

# STATE OF COLORADO

## DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Bill Owens  
Governor

James T. Rizzuto  
Executive Director

July 15, 1999

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:

In an attempt to provide you with the most thorough understanding of our program, we have responded to your April 14, 1999 letter to Dean Woodward in two ways:

1. a specific response to each question (attached); and
2. limited modifications to the Title XXI State Plan narrative to
  - a. incorporate issues you raised in your April 14<sup>th</sup> letter; or
  - b. modify changes to the program since its inception. Item 2b is not intended as a revision to the plan—merely an update to better describe the program as currently implemented.

We hope this information is helpful. Please feel free to contact Barbara Ladon at 303-866-3227 with additional questions.

Sincerely,

James T. Rizzuto  
Executive Director

cc: Dee Raisel  
HCFA Region VIII

RESPONSES TO HCFA'S QUESTIONS AND COMMENTS ON THE  
COLORADO HEALTH PLAN PLUS (CHP+)  
TITLE XXI STATE PLAN AMENDMENT

Section 6 Coverage Requirements for Children's Health Insurance

Section 6.2

1. You have clarified that one benefit package is being offered (that labeled as "Benefits in Counties where HMOs are Available") and that copayments as described in Attachment 7 are correct. Please correct and resubmit Section 6 of the template to reflect only the correct benefit package. In addition, copayments listed in Section 6 should be either corrected to correspond with those in Attachment 7, or removed from Section 6 entirely (since it is not necessary to restate them in Section 6.)

Colorado currently offers only one benefit package to children enrolled in its CHIP. The benefit package that is offered is labeled as "Benefits" on Page 40 in Section 6.2, a copy of which is also attached to this packet.

Section 7. Quality and Appropriateness of Care

Section 7.1

2. Your annual report indicates that until you are able to collect adequate HEDIS data, other sources or data will be used to measure quality. Please specify these data sources as a part of your plan.

The paragraph on CHP+ performance data from the approved state plan is still applicable. The following paragraph will be added to the amendment:

"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+ Quality Assurance Working Group is meeting regularly to finalize a recommended quality assurance plan. They will recommend a strategy to the Department and will comply with any additional guidelines promulgated by HCFA, NCQA, and CAHPS."

This paragraph is identical to the paragraph in the approved state plan, except for the deletion of the sentence regarding encounter data, which the program does not plan to collect due to cost.

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

3. In our previous conversation, it was our understanding that the budget would be revised to reflect Federal fiscal years. The revised budget (Attachment B of your response) is still using State fiscal years. In addition, the revised budget still reflects administrative costs that are in excess of 10 percent of the total. Please revise the budget to address these errors.

**Components of the CBHP Budget for FFY 1999**

Funding for FFY year 1999 reflects federal financial participation at a rate of 65.07%. Federal reimbursement for administrative costs is included only up to 10% of health care costs.

<b>Item</b>	<b>Total</b>	<b>State Funds</b>	<b>Federal Funds at 65.07%</b>
Contract Operations and Administration	\$ 2,738,394	\$2,065,142	\$673,252
Enrollment Broker	\$ 261,706	\$ 261,706	\$0
Premium Collection & Capitation Payment	\$ 396,399	\$ 396,399	\$0
Other Administration	\$ 420,000	\$ 420,000	\$0
<b>Subtotal of Administration</b>	<b>\$3,816,499</b>	<b>\$3,143,247</b>	<b>\$ 673,252</b>
Health Care Costs	\$9,680,401	\$3,381,364	\$6,299,037
Premiums Collected	(\$ 368,473)	(\$ 128,708)	(\$ 239,765)
CCHP phase-out health care	\$ 1,221,721	\$1,221,721	\$0
<b>Total Health Care Costs</b>	<b>\$10,533,649</b>	<b>\$4,474,378</b>	<b>\$6,059,272</b>
<b>Grand Total Program</b>	<b>\$14,350,148</b>	<b>\$ 7,617,624</b>	<b>\$6,732,524</b>

**Components of the CBHP Budget for FFY 2000**

Funding for FFY 2000 reflects federal financial participation at a rate of 65.00%. Federal reimbursement for administrative costs is included only up to 10% of health care costs, including the health care risk pool.

<b>Item</b>	<b>Total</b>	<b>State Funds</b>	<b>Federal Funds @ 65.00%</b>
Contract Operations and Administration	\$ 2,850,213	\$ 924,902	\$ 1,925,311
Enrollment Broker	\$0	\$0	\$0
Premium Collections	\$ 805,517	\$ 805,517	\$0
Other Admin	\$ 215,000	\$ 215,000	\$0
<b>Subtotal Administration</b>	<b>\$3,870,730</b>	<b>\$1,945,419</b>	<b>\$1,925,311</b>
Health Care Services	\$28,375,885	\$ 9,931,560	\$18,444,325
Family Premiums Collected	(\$1,717,736)	(\$ 601,208)	(\$ 1,116,528)
<b>Grand Total Program</b>	<b>\$30,528,879</b>	<b>\$11,275,771</b>	<b>\$19,253,108</b>

