Contract No.: HHS-100-01-0002
MPR Reference No.: 8782-071

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CONGRESSIONALLY MANDATED EVALUATION OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Site Visit Report: The State of Colorado's Child Health Plan Plus (CHP+)

March 28, 2002

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I. PROGRAM OVERVIEW

Colorado's Title XXI program, known as Child Health Plan Plus (CHP+), is a separate child health program that covers children through age 18 with family incomes up to 185 percent of the Federal Poverty Level (FPL). Colorado's Title XXI plan was the second state plan submitted to the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services, CMS) and the first separate child health program approved by the agency. (The South Carolina and Alabama plans were approved on or about the same date, but both of these states chose to use Title XXI funds to expand their Medicaid programs.)

Colorado was able to submit its Title XXI plan within just two months of the passage of the federal legislation that established the State Children's Health Insurance Program (SCHIP) because its proposed program built upon an existing state-funded managed care program for low-income children called the Colorado Child Health Plan (CCHP). The state had planned to expand the state-funded program using savings realized from enrolling Medicaid recipients in managed care, but rapidly shifted gears when the SCHIP legislation was signed into law in order to obtain federal matching funds. In the legislation authorizing the program expansion, the Colorado General Assembly called for the program to be structured as a public-private partnership under the administration of the Colorado Department of Health Care Policy and Financing (HCPF), the agency responsible for the state's Medicaid program. The legislation also required that several key functions, including eligibility determination and outreach, be contracted out to a private entity.

Colorado implemented CHP+ in April 1998, covering children through age 18 with family incomes up to 185 percent of the FPL (Table I.1). From the start, services were provided to most

TABLE I.1

SCHIP STATE PLAN AND AMENDMENTS

Document	Dates			Description
	Submitted	Approved	Effective	
Original Submission	10/14/97	2/18/98	4/22/98	Submitted a Title XXI state plan to expand the Colorado Child Health Plan (CCHP), a state-funded program providing basic medical services to low-income children. The CCHP benefit package was expanded to bring it into compliance with Title XXI. The original state plan expanded services to cover children through age 17 who were below 185% of the FPL.
Amendment 1	1/19/99	9/21/99	4/22/98	Expanded plan to include children through age 18 at or below 185% of the FPL.
Amendment 2	12/20/00	3/28/01	10/1/00	Eliminated monthly premiums and implemented an annual enrollment fee for families between 151 and 185% of the FPL.
Amendment 3	12/27/00	3/28/01	10/1/00	Made changes to the application and enrollment process and to the service delivery system.

SOURCE: Centers for Medicare and Medicaid Services (CMS), *Colorado Title XXI Program Fact Sheet.* CMS web site http://www.hcfa.gov/init/chpfsco.htm

NOTES: SCHIP=State Children's Health Insurance Program. FPL=federal poverty level.

children through HMOs and, where HMOs were not available, through the statewide provider network established for the earlier state program. Families with incomes above 100 percent of the FPL were charged monthly premiums ranging from $9 to $30 depending on family income and the number of children in the family. On January 19, 1999, the state submitted an amendment to clarify that the age cut-off for the program was 18 years, not 17 years as indicated in the original state plan (Table I.2). In summer 2000, controversy erupted over the CHP+ premium structure, and in October the state declared a "premium holiday" and then substituted a annual enrollment fee for the monthly premiums. (The amendment to the state plan eliminating the premium structure was approved by CMS the following March.) The state's third state plan amendment, submitted one week after the second, sought CMS approval of changes in the enrollment process and delivery system that were implemented when the premiums structure was eliminated.

As of July 2001, 33,567 children were enrolled in CHP+**.** Although Colorado was among the first states to implement its Title XXI program and among the few with an existing state-funded program to build upon, enrollment growth during the first two years of CHP+ was modest, as the members of the public-private partnership struggled to define their roles and launch the new program. Then, in the summer and fall of 2000, CHP+ was hit by wave upon wave of negative publicity, as the press seized upon reports that the many families who were in arrears on their CHP+ premium payments would be turned over to collection agencies, that the state had enrolled too few children to spend its 1998 Title XXI allotment and was about to "lose" half of those federal funds, and that the state owed the federal government a refund because administrative costs for CHP+ had exceeded the cap for federal financial participation. The furor over premium collections spurred the state legislature, with prodding from the governor, to

TABLE I.2

MEDICAID AND SCHIP INCOME ELIGIBILITY STANDARDS, EXPRESSED AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL (FPL)

	Age (in Years)			
	Up to 1	1-5	6-18[a]	18[b]
Medicaid standards in effect August 1997	133%	133%	100%	37%
SCHIP separate child health program (Children's Basic Health Plan – marketed as Child Health Plan Plus)	185%	185%	185%	185%

SOURCES: Centers for Medicare and Medicaid Services (CMS), "Eligibility Standards in the 50 States and District of Columbia," January 2001.

NOTES: SCHIP=State Children's Health Insurance Program (Title XXI).

[a]Children born after September 30, 1983, who are more than 5 years of age. The eldest children in this group are now age 18. In February 1998, when CHP+ was implemented, the age range covered under Title XIX Medicaid up to 100 percent of the FPL was 6-14 years.

[b]Children born on or before September 30, 1983, who are less than 19 years of age. The youngest children in this group are now age 18. In February 1998 when CHP+ was implemented, the age range covered under Title XIX Medicaid up to 10 percent of the FPL was 14-18.

substitute an annual enrollment fee for monthly premiums in CHP+, a change widely viewed as a highly positive step. Members of the public-private partnership believe CHP+ is now poised to deliver on its promise, as the partners are working together more effectively, enrollment has picked up, and the benefit package is about to expand to include dental care.

This case study is based primarily on a visit to Colorado conducted July 23-27, as part of the Congressionally-Mandated Evaluation of the State Children's Health Insurance Program. The visit included interviews with state agency staff, legislators, staff of the contractor that manages key CHP+ functions, front-line eligibility workers, health care providers, child health advocates, and staff of organizations involved in outreach and application assistance. (See Appendix A for a list of informants.) Our time on site was divided between Denver (the state's capital and largest city) and the small city of Alamosa in the San Luis Valley in south-central Colorado. In June 2001, Denver County accounted for 18 percent of CHP+ enrollees (and the Denver metropolitan area for 56 percent). The six-county San Luis Valley accounted for about 5 percent of enrollees. Nearly half the valley's population is Hispanic, and the poverty rate is two or three times that of the state. The area is largely rural and attracts a sizeable number of migrant workers.

