

December 30, 1997

Ms. Sherrie Fried
Division of Integrated Health Systems
Health Care Financing Administration
Mail Stop C3-18-26
7500 Security Blvd.
Baltimore, Maryland 21244-1850

Dear Ms. Fried:

Thank you for your questions regarding the Colorado Title XXI State Plan that the Colorado Department of Health Care Policy and Financing received on November 26, 1997. We are pleased to submit to you our responses, which we hope you will find complete and substantive. Please note that Attachments Three and Four contain a revised benefit package and a revised premium schedule.

We would like to thank the Regional Offices of the Health Care Financing Administration and the Health Resources and Services Administration for meeting with us in early December to clarify and explain the questions. We look forward to working with the Regional and Central Offices to implement this unique program for children.

Please contact Sarah Schulte at (303) 866-3144 or Laura Tollen (303) 866-3132 if you have any questions regarding these responses.

Sincerely,

Bernard A. Buescher
Acting Executive Director

BAB/scp

**TITLE XXI STATE PLAN
COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING**

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January 28, 1998

* Included in copies provided to HCFA, but not included in this condensed version of the response because of the volume of these materials. Copies will be made available upon request.

Responses to HCFA Questions and Comments on the Colorado Health Plan Plus (CHP+) Title XXI State Plan

Section 2. General Background and Description of State Approach to Child Health Coverage

Section 2.2.2

How will CHP+ interact with the Kaiser School Connection, voluntary practitioner program, and the existing mental health capitation program for low income children?

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 serve 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 the Kaiser Connections program may have reached its cap by the time that CHP+ begins enrollment. When the pilot is over, Kaiser will evaluate and decide how to continue the program. Kaiser has been involved in CHP+ design and does not intend to have a program that competes with CHP+. They may target a different population or coordinate their program with CHP+.

In the current CHP program, voluntary practitioner programs are CHP providers and perform outreach functions for the CHP program. Under CHP+, these providers could contract with a CHP+ 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 to 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 for CHP+ enrollees for non-covered services-either services that are not covered under the CHP+ benefit package or benefits that have been exhausted under the CHP+ plan. However, these services are not entitlement services, and availability varies by services, recipient, and geographic area.

Section 2.3

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 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 addressed individually below.

Communication: All user institutions will sign a statement of intent regarding the appropriate use of the CHP+ system. Each institution will be expected to provide 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 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 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 restricted to authorized CHP+ employees and their agents.

Network: Communication with the system via the network will be 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 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 carefully monitored and controlled. Only the protocols required to access the system will be 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 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 access to the contents of a single transmission. The encryption algorithm will use a 128-bit key as a minimum. Password and/or encryption will restrict access to the private key required at the server for the implementation of SSL. In addition, all users will be 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 required to gain access to the system. The login ID and password will be specified by our central administration staff. Criteria for formatting the login ID and password will be strictly enforced by security software on the server operating system. Passwords will be

changed regularly by the CHP+ administrator and disseminated via mail or phone to the local system administrator. In addition, server browsing will be 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 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 encrypted. The communications protocols, source addresses, and destination addresses will be controlled. A policy governing appropriate design and use will be 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 3.2

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 with 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 define "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.

In addition, the CHP+ program will build on the five-year collaborative relationship of the current 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 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 with staff at HCP to convey the needs of the managed care plans and assist the HCP in developing a case management product that is attractive to these plans.

What utilization control methods are currently employed by Colorado Child Health Plan that are being brought over into CHP+? If these methods are at the discretion of the primary care provider, how does the state ensure that adequate and appropriate utilization controls are applied? How does the State monitor utilization rate in fee-for-service areas?

Section 3.2 of the State Plan explains the current FFS utilization controls currently used by CHP that will be used by the FFS CHP+ program, including referrals, prior authorizations and educational activities. In addition, Primary Care Physicians providing services in non-HMO counties will be paid a per member per month capitation, so risk for utilization of primary care services is born by the PCP. The contract with the PCPs will also require them to obtain permission from CHP+ for any non-primary care service referral and only for medically necessary services. Referrals to specialists are recorded and tracked by Blue Cross Blue Shield to ensure that only PCP and CHP+ approved services are provided to an enrollee. CHP+ review criteria are developed by the CHP+ Medical Director and the Quality Improvement and Utilization Review Committee. Please see question 13 for a further discussion of retrospective and concurrent quality assurance and utilization review activities conducted by this committee.

State law (page 16 of Senate Bill 97-5) requires managed care organizations to actively seek the participation of essential community providers (ECPs). How will these ECPs be integrated into the Title XXI delivery system?

The CHP+ program will only contract with HMOs that contract with the Colorado Medicaid program in accordance with HB 1304. To retain their Medicaid contracts, these HMOs must fulfill the ECP requirements of SB 75. Therefore, the CHP+ anticipates that the CHP+ HMO networks will include these providers. The Department anticipates that ECPs will include Community Health Centers, Community Mental Health Centers, Public Health Agencies, School-Based Clinics, Family Planning Clinics, and other indigent care providers.

How will mental health services under CHP+ be coordinated with existing community services programs for children with mental illness and serious emotional disturbances which are at least partially funded through the Block Grants for Community Health Services, Public Health Service Act, Subpart I; also, how will mental health services be coordinated with substance abuse services provided under Subpart II?

CHP+, in conjunction with the HMOs, will develop a list of resources which must be in the HMO's CHP+ member handbook. This resource list will include mental health and substance abuse providers available for wrap-around services.

In addition, the Department has a Robert Wood Johnson Foundation Medicaid Managed Care Grant to strengthen relationship between Medicaid HMOs and community-based organizations, focusing on care coordination for clients with mental health needs. Work groups are focusing on identifying information and referral points and developing plans to educate care coordinators and providers in HMOs and community-based organizations. The Department plans to establish practice patterns for Medicaid clients that will be used for CHP+, including new HMO contract requirements that ensure a smooth transition between plan-provided benefits and direct-service providers.

Section 4. Eligibility Standards and Methodology

Section 4.1.5

The Title XXI program has been legally defined as a means tested program and as such the 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 apply. The immigration requirements provided in this plan do not conform with these requirements. The State proposes providing care to legal immigrants under their plan. This is not allowed under the new welfare reform statute. How does the State justify their inclusion? If the State is unable to justify the inclusion of all legal immigrants, how will it verify which immigrants came to the US before 8/22/96 and which ones arrived after that date, as well as immigrants who have been in continuous residence for more than five years.

The State intends to comply 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. Authors of the original State plan did not thoroughly understand these requirements and had no intention of deviating from accepted protocols for immigrant applicants.

CHP+ eligibility technicians will use the I-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 receive 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.

Section 4.3

Please explain the "financial penalty" for failure to renew on time (page 26). What are the penalty amounts and how will they be implemented?

