associates

Gary Redabaugh  
Senior Group Consultant  
Blue Cross/Blue Shield of Colorado

Pat Butler  
Consultant

Richard Rush  
Vice President, Actuarial Services  
FHP Health Care

Ellen Day  
Gauthier Construction Company