II. BACKGROUND AND HISTORY OF SCHIP POLICY

CHP+ grew out of a state-funded program that was established by the Colorado General Assembly in 1990 to provide limited health benefits to low-income children in rural areas where there were few community health centers. The Colorado Child Health Plan (CCHP) was explicitly structured as a non-entitlement program, reflecting the legislature's strong anti-Medicaid sentiment. The program provided coverage for outpatient services up to an annual maximum of $10,000 per child to children through age eight with family incomes up to 185 percent of the FPL. Enrollees were expected to obtain inpatient services through the Colorado Indigent Care Program (CICP), which partially reimburses providers for uncompensated care. The legislature placed CCHP under the administration of the University of Colorado Health Sciences Center and directed that the program be financed with "gifts, grants, and donations" (Fender et al. 1999). (State funding for CCHP, funneled through the university, amounted to only $153,000 in its first year of operation.) Implemented in six rural counties in 1992, the program was later expanded to cover children through age 13 in 22 mostly rural counties. In 1996, the legislature made the first $1 million General Fund appropriation for the program.

The metamorphosis of CCHP began in 1997 with the passage of House Bill 97-1304, introduced by then-Representative (now Senator) Dave Owen. This legislation established the Children's Basic Health Plan, a state-funded basic benefit program for children through age 17 with family incomes up to 185 percent of the FPL. The legislature directed that premiums be charged and services be delivered through HMOs where available. At the same time, the legislature authorized the addition of an inpatient care benefit to the CCHP package and the expansion of the program to all 63 counties in the state. The intent was for the state to develop the HMO delivery system and premium structure and then roll CCHP enrollees into the new

program (CBHP), funding the program in large part through savings realized by enrolling Medicaid recipients in managed care. Expansion of CCHP began in May 1997. The following August, the U.S. Congress passed the federal SCHIP legislation, and the state scrapped its original financing strategy, opting instead (under H.B. 98-1325) to modify the Children's Basic Health Plan to conform to SCHIP requirements in order to obtain the Title XXI federal match.[1]

The choice of a separate program model for SCHIP was virtually a foregone conclusion in Colorado because the state had a long history of providing coverage to low-income children through the state-initiated program and was already on track to expand that program statewide. Moreover, opposition to expanding the Medicaid entitlement was strong. In 1996, the legislature, struggling with spiraling Medicaid costs in the context of a taxpayer bill of rights (TABOR) that capped increases in state spending at 6 percent, actually voted to withdraw from the Medicaid program. (The legislation was vetoed by Governor Romer [Fender 1999].) Although some public health advocates championed a Medicaid expansion for Title XXI, the legislature never gave serious consideration to this option. H.B. 97-1304 clearly stated that the program was not an entitlement and that the General Assembly would appropriate funds for the program each year and limit enrollment accordingly (H.B. 98-1325 reaffirmed that CBHP was to be a "non-Medicaid state subsidized insurance program.") The legislature considered creating a quasi-governmental authority to manage the program but reportedly chose not to because of concerns that the TABOR 6-percent cap on expenditure growth might apply, thereby squelching enrollment growth.

Legislators strongly favored privatization of the program, as well as "a strong managed care direction" to health care delivery (H.B. 98-1325). The initial authorizing legislation (H.B. 97-

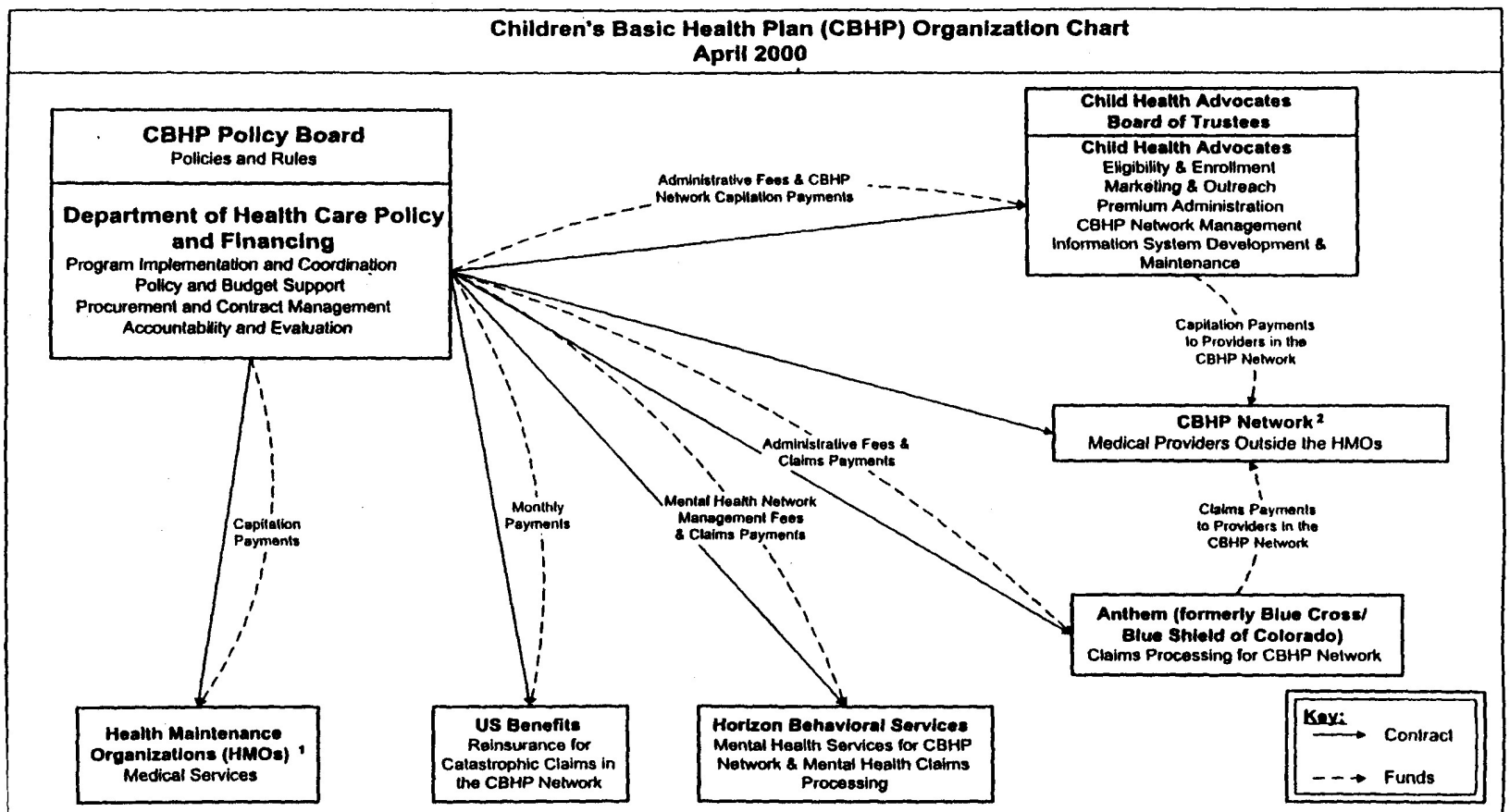
[1]Given this history, the state refers to its Title XXI program as "the Children's Basic Health Plan, marketed as Child Health Plan Plus (CHP+)." To streamline our presentation, we will generally refer to the program as "CHP+" throughout this report.