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.

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

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 only penalty imposed at that time will be an interruption in coverage. During the 30-day "grace period," if the family does submit a renewal application, the child will receive 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 on the child's official expiration date.

If a 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 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.

Please clarify whether the annual renewal process for children (page 26) will include information necessary for follow-up screening to determine that the child remains eligible for Title XXI.

The annual renewal process will require the same financial, residency, and age documentation that is required at the time of the family's first application. The only document that will 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.

Section 4.4.1

The process described in section 4.4.1 of the State plan for Medicaid screening does not appear to meet the statutory requirements for Medicaid screening. At a minimum, we believe that all children who are potentially eligible for Medicaid under the State plan as poverty-level children should be identified in the screening process. In States, which have not accelerated the phase-in of the poverty level children's group to cover children up to 19, the process must also identify, for children at ages not covered under the State's poverty-level group, all children potentially eligible under the optional categorically needy eligibility group described at 42 CFR 435.222, Individuals Under Age 21 Who Meet the AFDC Income and Resource Requirements. While the State may initially use a gross income screen which compares total family income against the applicable Medicaid standard, it must have a second income determination screen that verifies the child is not Medicaid eligible before enrolling the child in the CHP+. The initial gross income screen would eliminate from the eligibility process children whose gross family income was low enough that Medicaid eligibility would be almost certain. A second screen, in which a full income determination was made, would detect children whose gross family incomes exceeded the initial screening standard but who were nevertheless Medicaid-eligible when applicable income disregards were applied. Absent this second step, the State would not be meeting its responsibility to ensure that children eligible for Medicaid are enrolled for such assistance (sec. 2102(b)(3)). It is also expected that the State adequately inform every applicant about the right to apply for Medicaid, the advantages of Medicaid eligibility, and where and how to apply for Medicaid.

An interagency task force, comprised of members from the State's Medicaid-financing agency Department of Health Care Policy and Financing; the Department of Public Health and Environment; the Department of Human Services; the CCHP (to be CHP+ eligibility staff); and the State's Indigent Care Program, has spent multiple hours with a University of Colorado-based consulting team with expertise in defining and capturing the set of rules necessary to determine eligibility simultaneously for CHP+, Medicaid Families and Children, the Colorado Indigent Care Program, and the Health Care Program for Children with Special Needs.

By July 1998, the plan should have operationalized the rules-based engine documented herein as an enclosure (Attachment Two). During the transitional period, the Colorado Child Health Plan 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 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 listings along with categorical descriptors to the CHP+ database so that a correct assessment can be made of Medicaid income and assets.
3. Linking the asset in income records from 2 (above) to the family members identified in 1 (above) so that a correct determination can be made of the income and assets for the Medicaid Budget Unit.

The combination of the above three revisions should allow a correct determination of 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 in 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.

How would other commonly reported types of income, such as intangible income, reparation payments, per capita American Indian/Alaska Native (AI/AN) payments and cash gifts, be handled in the eligibility process? It is important to note that certain income is exempt under federal statutes and the plan must ensure appropriate handling of such. We encourage the state to include a blanket statement on how to count all income not specifically referenced.

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+ eligibility staff will ask the family to complete a "cash gift form" that must be signed by the giver and the recipient.

The attached rules worksheet contains greater detail about the treatment of types of non-work income on pages 6 and 7.

The state comments that children thought to be eligible for Medicaid will be referred to an appropriate office for enrollment (page 27). What specific, proactive steps will the state make to help ensure that these Medicaid-eligible children enroll in Medicaid?

Medicaid eligibility personnel, Colorado Indigent Care Program personnel, and Colorado Child Health Plan (to be CHP+) eligibility personnel are working closely to define a common rules-based eligibility system that would be accessible through eligibility sites throughout the state.

The task force is also working toward a shared application for both Medicaid Families and Children and the CHP+. That shared application will be distributed by the summer of 1998. 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. Medicaid eligibility technicians and CHP+ eligibility technicians will share information. A family denied CHP+ because the child appears eligible for Medicaid would have its financial, age and residency information forwarded directly to the appropriate county's social service agency. Similarly, children denied Medicaid would have information sent directly from that Medicaid eligibility site to a CHP+ site.

In counties that have access to both the Medicaid eligibility system and the CHP+ eligibility system, the same eligibility technician will be able to accomplish eligibility determination and enrollment for both programs.

Section 7. Quality and Appropriateness of Care

Section 7.1

Please clarify how the state intends to evaluate quality and appropriateness of care in all other non-HMO environments or for special populations.

For care delivered through the Colorado Child Health Plan provider network, plan administration provides both retrospective and concurrent quality assurance and appropriateness of care reviews.

Retrospective Review

Each year, the Blue Cross Blue Shield of Colorado Foundation funds an independent plan evaluation conducted by the Department of Health Outcomes in the University of Colorado Health Sciences Center. This evaluation examines quality, appropriateness, and access to preventive health services and acute care services to children with and without chronic illness. The study is conducted on several age bands. The evaluation, documented through on-site chart reviews by trained nurse practitioners, generally measures the quality and utilization outcomes of the following services.

Preventive Health Services

The study examines how preventive health services for children 6-60 months of age with Colorado Child Health Plan insurance compare to those of children with Medicaid and private insurance. Rates of immunization, vision and hearing screenings, risk assessment or screening for lead, and development assessments are among the measured outcomes.

Acute Care for Children without Chronic Illness

The study examines the ratio of emergency room to office evaluations for acute illness in a random sample of children without chronic illness with CCHP insurance compared to children without chronic illness with Medicaid or private insurance. The number of hospitalizations per child, comparative diagnoses of those hospitalized and avoidable hospitalization rates are among the measured outcomes.

The study also examines the rate of hospitalizations for acute illness in a random sample of children without chronic illness with CCHP insurance compared to children without chronic illness with Medicaid or private insurance. Numbers of office visits, hospitalizations, and frequency of symptoms for reactive airway disease are among the measured outcomes.

Appropriateness of Care for Children with Chronic Illnesses

For selected groups of children with chronic illness, the study examines how the appropriateness of care and subspecialty referral recommended to children with CCHP insurance compare to that given to children with Medicaid or private insurance. Frequency of referrals and diagnoses are among the measured outcomes.

For selected groups of children with chronic disease, the study compares the ratio of emergency room to office evaluations for acute exacerbations in children with CCHP insurance compare to that of children with Medicaid or private insurance.

The results of the 1996 retrospective study of the Colorado Child Health Plan are complete but not yet printed. The State will forward those results as soon as they are published.

