

STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Bill Owens
Governor

James T. Rizzuto
Executive Director

December 27, 2000

VIA FEDERAL EXPRESS

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. These changes are necessary to accurately represent the manner in which benefits in the Child Health Plan *Plus* Program are currently delivered.

Questions about the proposed amendments to the Colorado State Plan may be directed to Patrick Gordon, Service Delivery Manager for the Child Health Plan *Plus* program. He may be reached by phone at 303 866-5464 or by e-mail (patrick.gordon@state.co.us). Fax communications may be sent to 303 866-2803.

Sincerely,

~~James T. Rizzuto~~
Executive Director

cc: Karen Shields, HCFA Region VIII

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)

Benefits covered under the Child Health Plan Plus program are delivered to eligible children via a statewide managed care system, which includes HMOs and Prepaid Health Plans other Health Insurance Organizations (HIOs)(PHPs)-that are reimbursed under a capitated financing arrangement arrangement

A comprehensive description of the CHP+ managed care delivery system is set forth below:

HMOs:

Delivery of health services to Children's Basic Health Plan, dba Child Health Plan Plus, members is primarily through Health Maintenance Organizations (HMOs.). HMOs currently provide coverage in forty (40) of Colorado's sixty-three (63) counties, which includes approximately 70% of the eligible population. Additionally, service area expansions planned for the next 12 months will result in HMO coverage in all but seven (7) Colorado counties, and HMO enrollment of all but approximately 9% of the covered population. 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) statutes mandate requires that only plans willing to contract with Medicaid are eligible to serve CHP+ clients. This will measure ensures continuity of care -if child becomes that clients are not forced to change eligible for Medicaid during his or her 12 month period of continuous CHP+ coverage eligibility. providers each time their financial situation changes the program for which they are eligible. Currently, there are five (5) six HMOs under contract with the Colorado Medicaid program: Kaiser Permanente, Rocky Mountain HMO, Colorado Access, Community Health Plan of the Rockies, United HealthCare of 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 and in several rural counties throughout the state using community health centers and public hospitals for service delivery.

The Department has negotiated the HMO contract with six HMOs. 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.

CHP+ HMO 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 networks subcontracts, access to care and quality of care. The DOI subcontracts delegates -the quality and access-network review to the CDPHE. When a licensed HMO plan applies for a Medicaid contract, HCPF reviews and continually monitors several aspects of the HMO's the plan's structural quality, operation including provider contracting and credentialing procedures, network, utilization;-management, procedures for maintenance of access to care, quality improvement and grievance procedures, Any elements necessary for NCOA accreditation are deemed for the purpose of compliance in the HCPF quality review process.. HCPF reviews the Medicaid plans that apply to serve CHP+ clients. Where CHP+ contract standards vary from those of DOI and HCPF, the Department conducts additional reviews in coordination with the Medicaid, DOI, CDPHE, or other purchaser reviews. For example, an appropriate CHP+ network includes an adequate number of pediatricians and pediatric specialists within a reasonable distance of potential enrollees.

PHPHOs:

In areas of the State where coverage by HMOs is not available, the Department delivers covered benefits to children via contracts with other HIOPHPs that are financed under a global capitation arrangement. These HIOPHPs include Anthem Health of Colorado (for covered medical and pharmacy benefits), and Horizon Behavioral Services (for covered mental health benefits). Both Anthem and Horizon contract with Child Health Advocates, which provides management and fiscal services, and receives a monthly, global capitation payment from the Department for all expenses. Monthly capitation payments are made by the Department at the same per member per month rate established under contracts with participating HMOs.

Approximately 1500 primary care physicians, 700 specialists and 53 hospitals participate in the HIOPHP system, under contracts which include all of the gatekeeper, referral and prior authorization requirements required under HMO contracts. Comprehensive utilization management services are provided by the HIOPHPs, which authorize services according to the same medical necessity criteria established for participating HMOs. The scope of benefits

covered under the HOPHP system, including pharmacy and behavioral health services, is identical to those required under HMO contracts.

At the present time, approximately 30% of the enrolled CHP+ population is enrolled in the HOPHP portion of the statewide managed care delivery system maintained by the Department for the CHP+ program.

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

~~The former Colorado Child Health Plan developed its own statewide provider network, with provider contracts held by the University of Colorado Health Sciences Center (UCHSC). UCHSC held those contracts through a Memorandum of Understanding with the Department through June 30, 1999. As of July 1, 1999, HCPF has taken over responsibility for managing these contracts.~~ These physicians, hospitals and ancillary service providers provide services covered by the Children's Basic Health Plan, dba Child Health Plan Plus comprehensive benefit package in areas where HMO services are not available, mainly rural areas. 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 primary care physicians through capitation payments and reimburses specialty, inpatient, and pharmaceutical providers on a fee-for-service basis. Pharmacies accepting the PCS Health Systems plan 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 includes 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:** CHP+ uses the former Colorado Child Health Plan physician network of over 1,000 participating primary care providers to provide routine care and case management. Primary care providers receive a monthly capitation payment.~~

~~**Immunizations:** The Children's Basic Health Plan, dba, CHP+, aggressively encourages appropriate immunizations for its members. CHP+ pays physician network providers for the cost of the vaccine plus a \$10 per dose administration fee.~~

~~**Specialty Care:** Primary care providers refer CHP+ members to any one of over 1,500 participating specialists for medically necessary specialty care.~~

~~**Hospital Benefits:** The FFS/CHP+ network pays for all hospital benefits on a fee-for-service basis using the Colorado Medicaid rate. The plan has signed contracts with 57 hospitals throughout the state. These contracts are being amended to include inpatient care.~~

Pharmaceuticals: Pharmaceutical benefits are available to CHP+ members in the FFS system through the 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+ member prescriptions. The majority of Colorado's pharmacies belong to the PCS network.

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

All HMO and PHP contracts in the statewide managed care delivery system require comprehensive utilization management of covered benefits, and specify medical necessity criteria by which services must be authorized. Additionally, all contracts require that HMOs and PHPs ~~The Children's Basic Health Plan, dba CHP+, contract standards 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 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.~~

Fee for Service Network Utilization Controls

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

Primary Care Providers (PCPs)

All children in the statewide managed care delivery system are assigned to a primary care provider upon enrollment in the plan. 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. 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.

Prior Authorizations

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 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.

3.3 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 require that the plans have a process in place to permit special needs children to obtain a standing referral for specialty care.

The CHP+ HMO contract reads:

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

1. Have a biological, physiological or cognitive basis;
 2. Have lasted, or are virtually certain to last, for more than one year, and
 3. 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, diet, 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 HMO contracts commenced on July 1, 1998, specify a working relationship between the Health Care Program for Special Needs (Title V program) 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 is building on the five-year collaborative relationship of the 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.

Both the MCO and PHP delivery systems~~health delivery system and the fee for service delivery system under CHP+~~ continue to work collaboratively with HCP. CHP+ staff 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.