1304) directed HCPF to contract with an independent entity for several key administrative functions, including outreach, marketing, eligibility determination and enrollment, and with HMOs for health care delivery. The follow-up bill (H.B. 98-1325) established a Children's Basic Health Plan Policy Board to oversee the program and provide a public forum for discussion of major policy issues. In addition to four state agency heads, the board was mandated to include representatives of small business, the health care industry, an essential community provider, and a consumer. The legislation included a sunset provision, and the board was thus disbanded in August 2001. Responsibility for CHP+ policy-setting has now shifted to the Medical Services Board, which oversees the Medicaid program.

According to HCFP staff, the legislature wanted the state's SCHIP program to serve as a "bridge" to commercial coverage for enrollees, by allowing them to experience the kind of health care coverage offered by most employers. This intent is reflected in the benefit package, which is less generous than the Medicaid package, and in the mandated cost-sharing requirements. The legislation required both premiums and copayments but left the amounts to be determined by HCPF and the policy board.

When HCPF released the request for proposals for administrative support, only one potential contractor, an organization subsequently incorporated as Child Health Advocates (CHA), stepped forward. Incorporated in December 1998 and now led by one of the two individuals who administered the state-funded children's coverage program at the University of Colorado Health Sciences Center, CHA was established by a community group formed by the Rose Community foundation. The CHP+ contract was awarded to CHA in March 1999. Under the contract, CHA performs several key functions, including eligibility and enrollment, customer service, marketing and outreach, collection of fees, resource development, management of the

FIGURE II.1



Source: Office of the State Auditor analysis of agency data.

Notes:

1. The HMOs for the Children's Basic Health Plan are Colorado Access, Community Health Plan of the Rockies, Denver Health Medical Plan, Kaiser Foundation Health Plan of Colorado, Rocky Mountain HMO, and United HealthCare of Colorado. As of April 30, 2000, there were 16,640 children served by HMOs (68% of total enrollment).
2. The CBHP Network is composed of independent providers. Primary Care Physicians (PCPs) act as gatekeepers for referrals to specialized services and receive monthly capitation payments for furnishing primary care services. Network providers are reimbursed on a fee-for-service basis for specialized services. Children living in areas not served by HMOs receive care through the CBHP Network. As of April 30, 2000, there were 7,770 children served by the CBHP Network (32% of total enrollment).

provider network that serves children who are not in HMOs, invoicing for HMO capitation payments and information system development and maintenance (Figure II.1).

Staffing within HCPF for CHP+ is thin, with a total of nine staff members assigned to the program. In addition to designing the benefit and cost-sharing structures and other aspects of the program, HCPF is responsible for overseeing administration of the program, some aspects of which are performed by CHA. HCPF staff also manage contracts with the HMOs. CHA carries the contracts with a managed behavioral health care organization, a pharmacy network, and a third-party administrator that pays non-HMO claims. Just under 50 people at CHA are dedicated to CHP+, including 12 in eligibility determination, 7 in marketing and outreach, 7 in customer service, and 5 in information services.

To facilitate contract management, HCPF and CHA have established a "counterpart" system, whereby one or two individuals in each organization are assigned to manage each function covered by the contract (e.g., outreach and marketing). HCPF and CHA counterparts meet monthly to discuss issues and update the group on their activities. The contract managers also meet monthly, and CHA is required to provide monthly and quarterly reports documenting its performance. Under the contract, CHA must meet a variety of performance goals (for example, a requirement that complete applications be processed within 14 days of receipt) to be fully reimbursed. Payment is to be temporarily withheld for performance problems that can be corrected and permanently withheld for those that cannot.

Assessments of the unique operational structure of Colorado's Title XXI program vary. Several respondents, including HCPF and CHA staff, said that privatizing certain functions allowed the state agency to benefit from private-sector expertise in areas such as marketing. However, most respondents agreed that the relationship between HCPF and CHA has been uneasy, the now-defunct policy board was not as effective as it might have been, and lines of

authority were never clearly drawn. In an audit conducted in 2000, the state auditor concluded that "[the] administrative structure is overly cumbersome for a program with fewer than 25,000 participants."

According to one member of the policy board, neither HCPF nor CHA was prepared to take on the new responsibilities they were asked to assume with the implementation of CHP+, in that CHA's health care delivery network was inadequate to support a full-blown statewide program and neither CHA nor the state had experience with the kind of public-private partnership envisioned by the legislature. Both HCPF and CHA staff reported that there have been tensions between their two organizations, but both groups characterized their current relationship as "better" and expressed the belief that relations would continue to improve as each group adjusted to the other's organizational style. As one CHA manager put it, "the state taught us how to be accountable…and I hope we've taught them how to be less bureaucratic."