Concurrent Review

A Quality Assurance and Utilization Review Committee, comprised of the CCHP Medical Director, the CCHP Manager, four primary care physicians, one specialist physician, and two non-physician health professionals, is responsible for all aspects of Quality Assurance and Utilization Review for the CCHP provider network. Broadly defined, this includes administration of four overlapping functions:

- Evaluation and management of clinical quality and utilization
- Evaluation of access and service issues
- Patient/provider grievance process
- Overall program evaluation.

Evaluation and Management of Clinical Quality and Utilization

The objective of this activity is to improve the quality of health services by systematically monitoring practice patterns and reporting results to practitioners involved. The core of the process is education. Studies are designed to identify those areas where quality of care and cost effectiveness can be improved through feedback and education. Study topics are chosen based upon CHP+ patient demographic and disease characteristics. Study designs are based on objective, measurable, outcome-based standards that directly relate to the issues of:

- Accuracy and completeness of the medical record,
- Access to needed services, including specialties and emergency,
- Appropriate use of services and medication,

- Coordination and continuity of care,
- Follow-up of identified problems,
- Health education, and
- Patient satisfaction.

The goals of the studies are to determine whether patients/parents are informed of their health conditions and the services available to them, and services are delivered courteously, appropriately, and without duplication in the most cost effect setting. To accomplish this, review efforts encompass all services in preventive, primary, specialist and ancillary settings covered by CHP+.

The Committee is responsible for all phases of the quality and utilization review process, including prioritizing review topics, developing practice guidelines and standards and communicating these to prospectively affected providers, setting review schedules, developing data collecting strategies, interpreting screening and review results, recommending corrective action and documenting effectiveness, and recommending other actions/sanctions to achieve desired behavior.

Evaluation of Access and Service Issues

The Quality Assurance and Utilization Review Committee is responsible for assessing patient satisfaction with the quality of service provided by both CHP+ administration and CHP+ providers. The availability and acceptability of primary care providers, and access to routine, urgent and emergency care will be part of this assessment.

Patient/Provider Grievance Process

The Quality Assurance and Utilization Review Committee is responsible for organizing and managing the patient/provider grievance process for two types of issues - patient complaints and provider response to those complaints, and provider appeals to disciplinary actions.

Although it is anticipated that most patient problems can be resolved by simply making the provider aware of the situation, if the issue is not resolved at the provider/clinic level, there are provisions for Committee involvement in the case. The grievance process is also a means for providers to defend themselves against disciplinary actions. The process for both types of complaints is described in detail in the Patient/Provider Grievance Process section of this document.

Overall Program Evaluation

To assure that the Quality Assurance and Utilization Review Programs are as effective and efficient as possible, the Quality Assurance and Utilization Review Committee reviews all aspects of the program annually through the retroactive study described above. Review criteria evaluate study methodologies, trends in clinical service indicators, effectiveness of corrective actions, compliance with process guidelines and standards, and timeliness of responses. In carrying out this evaluation, the Committee reviews the materials and documentation in making decisions and audits records and logs that support the process. Review results along with relevant documentation are sent to the Chancellor of the University.

Please clarify how the state will evaluate the results of the CHP+ program. For example, will the State require HMOs to report CHP+ specific data so that the effects of this plan can be measured and analyzed to identify areas in need of improvement that are specific to the needs of these children?

CHP+ will collect CHP-specific performance data from participating HMOs when it is possible. Enrollment in any given HMO, however, may be too small to require CHP-specific reporting. Alternatives to CHP-specific reporting include combination with Medicaid reporting for a single plan or combining CHP-specific data across plans. The CHP+ Contracting and Quality Assurance Team will decide how this issue should be addressed and will comply with any additional guidelines promulgated by HCFA, NCQA and CAHPS. In addition, CHP+ will require that contracted HMOs reported a limited encounter data set that will include prescription drug codes.

Section 8. Cost Sharing and Payment Section

Section 8.2

Please verify whether American Indian/Alaska Natives (AI/ANs) are exempt from the plan's co-payment requirements. If so, please indicate if this applies only to those with access to IHS facilities or to all AI/ANs including urban Indians. Does this exemption also apply to premium requirements?

No, American Indian/Alaska Natives will not be 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.

The copayment for medical transportation (page 41) is \$15. This seems to violate the maximum \$6 copayment requirement for nonemergency use of the emergency room (2 times the nominal copayment amount) for those persons at or below 150% of poverty.

Please see the revised co-pays on the attached benefit package (Attachment Three).

Section 8.3

Are all enrollees subject to the same premium amounts effective January 1, 1998, or are only current CCHP enrollees offered premiums at half of that charged new enrollees?

All enrollees are subject to the same premium amounts, with the CHP+ annual enrollment fee counted towards the person's CHP+ premium. The half-price premiums for current CCHP enrollees have been eliminated. Please see attached revised premium schedules (Attachment Four).

Section 8.4.2

Please clarify what services are included as "well baby and well child care"?

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

CPT-4: Preventive medicine codes

99381	New patient under one year
99382	New patient (ages 1-4 years)
99383	New patient (ages 5 through 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)
99394	Established patient (12 through 17 years)
99431	Newborn care (history and examination)
99432	Normal newborn care

CPT-4: 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 Child Health Plan Plus follows the well-child visit schedule recommended by the American Academy of Pediatrics. The American Academy of Pediatrics recommends that children receive well-child visits at the following ages:

INFANCY	EARLY CHILDHOOD	MIDDLE CHILDHOOD	ADOLESCENCE
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Prenatal	1 Year	5 Years	11 Years
Newborn	15 Months	6 Years	12 Years
First Week	18 Months	8 Years	13 Years
1 Month	2 Years	10 Years	
2 Months	3 Years		
4 Months	4 Years		
6 Months			
9 Months			

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

Section 8.5

Attachment 6, "Child Health Plan Plus Family Premium Cost Sharing Cost" does not reflect the premium amounts detailed on page 56. Please clarify this discrepancy.

Please note that Attachment 6 to the original State Plan has been revised and updated. The new attachment is entitled, "Children's Basic Health Plan Recommended Premium Cost-Sharing." (Attachment Four) Section 8.5 is amended to read as follows:

Premiums for families through 100% FPL will be waived. For families between 101% and 149% with one child, premiums will be \$9/child/month, and for families with two or more children, \$15/family/month. Between 150% 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.

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?

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 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 the "shoe-box" approach to reimbursing families who have exceeded the 5% limit. Families will be asked to track expenditures and 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.

This approach appears 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, the State's recipients of the

Colorado Indigent Care Program have had experience with this "shoe box" approach. Recipients of services under the CICP are instructed to track expenditures and file for reimbursement for all expenditures that exceed 10% of the family's adjusted gross income. When the family receives notification of CICP eligibility, the eligibility technician notifies that family of the cap.

State planners feel that few families will reach their 5% limit. An analysis of the State's proposed premium schedule suggests that premiums payments will rarely exceed 1% of the family's adjust gross income.