**Budget Narrative**

***Contract Operations and Administration:***

The Department has entered into a contract through June 30,2000 with a Colorado Corporation, Child Health Advocates, to ~~perform~~ eligibility determination, outreach and marketing. The contractor is responsible for the following:

- Eligibility determination: includes application distribution and processing; referral of children to county Medicaid offices when determined to be likely eligible for Medicaid; enrolling children in CHP+.
- Data management: includes operating eligibility and enrollment system; managing the data base; producing reports to the State and to other contractors and HMOs; conducting ongoing support including backup and recovery of data, login ID and user support for local and remote users.
- Marketing: participate in design and development of marketing strategies and plans; implement mass media and community-based marketing efforts. Includes printing, handling and distributing application forms, brochures, and provider information.

- Outreach: community outreach to families likely to be eligible for CBHP and to related community-based agencies.
- Customer Service: maintain a 1-800 customer service line to answer questions about the plan and assist families; i.e. provide information to families about health care options under the plan.
- Resource Development: includes soliciting private donations and recruiting community partners for outreach, eligibility and enrollment.
- Family Premium Collection: the contractor will bill families monthly, receive and track payments, implement compliance procedures as established by the State, report monthly.

***Other Administration***

The Department will incur expenses for basic state program administration, support for the CBHP Policy Board, travel, legal services, actuarial services, auditing services, evaluation consultation and other consulting services.

***Health Care Costs***

Health care services will be purchased at an average age- and income-adjusted rate of \$64.62 per member per month in FFY 1999 and an estimated rate of \$67.86 per member per month in FFY 2000. Health care costs are offset by family premiums collected by the state.

4. Your response to our questions relating to the non-Federal share of Title XXI expenditures requires further clarification:
- Denver Health Intergovernmental Transfer – Please describe the funding source used by Denver Health to transfer funds to the State. In addition, please provide a detailed explanation of the flow of these funds.
  - Rose Community Foundation – The State fiscal year **2000** budget reflected in Attachment C references **two** types of donations the State proposes to receive from the Rose Community Foundation: a “financial contribution” in the amount of **\$218,000** and an “in-kind contribution” in the amount of **\$66,000**. However, the State’s independent Rose Community Foundation donation inquiry, currently under HCFA review, only describes a proposed “financial contribution” in the amount of **\$327,000** over an 18-month period. There is no discussion in the independent inquiry of in-kind services donated by the Rose Community Foundation. Therefore, please provide further detail on the proposed in-kind contribution from the Rose Community Foundation.
  - Robert Wood Johnson Foundation – Please provide details of the process followed to obtain the grant from the Robert Woods Johnson Foundation (RWJF). Specifically, did the State of Colorado apply to and receive approval from the RWJF for the **\$25,293**. Healthy Kids Grant? If not, please specify the applicant/grantee of the RWJF Healthy Kids Grant and describe the nature of the State’s relationship with the entity.

Sources of State Funds

State funds for the Colorado Children's Basic Health Plan in FFY 1999 and FFY 2000 are derived from several sources:

1. **State General Fund:** Fund in which general tax revenues, such as state sales and income taxes, are deposited.
2. **Intergovernmental Transfer from Denver Health:** The funding source used by Denver Health for the FY 98-99 transfer of funds to the State was a portion of the Federal Fiscal Year 1997-98 Disproportionate Share Hospital payment for Bad Debt. This was an intergovernmental transfer. No private funds were involved. Denver Health is a political subdivision of the State of Colorado, and is considered by Medicaid and HCFA to be a public hospital. Denver Health received the \$12,736,853 FY 97-98 Bad Debt funds from Medicaid on December 28, 1998. Subsequently, also on December 28, 1998, Denver Health transferred \$1,541,795 directly to the Title XXI Child Basic Health Program.
3. **Intergovernmental Transfer from University Hospital:** The funding source used by University Hospital for the FY 98-99 transfer of funds to the State was a portion of the Federal Fiscal Year 1997-98 Disproportionate Share Hospital (DSH) payment for Bad Debt. This was an intergovernmental transfer. No private funds were involved. University Hospital is a political subdivision of the State of Colorado, and is considered by Medicaid and HCFA to be a public hospital. University Hospital received the \$3,785,256 FY 97-98 DSH funds from Medicaid on December 28, 1998. Subsequently, also on December 28, 1998, University Hospital transferred \$458,205 directly to the Title XXI Child Basic Health Program. Additional Intergovernmental Transfers from University Hospital are expected in FFY 1999 and FFY 2000, each in an amount of \$650,000. No private funds are involved.
4. **Intergovernmental Transfer from Secretary of State:** Through the state appropriations process, the General Assembly elected to transfer funds from the Secretary of State to the CBHP Trust Fund. No private funds were involved. The Secretary of State is a political subdivision of the State of Colorado.
5. **RWJ Grants:** The RWJ State Initiatives Grant was awarded to the Department of Health Care Policy and Financing in April 1997. The initial amount of the grant was \$369,827 and included many functions, not the CHIP program at that time. Over time, with RWJ approval, a portion of this grant was used to support staff and consultants within the HCPCF. The grant was extended until October 2000. No additional funds were made available. The RWJ Healthy Kids Planning Grant was awarded to DHCPF in December 1997. An extension was granted through January 2000. No additional funds were made available. The grant is used to support staff and consultants within the DHCPF primarily for CHP+ outreach and evaluation efforts.