The role the policy board was supposed to play in operating CHP+ was unclear and, not surprisingly, reactions to its abolition were mixed. Respondents generally agreed that a lack of understanding of policy and programmatic issues on the part of some board members had hampered the board's effectiveness. (A near-complete turnover of the membership after the first two years contributed to this problem.) The state auditor critiqued the board for being slow to set program rules and develop a strategic plan for CHP+. But several advocates said the board had played an important role by providing a forum for public input into CHP+ policy and expressed concern that the Medical Services Board would not be able to devote as much time and attention to CHP+ because it is also responsible for Medicaid. State staff and several providers, however, saw the move as a positive step and said they believed it would help improve coordination between Medicaid and CHP+. One observer commented that placing CHP+ under the Medical

Services Board, with whom HCPF has a longstanding relationship, should give the agency more control over the program.

Vague lines of authority have complicated administration of CHP+. For example, it is unclear whether CHA is ultimately answerable to HCPF, the policy board (now the Medical Services Board) or its own board of directors. Policy board members appear to have felt hamstrung at times by the dictates of the legislature. For example, the board reportedly felt powerless to address the problem of unpaid premiums on its own or to prod the legislature to do so. CHA staff had difficulty adjusting to HCPF's approach to contract management, even though the agency's oversight appears to have been fairly lax for the first two years of the program. In the 2000 report, for example, the state auditor found that HCPF had failed to fully enforce contract provisions. Since then, however, CHA's performance and HCPF's vigilance have reportedly improved. (As of July 2001, CHA had been docked $48,000, or a little less than 1 percent of its total expected reimbursement of $5.5 million, for failure to meet contract terms.)

III. OUTREACH

A. INTRODUCTION

As required by the state legislature, HCPF has contracted out marketing and outreach functions to a private entity, Child Health Advocates (CHA). CHA is responsible for developing a detailed marketing plan, which is reviewed and approved by the state. To align marketing efforts with enrollment and eligibility trends, CHA has implemented an integrated system that links its marketing and enrollment databases. The system allows CHA to capture demographic information about families who request applications and to identify the source of submitted applications.

CHA's marketing director described the marketing strategy as having three key components: paid advertising, community-based outreach, and employer outreach. CHA collaborates with the Colorado Covering Kids initiative and participating HMOs on outreach, conducts statewide media campaigns, provides outreach materials and applications to community-based organizations, and conducts direct outreach to employers and health insurance brokers.

State administrators reported that the 10 percent limit on federal financial participation for Title XXI administrative costs hindered efforts to design and conduct an extensive outreach campaign, particularly in the first year of the program. This financial constraint is a major reason the state emphasizes community partnerships over statewide media campaigns. To supplement state and federal funding for marketing and outreach, CHA and the state are working together to raise funds from the private sector, as mandated by the state legislature.

B. STATEWIDE MEDIA EFFORTS

CHA's statewide marketing strategy includes mass media campaigns, conducted in collaboration with various partners, and broad distribution of CHP+ applications and

promotional items. These strategies were designed and implemented by CHA with input from HCPF staff. Key components of state-level outreach include:

- ***Mass Media.*** CHA has used paid television, radio, and print advertising to promote CHP+ and hired a public relations consultant to pursue free media coverage. CHA administrators estimated that last year's budget included $300,000 for the paid media campaign (including funds to purchase airtime) and $100,000 for promotional events. In 2000 and 2001, CHA tailored the national Covering Kids television commercial to include information about CHP+ and hired a media consultant to purchase time slots during programs likely to be viewed by CHP+-eligible families.

- ***Distribution of Promotional Materials.*** Any interested individual or organization can order CHP+ materials. Updates are distributed through SED sites, grantees and other community partners, such as schools and health clinics, on a regular basis. (As discussed in the next section, SED sites are community health centers and other community-based organizations that have been trained by CHA to help families complete the CHP+ application.) All materials are available in English and Spanish, and CHA is developing outreach brochures in five other languages.

- ***Collaboration with HMOs.*** HMOs and CHA jointly purchased airtime during the 2001 media campaign. In addition to sponsoring media coverage, HMOs have distributed CHP+ promotional materials at community events such as health fairs. (All materials must be approved by HCPF for content and message.) Colorado Access, an HMO operated by a coalition that includes a large network of community health centers, has been most active in advertising CHP+. In its television and print ads, Colorado Access includes its own logo, as well as the logo of local health centers to promote the community providers.

- ***Hotline.*** The Department of Public Health and Environment operates a toll-free hotline (the "Family Help Line") to provide information about CHP+, Medicaid and the indigent care program. The hotline number is listed on the joint application for the three programs. If families require additional assistance completing the application or need more information about CHP+, they are referred by hotline staff to the closest satellite eligibility determination (SED) site or the CHA call center.

CHA has targeted special outreach efforts to particular groups. For example, CHA worked with the Latin American Research and Service Organization (LARASA), a Denver community-based organization, to develop a Spanish-language commercial, which was then aired on Univision, the Spanish television network. CHA has identified the need to use different marketing strategies for recently immigrated Latino families versus second- and third-generation

families and is collaborating with LARASA and other community agencies to develop culturally appropriate messages for these populations.

CHA has also promoted CHP+ to employers, focusing on those that do not offer or contribute to dependent coverage in order to avoid concerns about crowd-out. Insurance brokers have proved surprisingly strong allies in this effort. CHA administrators had expected brokers to be uninterested in making information about CHP+ available to employers when they meet to discuss commercial packages. Instead, they found that many brokers view promoting CHP+ as a community service and the coverage as an added value they can offer employers. CHA staff stated that employers are interested in CHP+ because they believe that it will reduce absenteeism and help them retain their workforce in a tight labor market. To encourage brokers to continue promoting CHP+, CHA worked with the Department of Insurance to develop a course on CHP+ eligibility requirements for which brokers can earn continuing education credits.

How CHA presents CHP+ depends both on the intended audience and the partner(s) with whom CHA is collaborating on a given campaign. In some circumstances, CHA markets CHP+ in such a way as to underscore the program's resemblance to commercial insurance, in order to distinguish it from Medicaid. For example, in the pamphlets designed for businesses to distribute to their employees, CHP+ is presented as an insurance program rather than a government program. As one HCPF staff member put it, the message is, " 'this is a program with cost sharing, not an entitlement program.' " In collaborative campaigns with Covering Kids, however, families are encouraged to "get coverage through CHP+/Medicaid," in keeping with the Covering Kids objective of promoting both programs. The "Hard Choices" campaign developed by the national Covering Kids office conveyed the message that families have hard choices to make between filling the refrigerator and buying insurance for their children, and that CHP+ provides an easy way not to have to choose between the two. The ads presented CHP+ as

"free/low-cost health insurance for kids" and made the point that "even if you work full-time, your children may still qualify."