Section 9. Strategic Objectives and Performance Goals for the Plan Administration

Section 9.8.3

We have concerns related to donations and require additional information in the following areas to determine whether these donations are bona fide:

University Hospital

The State of Colorado indicates that University Hospital would contribute a "donation" in the amount of \$650,000 to the Colorado Child Health Plan each year. However, because University Hospital is a public hospital, the contribution does not appear to be a provider related donation. Instead, this appears to be an intergovernmental transfer. To the extent the University Hospital contribution did not originate from an impermissible tax or donation, the \$650,000 would not be subject to the donation law under 1903(w) of the Act. Therefore, we request that the State of Colorado describe its compliance with section 1903(w)(6)(A) of the Act by further explaining the funding source used by University Hospital to make the contribution to the State. To the extent this money is appropriated to the facility by the State and is not derived from an impermissible health care related tax or donation, the State should revise the State plan page to reflect an intergovernmental transfer and not a donation.

As noted on the attachment, CHP+ is requesting to revise Page 75 of its State Plan to show an intergovernmental transfer of \$650,000 from University Hospital to the Child Health Plan (Attachment Five)

A provision of Senate Bill 90-25 (26-17-115, Section 2, CRS), which created the Child Health Plan, specifies that the sum of \$650,000 in federal funds be used for implementation of the Colorado Child Health Plan. The statute says that the source of these funds was moneys appropriated to the University Hospital Indigent Care Indigent Care Program. University Hospital annually has contributed \$650,000, received as a Medicaid teaching subsidy, to the Colorado Child Health Plan.

Explanation of source of funds

Private Foundations

The State of Colorado indicates that six (6) private foundations would contribute "donations" in the amount of \$335,676 to the Colorado Child Health Plan each year. It appears that each of these meets the definition of a provider related donation in accordance with section 1903(w)(2)(A) of the Act in that they are entities related to health care providers. However, in order to determine whether the donations are bona fide in accordance with section 1903(w)(2)(B), more information is needed from the State. Specifically, the State should provide a description of each foundation, including the purpose of each foundation and the source(s) of funding for each foundation.

The \$225,000 noted on page 74 of the State Plan is the amount local foundations have committed to donate to support the start-up costs of the Children's Basic Health Plan. This does not represent an annual level of contributions from the foundations listed, but rather is first-year "seed" money. It is the intention of CHP+ to pursue additional support from these and other foundations in future years.

The amount cited in your question, \$335,676, is the \$225,000 start-up funding discussed above plus the \$110,676 in grant funds CHP+ had requested from the Robert Wood Johnson Foundation. Since the time our State Plan was submitted, the RWJ Foundation has awarded a one-year \$100,000 Healthy Kids Replication grant to CHP+. The grant period is December 1, 1997 through November 30, 1998.

The paragraphs below provide a description for each of the local foundations, as well as the Robert Wood Johnson Foundation.

University of Colorado Foundation - The reference on page 74 of our State Plan to the Colorado Foundation, was not complete, as the full name is the "University of Colorado Foundation."

The Foundation was established in 1967 at the direction of the University of Colorado Board of Regents as an independent, privately governed, nonprofit corporation chartered under the laws of the State of Colorado. Its mission is to raise and manage private support to advance the University of Colorado and its programs.

Operating funds originate from several sources: from money paid by the University of Colorado and each of the campuses under contractual arrangements for fund-raising services; from short-term interest earned on gifts before they are used by the University; from 5 percent of all current gifts (non-endowed and non-capital); from 2.25 percent of endowed gifts (collected from investment income); from .50 percent of the fair market value of the Long Term Investment Pool; and from unrestricted assets held by the Foundation which generate modest earnings toward operating costs. The Foundation's 1995-1996 annual report contains an audit report by Arthur Anderson LLP dated October 8, 1996, showing the Foundation with total liabilities and net assets of \$276,323,173. A copy of the Foundation's most recent annual report is included in Attachment Six.

The University of Colorado Foundation has committed \$90,000 to support start-up of the Children's Basic Health Plan (CHP+). The Colorado Child Health Plan, upon which the CHP+ builds, is a University of Colorado Health Sciences Center grant program, and is administered by the University. Legislative authority for the Colorado Child Health Plan sunsets on June 30, 1998. The Foundation, cognizant of the importance of affordable health insurance coverage for Colorado low-income children, is committed to assisting with start-up of the CHP+.

The Piton Foundation - Founded in 1976, The Piton Foundation operates as the philanthropic investment division of the Gary-Williams Energy Corporation. Legally independent from the corporation, Piton is linked to Gary-Williams through their shared executives who serve both on the corporate and foundation management teams, and through a unified operating philosophy incorporating community vitality with profitability as the paramount measures of business success.

The mission of The Piton Foundation has remained constant for more than twenty years -- strengthening Denver low-income neighborhoods and families. To that end, the foundation has invested more than \$45 million in projects and missions serving the Denver community, primarily through grant making. The foundation focuses on the following five interrelated areas affecting low-income families and neighborhoods: improving public education, revitalizing neighborhoods, promoting economic opportunity, strengthening families, and promoting citizen involvement. CHP+ has received a \$20,000 grant from The Piton Foundation for start up costs related to CHP+.

Excerpts from the Foundation's most recent annual report are included in Attachment Seven.

The Denver Foundation - The Denver Foundation, one of the oldest community foundations in the country, was established in 1925. Today it is one of the 40 largest out of some 600 community foundations nationwide. It is organized to generate funds from the general public for charitable distribution within the State of Colorado.

The main purpose of The Denver Foundation is to improve the quality of life in the Denver metropolitan area. Last year, the foundation paid more than \$3.1 million in grants to non-profit organizations in the Denver area. There were more than 300 grants overall, with an average amount of approximately \$10,000. A March 20, 1997 audit report by Nelson-Skala & Associates shows the foundation had a fund balance of \$71,864,620 as of December 31, 1996. (See excerpts from the Foundation's annual report in Attachment Eight.)

The Denver Foundation has made a grant in the amount of \$25,000 to support start-up of the Children's Basic Health Plan.

Blue Cross Blue Shield of Colorado Foundation - The mission of the Blue Cross Blue Shield of Colorado Foundation is to enhance and increase health care for children in underserved families. The Foundation identifies as its ultimate tasks "to support programs that provide solutions to the problem of inadequate access to quality and affordable health care for children." The majority (65 percent) of the Foundation's annual contributions is made to projects that address access to health care for children and underserved families. Since 1990, the Foundation has contributed more than \$1.3 million to organizations committed to improving the health of the Colorado community. The

Foundation has indicated it will contribute \$40,000 to support expansion and quality assurance of the Colorado Child Health Plan.