6. Financial Contribution from the Rose Community Foundation: Total contribution of \$327,000. The total amount is expected to be received by the state in FFY 1999, and will be expended for SED site development, as required by conditions of the donation and the Contractor's bid and contract with the State. RCF's in-kind contributions of \$66,000 are for fiscal management consultation and organizational development assistance to the Department's contractor.

**ADDENDUM:**

We have been asked by Cindy Shirk to provide HCFA with a plan for changing the ER premium for enrollees under 100 percent of poverty from \$5 to \$3. We would like to again take the opportunity to voice our disapproval of this policy. A major goal of this program is to encourage families to have a medical home and to seek regular care from a primary care physician. Colorado providers would always provide emergency care in an emergency room regardless of ability to pay. The copayment policy creates a disincentive for families to seek care through a primary care physician. However, we agree to comply with HCFA's ruling.

Because of the nature of our program, there will be several steps to implementing the change:

1. Consultation with our actuary to determine the impact on the health care rate;
2. Notification of and review/approval by the Joint Budget Committee of the legislature which provides budgetary authority to the Colorado CHP+ program if there is a rate impact;
3. Notification of any rate/benefit change to the six participating HMOs, the FFS network administrator, the FFS medical and mental health claims payors and appropriate contract amendment.
4. Notification to providers and recipients through addenda to brochures, provider and client newsletters, hospital notices, etc.

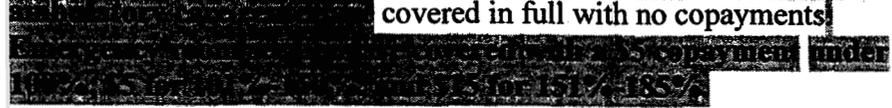
We expect this process to take four months from written notice by HCFA.

**BENEFITS**

- 6.2.1.  Inpatient services (Section 2110(a)(1))

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

- 6.2.2.  Outpatient services (Section 2110(a)(2))

Outpatient services  covered in full with no copayments. 

- 6.2.3.  Physician services (Section 2110(a)(3))

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

- 6.2.4.  Surgical services (Section 2110(a)(4))

Covered in full 

- 6.2.5.  Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))



- 6.2.6.  Prescription drugs (Section 2110(a)(6))

Covered for outpatient prescription drugs with , \$1 copayment  and 150% FPL and \$3 generic prescription copayment for above 150% FPL and \$5 copayment for brand name prescription above 150% FPL.

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

- 6.2.8.  Laboratory and radiological services (Section 2110(a)(8))

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

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

Prenatal maternity care covered in **full** with no copayment.

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

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

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

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

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

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

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

- 6.2.14.  Home and community-based health care services (See instructions) (Section 2110(a)(14))
- Home health care covered in full with no copayments.
- 6.2.15.  Nursing care services (See instructions) (Section 2110(a)(15))
- 6.2.16.  Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)).
- 6.2.17.  Dental services (Section 2110(a)(17))
- Coverage in connection with treatment of the teeth or periodontium is excluded unless such treatment is performed by a physician or legally licensed dentist, is begun within 72 hours after an accidental injury to sound natural teeth. Also not excluded (state mandate) is orthodontic and prosthodontic treatment for cleft lip or cleft palate for newborns.
- 6.2.18.  Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19.  Outpatient substance abuse treatment services (Section 2110(a)(19))
- Limited Coverage. 20-visit limit. Inpatient is not covered.  
~~\$0 under 100%, \$2 for 101%-150%, \$4 for 151%-185%.~~
- 6.2.20.  Case management services (Section 2110(a)(20))
- Covered when medically necessary with no copayment.
- 6.2.21.  Care coordination services (Section 2110(a)(21))
- 6.2.22.  Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 30 visits per diagnosis covered per year. ~~\$0 copayment for ind. 100%~~ and \$2 copayment for ~~enrollees~~ between 101% and 150% FPL and \$5 copayment for above 150% FPL.
- 6.2.23.  Hospice care (Section 2110(a)(23))
- Covered in full with no co-payment.
- 6.2.24.  Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))

- 6.2.25.  **Premiums for private health care insurance coverage (Section 2110(a)(25))**
- 6.2.26.  **Medical transportation (Section 2110(a)(26))**  
Hospital and emergency room transport covered.
- 6.2.27.  **Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))**
- 6.2.28.  **Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))**

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

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

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

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

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

**Autism coverage** will be included with \$2 co-payment for 50% FPL and \$5 copayment for above 150% FPL.

**Skilled nursing facility** covered in full with no co-payments. Care must follow a hospital confinement and the skilled nursing facility confinement must be the result of an injury or

sickness that was the cause of the hospital confinement. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.