Most observers believe that CHP+ is perceived as distinct from Medicaid but some fear that the joint application creates an association with Medicaid that is damaging to CHP+. One application assistor in the San Luis Valley commented that people see the two programs as one and the same because of the Medicaid questions on the application and added that there is a stigma attached to Medicaid because of the experiences families have had with county departments of social services. One HMO purposely markets its CHP+ and Medicaid coverage separately, and staff said that CHP+ is not marketed as a government program because of the "welfare" stigma attached to programs such as Medicaid. Some county social services staff believe that perceptions of Medicaid have improved because of the involvement of private-sector HMOs in service delivery and because the new joint application presents Medicaid, CHP+ and the indigent care program as "an insurance package," but another DSS worker said that the families she comes into contact with "still associate Medicaid with needing welfare."

As noted, the Covering Kids initiative is an important outreach partner. Although the state grantee, the Department of Public Health and Environment, has focused less on outreach than on simplifying enrollment and renewal procedures, the state project helped develop an outreach "best practices" manual highlighting effective outreach activities, funded such non-traditional partners as the Food Bank of the Rockies and Colorado State University to distribute promotional materials from the National Covering Kids campaign to the families they serve and, as discussed in the next section, provided outreach training to grantees.

The involvement of multiple organizations in promotional efforts has reportedly caused some confusion among families, especially since materials developed by HMOs, Covering Kids and community-based organizations may bear their own names and telephone numbers. For

example, Covering Kids promotional materials publicize the National Covering Kids telephone hotline number instead of the Family Help Line number. For this reason, CHA and the state have been cautious about using promotional materials other than their own to promote the program. Similarly, the enrollment cards issued by at least some participating HMOs initially bore only the plan names. Now, the cards identify the program as "CHP+, offered through" whatever HMO issued the card.

C. COMMUNITY-BASED EFFORTS

Community-based outreach is a critical component of the CHP+ marketing plan. CHA has enlisted a wide array of "community partners," including Head Start programs, schools, community health centers, United Way agencies, public health departments, county departments of social services, and WIC clinics, to promote CHP+ to their clients. CHA provides partners with promotional materials, such as brochures and posters, and conducts outreach training. Training sessions include specifics about the benefits offered through CHP+, procedures for completing an application, as well as information on eligibility and providers. A small subset of community partners (about 80 sites) are certified as Satellite Eligibility Determination sites. Located in 25 counties throughout the state, SED sites include community health centers, county nursing services, school-based health centers, and other health care providers. In addition to conducting outreach and "inreach" for CHP+, SED sites offer individual application and enrollment assistance to families.

Many of the community-based outreach efforts are funded through mini-grants awarded by CHA and the statewide Covering Kids initiative. Twenty-two community organizations, including Catholic Charities of Denver and Valley Wide Health Services, received mini-grants ranging from $2,000 to $50,000 in 2001. Activities conducted by grantees include distribution of applications at schools and community events; a door-to-door campaign using bi-lingual staff

to promote CHP+ to the Latino immigrant population; provider education seminars on CHP+ eligibility rules; enrollment nights; and outreach to employers. For example, one group received a mini-grant to raise awareness of CHP+ among pediatric providers in four counties in the Denver metro area.

The Covering Kids initiative sponsors three community-based interventions. The pilot projects in Prowers and Adams Counties have focused on building coalitions within their communities to promote children's coverage. The Denver pilot project, housed at Denver Health, has focused primarily on outreach through the Denver Public Schools. The Denver pilot project collaborates with the Free/Reduced-Price School Lunch Program to send CHP+ flyers home with each child at the beginning of the school year. Denver Covering Kids staff then follow up with families who return the flyer indicating that they are interested in receiving more information about CHP+. Between August 2000 and April 2001, Covering Kids staff attempted to contact more than 4,000 families who requested additional information. The Denver project also educated school nurses and staff of school-based health centers about CHP+ and how to refer families to Covering Kids.

Other community organizations have received funding from private foundations to promote CHP+. Denver Health Medical Center's Community Voices program used funding from the Kellogg Foundation and The Colorado Trust to contact employers who do not offer dependent coverage and to participate in community events to increase awareness of CHP+.

D. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

Despite these statewide and community-based outreach efforts, advocates and application assistors contend there are still large numbers of eligible families who are not aware of CHP+. CHA and state staff acknowledged that the reach of the outreach campaign has not had as broad a reach as could be desired, but said that the 10 percent limit on federal financial participation for

SCHIP program administration has restricted funds available for outreach. In addition, the campaign has had to work against a wave of negative publicity about monthly premiums, as well as an ingrained resistance to government programs among many eligible families. HCPF staff believe that the agency could not promote CHP+ more effectively than CHA has, and support the legislature's decision to require private-sector involvement in outreach, because they also believe that media and marketing are much better understood by the private sector than by government.

CHA currently has only limited data with which to evaluate the effectiveness of various outreach efforts but is developing a system to determine which sites and events produce the most applications. The strategy includes using the tracking number on the applications to determine the point of distribution. Now that CHA distributes applications for CHP+ and Medicaid, where at one time it distributed only CHP+ applications, staff are in a better position to monitor the flow of applications to and from community organizations.

CHA staff stated that the most successful short-term outreach effort was the media campaign, which reached many families who had no previous knowledge of CHP+. After the first CHP+ commercial aired, the volume of calls to CHP+ customer service tripled. However, respondents generally agreed that the most effective long-term outreach effort has been activities coordinated by community agencies, particularly those that involve one-on-one contact between parents and staff of trusted organizations. Support from community agencies reportedly waned while premiums were in effect but has rebounded since they were eliminated. CHA staff stated that a key objective of partnering with community agencies is to build an infrastructure that can be sustained without additional state funding, as there is some concern that Colorado, like Rhode Island, may reduce funding for outreach and marketing. State administrators added that they had learned from the private sector that there are no "magic bullets" when it comes to outreach and

that the need to present information about the program through as many venues as possible makes community-based outreach vital.