The Rose Community Foundation - The Rose Community Foundation was established with proceeds from the for-profit conversion of Rose Medical Center in April 1995. The foundation is self-perpetuating, with funds generated by the interest earned on investments. For the fiscal year ending June 30, 1996, investment income alone was \$9.9 million.

The Foundation exists to enhance the quality of life in the greater Denver community by promoting the development of a healthy community. The foundation believes that a healthy community includes: an atmosphere of mutual concern and responsibility; safety within neighborhoods and within families; access to quality health care, services and education; access to basic needs (food, shelter, work); respect for diversity; strong leaders and associations; a strong and vital economy; a rich cultural life; and self-empowerment. According to an audit report by Arthur Anderson LLP dated October 11, 1996, the Foundation had total liabilities and net assets of nearly \$183 million as of June 30, 1996. A copy of the audit report may be found in Attachment Nine.

The Rose Foundation has expressed strong support for the CHP+ and has invited the nonprofit entity to submit a grant application for \$50,000 as an initial contribution.

Robert Wood Johnson Foundation - The RWJ Foundation was established as a national philanthropy in 1972 and today is the largest U.S. foundation devoted to health care. The Foundation concentrates its grant making toward three goals:

- to assure that all Americans have access to basic health care at reasonable cost;
- to improve the way services are organized and provided to people with chronic health conditions; and
- to promote health and reduce the personal, social, and economic harm caused by substance abuse -- tobacco, alcohol, and illicit drugs.

The Robert Wood Johnson Foundation, based in Princeton, New Jersey, has awarded numerous grants to the State of Colorado for a variety of initiatives. In December 1997, CHP+ learned that it is the recipient of another grant from the Foundation. As noted previously, a Healthy Kids Replication Grant in the amount of \$100,000 will be used to support start-up of the Children's Basic Health Plan.

Blue Cross Blue Shield of Colorado

It appears that the fee-for-service claims processing services donated by Blue Cross Blue Shield of Colorado meets the definition of a provider related donation in accordance with section 1903(w)(2)(A) of the Act in that it is an entity related to health care providers. However, in order to determine whether the donations are bona fide in accordance with section 1903(w)(2)(B), more information is needed from the State. Please describe this "in kind" donation mechanism. Included in this description should be the effective date of this donation mechanism, the estimated dollar amount of the in kind donation, and whether or not the State claims these services as an administrative expense.

Blue Cross Blue Shield of Colorado provides the following services for the current Child Health Plan program at no charge:

- Establishing and maintaining member eligibility
- Producing member identification cards
- Loading and maintenance of CHP contracted provider files
- Loading and maintenance of CHP pricing files
- Referral entry
- Claims processing and coordination of benefits activities
- Customer inquiry resolution

The Blue Cross Blue Shield 1997 annual budget for these services is \$143,377.

CHP+ does not claim this donation as an administrative expense because of the program's expectation that it will exceed the 10% administrative cap during the first year. CHP+ may claim this donation as an expense in future years when the program's administrative expenses are below the 10% of the program's budget.

Is it reasonable for the plan to rely on Blue Cross/Blue Shield's donation of fee-for-service claims processing given their current request to move from non-profit to profit status? What assurances has the State received? Has any contingency plan been developed should the need arise?

Yes, the State has received numerous assurances from Blue Cross Blue Shield that that Managed Care Organization will continue to process claims, process referrals and authorizations and produce health cards for the fee-for-service portion of the CHP+. They have indicated a willingness to accept a nominal sum in return for continuing as the CHP+ third party administrator when the State begins to receive federal funds for implementation of its full benefit package. This should be a relatively small administrative cost. The majority of activity will occur during the period between a child's determination of eligibility and the family's selection of a Managed Care Organization. Most recent assurances were delivered by the Chief Executive Officer of Rocky Mountain Health Services, the parent company for Blue Cross Blue Shield of Colorado, Nevada and New Mexico, at a meeting on December 11, 1997, at 4 p.m. Both the Medical Director and the Executive Director of the CHP+ were present. There is no need to develop a contingency plan until July 1, 1999, at the earliest. At that time the State feels that the new Medicaid Management Information System, Consultec, will be ready to assume the duties currently performed by Blue Cross Blue Shield.

Section 9.9

Has the State held any public meetings to provide opportunities for a wide array of consumers, lay persons, advocates, public entities, and special populations to provide input into the development of this program?

A myriad of opportunities has been available for public input as the program has been developed. The primary venues are discussed below:

- **Policy Board and Working Teams** -- The State has made a real effort to involve consumers, advocates, and others in the development of the plan. As noted in our State Plan, five task forces were established over the summer to work on various aspects of plan development. The minutes of task force meetings are attached as Attachment Ten.

While many participants represent providers, plans and government agencies, we also have involved consumers and members of the Denver metro area business community.

- **Focus Groups** -- One of the task forces, the CHP+ Marketing Team, has sponsored four focus groups in various communities to ascertain interest in the plan. A fifth is scheduled early next year. Carmen Padillo, an experienced bi-lingual facilitator, led each group, with approximately ten participants in each. Ms. Padillo is the Executive Director of the Urban Children's Coalition and Project Director for the Family Preservation Family Support Group of Northwest Denver. The date, location and audience for each focus group meeting follows:

Date	Location	Audience
November 18	Salud Family Center Fort Lupton, CO	Families known to the Center
December 2	Kaiser-Permante Denver, CO	Parents of children enrolled in Kaiser Connection
December 9	Salud Family Center Fort Lupton, CO	Spanish-speaking families known to the Center
December 16	Aurora First Presbyterian Church Aurora, CO	African-American and Native American Families
January 6	Arvada, CO	Asian-American Families

A copy of the questions used to frame the discussion is included as Attachment Eleven.

- **Meetings With Interested Parties** -- Department staff have met with representatives of a host of interested organizations, including the Colorado Developmental Disability Planning Council (Beverly Hirsekorn), the

Colorado Hospital Association (Larry Wall), the Colorado Medical Society Medically Indigent Committee, LARASA, Oral Health Program in the Colorado Department of Public Health and Environment, Kids in Need of Dentistry, Family Voices (Sally Maxey), an organization of the county departments of social services, Colorado Community Health Network, Colorado Association of Commerce and Industry, a Denver University Graduate Class in Health Care Systems, the Colorado Public Health Association, the Colorado Visiting Nurse Association, Denver Health and Hospitals, Colorado Division of Insurance, the Colorado Forum, Colorado Rural Health Network, Planned Parenthood of the Rocky Mountains, Bright Beginnings, and The Alliance.

- **Legislative Hearings** -- Consumers and advocates had the opportunity to testify before state legislative committees to provide input on the legislation that ultimately created and defined the Children's Basic Health Plan. These hearings were well attended, and state lawmakers had the benefit of hearing from parents and advocates who supported the concept, as well as representatives of some entities opposed to House Bill 97-1304.
- **Public Hearing** -- A public hearing on a proposed rule for the Children's Basic Health Plan was held on January 5, 1998. Notice of proposed rule making was published in accordance with state requirements, and stakeholder representatives received notice directly from the DHCPCF. The proposed rule concerns financial management of CHP+, as mandated in House Bill 97-1304.

Section 9.10

Please clarify whether modifications to the Medicaid Management Information System (MMIS) are for purposes of the Title XXI program. If so, these modifications could be made at the enhanced rate subject to the 10 percent administrative cap. However, Title XXI changes whose costs exceed the cap will be eligible for reimbursement at the regular administrative match of 50 percent, even if these are MMIS changes. MMIS rates of 75 percent and 90 percent FFP are not applicable since such match is explicit to Title XIX not Title XXI.

Yes, the modifications to the Medicaid MMIS are for the purpose of implementing the Child Health Plan Plus. These modifications add the functionality of premium collections and capitation payment for a new program required by the CHP+.

Does the state plan to use cost allocation for the Colorado Benefits Management System (CBMS) in order to divide the system cost among the various programs that will be served? Will Title XXI fund the entire cost of CBMS?

The CHP+ eligibility system will serve as a prototype for the CBMS project. Title XXI will only fund the development of the rules-based eligibility system for the CHP+. Title XXI will not fund the entire cost of CBMS. However, when the full CBMS system is bid out, the cost of the system will be allocated across all major programs, including CHP+.

Pages 2 and 72 indicate that enrollment will be permitted only up to the level of funding made available by State appropriations and through private funding. The State has approximately 160,000 uninsured children but anticipates enrolling about 8500 in the first year, 10,700 in the second year and 23,000 in the third year. How will the cap on enrollment be implemented? Why is the count of number of children participating so low? Would the State share the assumptions upon which enrollment figures provided on page 72 are based?

The Department is proposing a rule regarding the steps the Department will take to ensure that enrollment in the plan does not exceed available resources. See Attachment Twelve for details of how the Department plans to limit enrollment to remain within available funding. The Department held a public hearing on the proposed rule on January 5, 1998.

The count of number of children participating is low because the number of children that can enroll in the plan is constrained by the funding that is available to support the program. According to HB97-1304, "Beginning in fiscal year 1998, appropriations to the trust may be made by the General Assembly based on the savings achieved through reforms, consolidations, and streamlining of health care programs realized through actual reductions in administrative and programmatic costs associated with the implementation of this article and not decreases in the number of caseloads of such programs." The level of savings anticipated to be available to fund the program is outlined on page 73 of the State Plan. The enrollment figures presented on page 72 reflect how many children could enroll, given the level of funding described on page 73.

The estimated funding levels constrain the number of children that can be enrolled in the CHP+ and, as a result, affect the assumptions used to arrive at the final enrollment projections. A detailed description of the enrollment calculations is presented in Exhibit A in Attachment Thirteen. In SFY97-98 there is only enough funding to maintain an average monthly enrollment of 11,747 children with a slight growth to 12,635 in SFY98-99. In SFY97-98, if enrollment were allowed to grow at its natural rate, it is anticipated that enrollment would be much higher than that represented here. If additional state-level funding is identified, projected enrollment will be adjusted accordingly.

The number of children who switch from the CHP to the CHP+ affects enrollment projections. Families who have enrolled in the CHP prior to the approval of the State Plan are statutorily guaranteed 12 months of outpatient pediatric care for their \$25 enrollment fee. Even though the CHP+ will be available to all CHP enrollees, it is anticipated that some of these children will prefer to keep the outpatient benefit package for their 12 months of eligibility rather than switch. Therefore, in SFY98-99 there will be a phasing out of children receiving outpatient only benefits while the majority of children (children who switched to the CHP+ and any new enrollees) will receive comprehensive benefits through HMOs.

To calculate the number of children still choosing outpatient benefits, it was assumed that 66% of Child Health Plan enrollees switch to comprehensive benefits. This assumption is based on the fact that approximately 66% of CHP enrollees are in families with incomes less than 150% of poverty. These children will most likely switch to the CHP+ because the premiums will be very low and for many families, the CHP+ will be free. Of the projected 12,783 children projected to be enrolled in the Child Health Plan and the CCHP+ combined, 8,564 are enrolled in comprehensive benefits in the CCHP+ and the remaining 4,218 children choose to remain in outpatient only benefits through the CHP. These calculations are detailed in Exhibit B in Attachment Thirteen.

Enrollment estimates for SFY98-99 are also constrained by available funding and the number of children who have yet to have exhausted their 12 months of eligibility for the outpatient only benefit. FY98-99 enrollment calculations include an assumption that the remaining children in the CHP are phased out of outpatient benefits in equal proportions across the remaining 12 months after the CHP sunsets on June 30, 1998. Enrollment estimates for SFY99-00 are limited only by funding. These calculations are detailed in Exhibit C in Attachment Thirteen.

The State Plan includes only expenditures for children enrolling in comprehensive benefits through the CHP+. Total expenditures for children enrolling outpatient only benefits are state-only funds and were not included in the State Plan because these expenditures do not qualify for federal match under Title XXI. However, as the above discussion illustrates the number of children who remain in the CHP and the state's expenditures for such services affect the funding available for the CHP+ and, consequently, CHP+ projected enrollment.

The state intends to use savings from Medicaid managed care to fund the child health program (page 73). Please provide the analysis supporting that over \$7.5 million will be raised between 1998 and 2000 from Medicaid managed care savings.

House Bill 97-1304 and Senate Bill 97-5 both require CHP+ to submit an annual report to the Colorado General Assembly on the savings CHP+ expects to receive from reforms, consolidations, and streamlining of health care programs. This report was submitted to the Colorado General Assembly on October 1, 1997 and details the analysis used to calculate the savings from enrollment of Medicaid clients into managed care. A copy of this report is presented in Attachment Fourteen.

CHP+ BENEFIT PACKAGE
Final Children's Basic Health Plan Benefits
(As of 12-18-97)

Note: For children with family income up to 100% of the Federal Poverty Level, there is no cost-sharing.

Description of Benefit		Copoly	
		101-150% FPL	151 -185% FPL
Annual deductible	Not applicable.	None.	None.
Individual			
Family		None.	None.
Out-of-Pocket Maximum	Maximum amount enrollee has to pay out of pocket in any one year for covered benefits.	5% of annual family income adjusted for family size.	5% of annual family income adjusted for family size.
Inpatient			
Family			
Hospital and Emergency Room Transport	Covered.	\$6. Waived with hospital admission.	\$6. Waived with hospital admission.