Respondents also identified ineffective outreach strategies. Activities that produced disappointing results included efforts to broadly distribute applications and promotional materials at events such as health fairs. For example, the Rio Grand and Alamosa public health departments worked with local schools to organize "back-to-school" events and offered application assistance to families during school open-house or sports nights but got little response. Based on these experiences, respondents identified several ways to improve outreach efforts. For example, the program coordinator at the Denver Covering Kids pilot project said that the pilot needs to begin focusing more on the adolescent population, and advocates recommended that the various organizations involved in outreach better coordinate their activities in order to promote CHP+ in a broader range of settings.

IV. ENROLLMENT AND RETENTION

A. POLICY DEVELOPMENT

Colorado's approach to enrollment and retention has been shaped primarily by two factors: (1) the requirement that HCPF contract out enrollment functions to a private entity, and (2) the large role of county Departments of Social Services (DSS) in Medicaid eligibility determination. Colorado is one of only a handful of states in which Medicaid eligibility determination is jointly administered by the state Medicaid agency and county agencies. Although the state is responsible for setting basic policy, county employees are responsible for eligibility determination. Moreover, each Colorado county is autonomous, leading to significant cross-county variation in Medicaid eligibility determination and enrollment processes. This variation considerably magnifies the challenges involved in coordinating Medicaid and CHP+.

In summer 2001, the Colorado General Assembly took an important step to streamline the screen-and-enroll process, by approving legislation to allow state agency employees to determine Medicaid eligibility for the first time. Starting in February 2002, three full-time equivalents (FTEs) were placed at CHA to determine Medicaid eligibility for applicants who mail their applications to CHA and who are found upon an initial screening to be potentially Medicaid-eligible. At the time of our visit, CHA had to forward all such applications to county DSS offices for Medicaid eligibility determination. County DSS staff were reportedly reluctant to share responsibility for eligibility determination—resistance that several observers attributed to fears of job loss on the part of DSS workers, but that some DSS staff said was due to concerns about accuracy—but there was no serious opposition to the legislation.

In June 1998, Colorado implemented a joint application for Medicaid and CHP+, called the "Application for Colorado Health Care" (Table IV.1). A revised version of the form, which can

also be used to apply to the indigent care program, was implemented in late 2000. Developed with the assistance of a marketing firm and with input from consumer focus groups and a committee comprising staff of state agencies, Covering Kids and other community groups, the new form is twice as long (eight pages) as the earlier version. According to HCPF and CHA staff, length was deemed less important than readability, so room was made to insert directions next to questions that had historically proved difficult for applicants and to add more space for applicants to enter information. Medicaid and CHP+ applicants are required to furnish documentation of either the current or previous month's income. (The requirement that applicants document income deductions was dropped in 2000.)

Application procedures for CHP+ were also shaped by the structures that were put in place to promote enrollment in the state-funded program that predated Title XXI. The state's network of 82 Satellite Eligibility Determination (SED) sites, established under the Colorado Child Health Plan, assists families in applying for CHP+. The network was established because program administrators believed that families who need help completing the application would be more comfortable seeking assistance from people and organizations they know and trust. Sites have been selected based on their accessibility to eligible families and on the degree to which the CHP+ application process can be integrated into existing procedures at the site (Child Health Advocates 2001). About one-quarter of the sites have received additional training so that they are able to submit applications electronically. (To be certified to do electronic submissions, sites must maintain a 90 percent accuracy rate for three months.)

TABLE IV.1

APPLICATION AND REDETERMINATION FORMS,
REQUIREMENTS AND PROCEDURES

Characteristic	SCHIP	Medicaid[a]
APPLICATION		
Form		
Joint form	Yes[b]	Yes
Length	8 pages	8 pages
Languages	2 (English and Spanish)	2 (English and Spanish)
Verification Requirements		
Age	No	No
Income	Yes[c]	Yes
Deductions	No	Yes
Assets	No	Yes
State residency	No	No
Immigration status	No	Yes[d]
SSN	No	Yes
Enrollment Procedures		
Mail-in application	Yes	Yes
Phone application	No[e]	No
Internet application	No[f]	No
Hotline	Yes	Yes
Outstationing	Yes	Yes
Facilitated enrollment	Yes[g]	Yes
REDETERMINATION		
Same form as application	Yes	No
Pre-printed form	No	No
Mail-in redetermination	Yes	Yes
Income verification required	Yes	Yes
Other verification required	No	Yes

SOURCE: Donna Cohen Ross and Laura Cox, *Making it Simple: CHIP Income Eligibility Guidelines and Enrollment procedures: Findings from a 50-State Survey,* Kaiser Commission on Medicaid and the Uninsured, October 2000; *Annual Report of State Children's Health Insurance Plans Under Title XXI of the Social Security Act: Colorado* November 2000.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI).

TABLE IV.1 (*continued*)

[a]Children's programs.
[b]Form is also used by the Medicaid and Colorado Indigent Care Program (CICP).
[c]Verification of earned income only.
[d]Required only of qualified aliens.
[e]CHA is in the process of testing a phone application.
[f]Some SED sites can submit applications to CHA via the internet, but individuals cannot.
[g]CHP+ has 22 satellite eligibility sites (SEDs) that can file applications electronically. Applications manually processed by non-electronic SED sites are entered at CHA. All other applications are processed by CHA.

The state is in the process of developing an integrated program data system, the Colorado Benefits Management System (CBMS), to house application, eligibility, and benefits data for Medicaid, CHP+, the Colorado Indigent Care Program, TANF, Food Stamps and several other assistance programs. The new system will include an integrated rules engine to determine eligibility for multiple programs. The system has been under development since 1997, and the state expects to begin phasing in components this year. HCPF and advocates hope the legislature will modify state law so that any authorized CBMS user, not just county DSS staff, may perform Medicaid eligibility determinations, as the system itself will make the determination.