Inpatient	Covered.	\$0	\$0
Outpatient/ Ambulatory Surgery	Covered.	\$0	\$0
Medical Office Visit (including physician, mid- level practitioner, & specialist visits)	Covered.	\$2	\$5
Laboratory & X- ray Services	Covered.	\$0	\$0
Preventative Care	Covered. Same benefits as mandated under the Standard Health Benefit Plan (e.g. immunizations, well-child visits and health maintenance visits.)	\$0	\$0
Maternity Care Prenatal Delivery & inpatient well baby care	Covered. Covered. State law requires infant to be covered for first 30 days.	\$0 \$0	\$0 \$0
Neurobiologically- Based Mental Illnesses (effective 1/98)	Covered. Treated the same as any other mental health condition (e.g. there are no limits on the number of hospital days covered.)	\$2/office visit; \$0/admission	\$5/office visit; \$0/admission
All Other Mental Health Institutional care Outpatient care	Limited coverage . 45 days of inpatient coverage with the option of converti ng 45 inpatient days into 90 days of day treatmen t	\$0 \$2	\$0 \$5

	<p>services.</p> <p>Limited coverage . 20 visit limit.</p>		
Alcohol & Substance Abuse	Limited coverage. 20 visit limit.	\$2	\$5
Physical, Occupational, and Speech Therapy	Limited coverage. 30 visits per diagnosis per year.	\$2	\$5
Durable Medical Equipment	Limited coverage. Maximum \$2,000/year paid by plan. Coverage for lesser of purchase price or rental price for medically necessary durable medical equipment, including home administered oxygen.	\$0	\$0
Organ Transplants	Limited coverage. Will include those transplants covered by the Standard Plan including 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 they are medically necessary and the facility meets clinical standards for the procedure.	\$0	\$0
Home Health Care	Covered.	\$0	\$0
Hospice Care	Covered.	\$0	\$0
Outpatient Prescription Drugs	Covered.	\$1	<p>\$3 - generic.</p> <p>\$5 - brand name.</p>
Skilled Nursing Facility Care	Covered.	\$0	\$0

Vision Services	Limited coverage. Vision screenings are covered as age appropriate preventive care. Referral required for refraction services. \$50 annual benefit for eyeglasses.	\$2 for referral and refraction benefits only	\$5 for referral and refraction benefits only
Audiological Services	Limited coverage. Hearing screenings are covered as age appropriate preventive care. Hearing aides covered for congenital and traumatic injury; maximum \$800/year paid by plan.	\$0	\$0
Dentistry	Not covered.	-	-
Intractable Pain	Covered. Included as a benefit with the medical office visit copay.	Treated the same as any other medical condition	Treated the same as any other medical condition
Autism Coverage	Covered. Included as a benefit with the medical office visit copay.	Treated the same as any other medical condition	Treated the same as any other medical condition
Case Management	Not covered.	Not applicable.	Not applicable.
Nutrition Services	Limited coverage. Formula for metabolic disorders, total parenteral nutrition, enterals and nutrition products, and formulas for gastrostomy tubes are covered for people with documented medical need. Documentation includes prior authorization which lists medical condition including gastrointestinal disorders, malabsorption syndromes or a condition that affects normal growth patterns or the normal absorption of nutrition.	\$0	\$0
Lifetime Maximum	Not applicable.	None.	None.
Pre-existing Condition Limitations	No pre-existing condition limitations.	Not applicable.	Not applicable.
EXCLUSIONS	Experimental procedures, custodial care, personal comfort items, TMJ treatment, treatment for obesity, acupuncture, biofeedback, chiropractic	Not applicable.	Not applicable.

	<p>in vitro fertilization, gamete or zygote intrafallopian transfer, artificial insemination, reversal of voluntary sterilization, transsexual surgery, treatment of sexual disorders, cosmetic surgery, radial keratotomy, biofeedback, chiropractic services, private duty nursing, workers compensation, physical exams for employment of insurance, vision therapy (e.g. muscle exercises), routine foot care not medically necessary, services for members confined in criminal justice institutions and any treatment not medically necessary.</p>		
<p>Additional Policy Issues</p>			
<p>Definition of Medical Necessity</p>	<p>Committee agreed that in specifying elements of medical necessity, the recommendations of the American Academy of Pediatrics will serve as basis for the medical necessity definition.</p>		

**Children's Basic Health Plan
Benefit Design and Pricing Committee Recommendation for
Premium Cost-Sharing**

Federal Poverty Level	Number of Children	
	One Child	Two or more children
Under 63% FPL	Waived	Waived
63%-81% FPL	Waived	Waived
82%-100 FPL	Waived	Waived

101% 149% FPL	\$9/child/month	\$15/family/month
150%-169% FPL	\$15/child/month	\$25/family/month
170%-185% FPL	\$20/child/month	\$30/family/month
Over 186 % FPL	\$68/child/month	\$68/child/month

1997 Federal Poverty Levels

	Annual Family Income: 1 adult + 1 child	Annual Family Income: 1 adult + 2 children
63% FPL	\$6,684	\$8,398
81% FPL	\$8,594	\$10,797
100% FPL	\$10,610	\$13,330
150% FPL	\$15,915	\$19,995
170% FPL	\$18,037	\$22,661
185% FPL	\$19,629	\$24,661

Sources of Non-Federal Share of Expenditures

The Child Health Plan Plus operations will be funded from three primary sources: state General Fund, CHP cash reserves, and donations. The following paragraphs describe the origin and amount of each of these funding sources.

Colorado Child Health Plan Plus Sources of Non-Federal Funding SFY98-00			
	SFY97-98	SFY98-99	SFY99-00
Medicaid Managed Care Savings	\$ -	\$1,196,881	\$6,570,015
CHP General Fund appropriation	\$1,013,598	\$1,013,598	\$1,013,598
One-time General Fund appropriation	\$2,000,000	\$ -	\$ -
Private Grants	\$225,000	\$110,676	\$ -
University Hospital Intergovernmental transfer	\$650,000	\$650,000	\$ 650,000
CHP Cash Reserves	\$1,970,482	\$ -	\$ -
Total State and Private Funding Available	\$5,859,080	\$2,971,155	\$8,233,613
Less state-only expenditures for children receiving non-comprehensive benefits	(\$2,796,406)	(\$588,954)	\$ -
Less carryover of funding in Trust	(\$1,400,000)	\$1,400,000	\$ -
Total Non-Federal Funding	\$1,662,674	\$3,782,201	\$8,233,613

State General Fund

Medicaid Managed Care Savings

The state law (C.R.S. 26-4-113(7)(c)) expresses the intent that a portion of the general fund share of the savings realized from increased enrollment of Medicaid clients into managed care be appropriated to the Children's Basic Health Plan. Medicaid clients who enroll in managed care choose between the Primary Care Physician Program (PCP) and Health Maintenance Organizations (HMOs). HMOs are paid a capitated rate which the Department sets at 95% of fee-for service costs. In other words, for each client enrolled in an HMO, the Department realizes a 5% per capita savings.

Colorado Child Health Plan State General Fund Appropriation

The Colorado Child Health Plan currently receives a state General Fund appropriation of \$1,013,598.

One-time General Fund Appropriation

House Bill 97-1304 created the Children's Basic Health Plan Trust and included a one-time \$2 million General Fund to the Trust to fund the expansion of the Colorado Child Health Plan and the start-up costs of the Children's Basic Health Plan. Enrollment is limited below available funding in SFY97-98 to allow funds to be carried over to SFY98-99 to maintain SFY98-99 enrollment levels. In general, any unspent funds held in the Trust do not revert back to the General Fund at the end of the state fiscal year and can be carried forward to be spent in future years.

Intergovernmental Transfer

University Hospital contributes a donation in the amount of \$650,000 to the Colorado Child Health Plan each year.

Donations

Local foundations have contributed \$225,000 in private funds to support the start-up costs of the Children's Basic Health Plan. These commitments include \$90,000 from the Colorado Foundation, \$20,000 from the Piton Foundation, \$25,000 from the Denver Foundation, \$40,000 from the Blue Cross/Blue Shield Foundation, and \$50,000 from the Rose Foundation. In addition, *CHP+* of Health Care Policy and Financing has applied for \$110,676 under the Robert Wood Johnson's Healthy Kids Replication Program.

Colorado Child Health Plan Cash Reserves

At the beginning of SFY97-98, the Colorado Child Health Plan held \$1,970,482 in cash reserves. This reserve includes University Hospital donations made to the CHP that could not be spent in previous years.

ATTACHMENT SIX:

UNIVERSITY OF COLORADO FOUNDATION ANNUAL REPORT

ATTACHMENT SEVEN:

PITON FOUNDATION ANNUAL REPORT

ATTACHMENT EIGHT:

DENVER COMMUNITY FOUNDATION ANNUAL REPORT

ATTACHMENT NINE:

ROSE FOUNDATION ANNUAL REPORT

ATTACHMENT TEN:

WORKING TEAM MINUTES

ATTACHMENT ELEVEN:

FOCUS GROUP QUESTIONS

Available Upon Request

ATTACHMENT TWELVE:

CHP+ PROPOSED RULE

Proposed Rule Promulgated Pursuant to HB 97-1304

Rule CHP+-98-1, Concerning Financial Management of the Children's Basic Health Plan

I. Statement of Basis and Purpose

A. Basis. The authority for this rule is based on HB 97-1304, as codified in C.R.S., sections 26-19-104 and 26-19-108(1).

- A. Purpose. **This rule provides for financial management of the Children's Basic Health Plan, in order to ensure that sufficient funds are present in the Children's Basic Health Plan trust to implement provisions of C.R.S., sections 16-19-101, et seq.**

I. Definitions

- A. **"applicant" means a child submitting an application for enrollment in the Children's Basic Health Plan, or on whose behalf an adult submits an application for the Children's Basic Health Plan.**
- B. **"application" means an application for enrollment in the Children's Basic Health Plan.**
- C. **"department" means the Department of Health Care Policy and Financing.**
- D. **"director" means the Executive Director of the Department of Health Care Policy and Financing.**
- E. "enrollee" means any child that has enrolled in the Children's Basic Health Plan.
- F. "plan" means the Children's Basic Health Plan authorized under C.R.S. section 26-19-101, et seq.

I. Enrollment Projections

In order to ensure that enrollment in the plan does not exceed available resources, the director shall compile monthly reports of enrollment, including the data elements listed below. In addition, the director shall make projections, at least quarterly, of expected enrollment in the next quarter. Enrollment projections shall be based on the following for, at a minimum, the most recently-completed three-month period:

- A. **Total number of applications distributed by the plan, by month;**
- B. Total number of applications received by the plan, by month, by age of applicant, and by family income of applicant;
- C. Total number of applications approved by the plan, by month, by age of applicant, and by family income of applicant;
- D. Total number of applications disapproved by the plan, by reason for disapproval, by month, by age of applicant, and by family income of applicant;
- E. Inventory of applications left unprocessed at the end of each month, by age of applicant, and by family income of applicant (if possible);
- F. Average length of time for processing an application, by month;
- G. Total number of children disenrolling from the plan, by month, by age of enrollee, by reason for disenrolling, and by family income of enrollee.

I. Cost Projections

In order to ensure that enrollment in the plan does not exceed available resources, the director shall compile monthly reports of plan expenditures, including the data elements listed below. In addition, the director shall make projections, at least quarterly, of expected expenditures in the next quarter. Expenditure projections shall be based on the following for, at a minimum, the most recently-completed three-month period:

- A. **Projected quarterly enrollment, based on calculations under section (III) of this rule, by age and family income of expected enrollees.**
- B. Total capitation payments for capitated managed care organizations by month (classified by date of service), and by age or age group of enrollee.
- C. Total fee-for-service payments for enrollees not covered under Health Maintenance Organizations, by month (classified by date of service), and by age or age group of enrollee.
- D. Total enrollee premiums collected, by month, by age or age group of enrollee, and by family income of enrollee.
- E. Total administrative costs, by month.

V. Limits on the Plan to Ensure that Costs Stay Within Available Funding

At least quarterly, and based on enrollment and cost projections developed under sections (III) and (IV) of this rule, and based on the annual appropriation for the plan and any grants or donations, the director shall

determine whether sufficient funds exist to continue current enrollment patterns in the next quarter. If the director determines that projected enrollment and associated costs will exceed the available funds in the next quarter, the director will take immediate action to modify enrollment procedures, enrollee cost sharing, or benefits to ensure that the next quarter's enrollment and associated costs do not exceed available funds in that quarter. In this circumstance, the director may modify enrollment procedures, enrollee cost sharing, or benefits in either of the following ways:

A. Cap enrollment for all applicants at the level that will ensure costs do not exceed available funds in the next quarter, and create a waiting list of approved applicants. Such waiting list shall be divided into two lists as follows:

1. A list of approved applicants with gross family income up to 133% of the federal poverty level or who would qualify for Medicaid as if there were no asset testing; and
2. A list of approved applicants with gross family income from 134% through 185% of the federal poverty level.

As space becomes available under the plan, approved applicants on the first waiting list will be enrolled first. Once this list is exhausted, applicants on the second waiting list will be enrolled.

A. Set two different enrollment caps, as follows, at a level to ensure costs do not exceed available funds in the next quarter:

1. One cap for applicants with family incomes up to 133% of the federal poverty level or who would qualify for Medicaid as if there were not asset testing; and,
2. A lower cap for applicants with gross family income from 134% through 185% of the federal poverty level.

Under this option (B), the director will establish waiting lists in the same manner as described under section (A) above.