B. ENROLLMENT PROCESSES

Coordination between Colorado's CHP+ and Medicaid programs is complicated by differences in their eligibility policies, most notably the asset test that is required in Medicaid but not in CHP+ (Table IV.2). The Medicaid program has asset limits of $1,500 for vehicles and $1,000 for liquid assets. Although CHP+ initially limited vehicle net asset value to $4,500, the asset test was eliminated in December 1999. Neither program permits presumptive eligibility for children. As mandated by the state legislature, CHP+ guarantees children 12 months of continuous eligibility from the date of application. The Medicaid program ordinarily redetermines eligibility on an annual basis, but does not guarantee 12 months coverage and requires families to report changes in their circumstances that may affect their eligibility. Both programs calculate eligibility income by offsetting gross income with specific income disallows. Although the first formal CHP+ eligibility rule, implemented December 1999, required that CHP+ eligibility be determined using gross income with no offsets, the General Assembly subsequently brought the rule in line with policies for the Colorado Indigent Care Program, allowing deductions for childcare, alimony, child support, health insurance, and medical expenses (effective October 1, 2000).

TABLE IV.2

SCHIP AND MEDICAID ELIGIBILITY POLICIES

Policy	SCHIP	Medicaid
Retroactive eligibility	Yes[a]	Yes, up to 3 months prior to the date of the application
Presumptive eligibility	No	No
Continuous eligibility	Yes-12 months	No
Asset test	No	Yes

SOURCE: Centers for Medicare and Medicaid Services (CMS), *Annual Report of State Children's Health Insurance Plans Under Title XXI of the Social Security Act: Colorado,* November 2000.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI).

[a]Eligibility is retroactive to the date of the application.

As noted, the indigent care program was a critical component of coverage for low-income children when the state's outpatient-only program was in place, and it remains an important safety net for CHP+-eligible children by providing retroactive coverage that CHP+ does not. (If children apply to both programs, costs incurred before they applied are covered by the indigent care program if they are found eligible for that program, regardless of whether they are found eligible for CHP+.) The indigent care program is not an insurance program, but instead provides partial reimbursement to participating hospitals and clinics who offer care to eligible underinsured and uninsured residents. Eligibility is restricted to families with incomes below 185 percent of the FPL. Copayments are based on income, as they are in CHP+, but are set at higher levels. Similarly, total health care expenditures for covered services are capped at 10 percent of family income, versus 5 percent for CHP+.

There are three ways that applicants can enter the CHP+ eligibility determination system: (1) mailing an application to CHA directly or through any community partner, (2) applying at a SED site, (3) applying at a county DSS office (Figure II.1). In state fiscal year 2001, 54 percent of the applications received by CHA were mailed by applicants, 31 percent were submitted through SED sites, and 16 percent came from DSS offices. Each process is described below.

- ***Mail-in process***. If a family or any partner mails an Application for Colorado Health Care to CHA, CHA staff use an electronic rules engine to screen for Medicaid eligibility. Up until February 2002, if the applicant appeared to be eligible for Medicaid, CHA sent the application with an explanatory cover letter to the county DSS office to determine Medicaid eligibility. (As noted, this process changed when three FTEs were placed at CHA to determine Medicaid eligibility.) If the applicant does not appear to be eligible for Medicaid, CHA staff determine eligibility for CHP+. Applicants who are obligated to pay an enrollment fee are billed after they are approved. Applicants in counties with a choice of HMO who did not select an HMO and primary care provider on their application are randomly assigned to one, but must approve the selection to be enrolled. (Until April 2001, families who failed to select an HMO on their application were denied coverage.)
- ***SED process***. If a family asks for help at a SED site, staff at more active sites will generally make an appointment with the family and ask parent to bring with them the

documentation needed to complete the application. Most sites accept "walk-ins," as well. The application submission process used by a SED site depends to some extent on the site's electronic capabilities. All sites can access the CHP+ eligibility database and rules engine through the Internet to check eligibility status and screen for Medicaid eligibility. As noted, 22 sites have been certified by CHA to take the further step of submitting CHP+ applications electronically. When an applicant completes the Application for Colorado Health Care at a SED site, staff first screen for Medicaid eligibility either manually or electronically. If the applicant is potentially eligible for Medicaid, staff send the application to the county DSS office. If the applicant does not appear to be eligible for Medicaid, staff send the application to CHA to determine eligibility for CHP+. SED sites were originally reimbursed $12.55 for each application submitted in hard copy and $15 for each submitted electronically. (SED sites that submit applications electronically must also submit the hard-copy forms to CHA for verification of documentation and original signature.) These payments nearly doubled in late 2001.

- ***DSS process***. At DSS offices, applicants complete either the Application for Colorado Health Care or, more commonly, a joint TANF/Medicaid/Food Stamp application. If the applicant is not Medicaid eligible, DSS can send either form to CHA to determine eligibility for CHP+. Until recently, DSS simply sent letters to applicants explaining why coverage was denied and referring them to the Family Health Line for information about CHP+, instead of actually forwarding the application to CHA. Several respondents reported that some DSS staff still do not forward applications.

C. REDETERMINATION PROCESSES

The renewal form for CHP+ is the same as the application form. CHP+ enrollees are required to complete the entire form again and to submit the same income documentation at renewal as at initial application. To improve retention, the state made several modifications to the renewal process in the summer and fall of 2000. Now, enrollees are mailed a post card shortly before they receive their renewal packet to let them know that it is coming and a second postcard 30 days before their termination date if they have not yet responded. SED sites are not typically involved in helping families complete the redetermination forms. The redetermination packet does not include the list of SED sites that is included in the initial application packet, but families are given the CHP+ customer service number in case they need help completing the form.

CHA processes the redetermination forms in the same way it does initial applications. Currently, forms are screened for potential Medicaid eligibility and forwarded to county DSS offices as appropriate. (They will no longer be forwarded when the three Medicaid eligibility workers are placed at CHA.) Families are asked not to pay the enrollment fee until the redetermination is completed and they are sent a bill, in case they are found ineligible.

On the Medicaid side, the screening process at redetermination differs from that at initial application. The Medicaid program uses a different form at redetermination because the joint application was deemed too bulky to mail; if a family is found to be no longer eligible for Medicaid, no paperwork is forwarded to CHA. (Depending on the reason for the case closure, the DSS office may or may not refer the family to CHA.)

D. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

Enrollment growth in Colorado's Title XXI program has been modest. The state estimated in its March 2000 evaluation that 69,157 children were eligible for CHP+ at baseline. As of July 2001, about half that number (33,567) were enrolled in CHP+ (Table IV.3). Given the fact that the state began with a base of enrollees from the state-funded program that preceded CHP+ and was among the first three states to have its Title XXI state plan approved, the pace of enrollment in Colorado has been relatively slow. Many observers we spoke with said that enrollment was hindered by the state's earlier premium structure and much negative publicity in the summer and fall of 2000 about possible collection actions against families who were in arrears. (See Chapter VII for further discussion of the state's cost-sharing policies.) Enrollment nearly flattened in 2000 as concerns increased about collection of premiums, then rebounded after premiums were eliminated. This year, for the first time, the state may face the prospect of capping enrollment at the legislatively imposed limit (set at 46,000 for 2002).

TABLE IV.3

ENROLLMENT TRENDS

Enrollment Measure	1998	1999	2000	July 2001
Number ever enrolled in federal fiscal year (FFY)	14,847	24,116	34,889	—
Number enrolled at year end (point in time)	11,704	17,783	23,375	33,567
Percent change in point-in-time enrollment	—	52%	31%	44%

SOURCE: Vernon K. Smith, *CHIP Program Enrollment: June 2000.* Kaiser Commission on Medicaid and the Uninsured, January 2001. Centers for Medicare and Medicaid Services (CMS), *State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for the 50 States and the District of Columbia for Federal Fiscal Years (FFY) 2000 and 1999*, website: http://www.hcfa.gov/init/fy99-00.pdf.

Medicaid enrollment may also have been boosted by the implementation of CHP+ and the joint application form. CHA staff reported that they forward to Medicaid one in five of the applications they receive. State Medicaid staff reported that total Medicaid enrollment has increased since CHP+ was implemented, although enrollment among families who qualify under Section 1931 provisions (based on former AFDC rules) is down.

Almost all respondents agreed that the revised joint application is easier for applicants than the earlier joint form, and CHA staff reported that the number of incomplete applications has dropped by 25 percent since the new form was introduced. (Currently, incomplete applications account for 6 percent of denials.) However, application assistors said that the joint application is by its very nature more complicated than a single-program application and is still too difficult for some families to complete on their own. SED staff also complained about having to make multiple copies of the application if family members appear to be eligible for different programs, as a copy of the form must be sent to each program and one or two more retained in the site's files. The requirement that families fully document one month's income is perceived to be a stumbling block for some who do not have pay stubs or who are unable to find four weeks' worth when they apply. Because the form is also an application for the indigent care program, which requires documentation of three months income, some application assistors ask families to bring three months worth of pay stubs when they come in to complete the application. (Although the documentation requirement may be more onerous for the indigent care program, some respondents noted that basing eligibility on three months of income instead of one is better for families whose income fluctuates from month to month—such as seasonal workers.)

Concerns about the CHP+ enrollment process generally focused on screen-and-enroll procedures and differences between Medicaid and CHP+ requirements. Several respondents said that having to ask about assets—a requirement for Medicaid but not for CHP+—is a barrier to

enrollment in both programs. However, one community-based enrollment specialist pointed out that the asset test in Medicaid is less of an issue than it was in the past, since families are now allowed to self-report their assets. The elimination of this documentation requirement was one of several steps the Medicaid program has taken to streamline the application process since the implementation of CHP+. Some HCPF and CHA staff attributed these changes to a "spillover" from CHP+, but Medicaid program staff said that streamlining efforts were already underway when CHP+ was implemented.

The county role in Medicaid eligibility determination further complicates the screen-and-enroll process and can significantly delay eligibility determination. People involved in CHP+ enrollment reported varying degrees of cooperation from county DSS offices, with some DSS workers eager to transfer paperwork and ensure that children are enrolled in the appropriate program in a timely manner and others much less helpful. Respondents also commented on the considerable variability in procedures and policies across DSS offices. For example, different offices use different sources to establish the value of automobiles for the Medicaid asset test, so CHA staff must vary the sources they use when screening for Medicaid eligibility. In addition, some offices reportedly require more documentation than others. According to one Covering Kids representative, "the state has said that documentation requirements for Medicaid and CHP+ are the same. But it doesn't play out that way at the local level…Verification problems are still a major barrier to enrolling in CHP+ and Medicaid. Families don't want to apply for Medicaid because they feel like they have to open their entire life to DSS."

There are widespread concerns and some hard evidence that Medicaid eligibles have been "dropping through the cracks" because of poor followup by some DSS offices. No system currently exists to track applications forwarded by CHA or SEDs to county DSS offices. A study by the state auditor found that CHA was informed about the case disposition of only 144 of

the 536 children whose applications were forwarded to the counties during a one-month period in early 2000; of the remaining 392 children, only 15 were actually enrolled in Medicaid (Office of the State Auditor 2000). In addition, almost 12 percent of the children enrolled in CHP+ at some time between May 1999 and April 2000 were simultaneously enrolled in Medicaid for anywhere from one to twelve months. (CHA staff assert that the problem of duplicate enrollment has been largely corrected.) The state auditor also found that the Medicaid program did not have processes in place to ensure that families who are found ineligible or disenrolled from Medicaid are informed about CHP+.

The contribution of SED sites to the enrollment process varies widely. Currently, 82 sites are certified to complete applications, but a handful of sites produce the vast majority of applications. In 2000, for example, the state auditor found that 32 of the 67 sites operating at the time generated fewer than 5 applications per month and 7 of the 32 averaged fewer than one per month. CHA and SED site staff agreed that SED certification is administratively burdensome (a "nightmare," according to the administrator of one site), and CHA managers added that it is not cost-effective to provide ongoing training and updates to SED staff who handle few applications, especially since turnover among these staff is high. Several respondents noted that the per-application payment of $12 to $15 does not cover the cost of application assistance and that sites that do not have a financial interest in getting children enrolled in CHP+ or Medicaid may be less able to justify the expense if their resources are very limited.

The role of SED sites in the application process may change, as the state is evaluating a plan to reduce the number of sites and delegate more responsibility to those that remain. In fall 2001, HCPF, CHA and Denver Health began pilot-testing a process whereby selected SEDs will actually determine CHP+ eligibility online and complete the enrollment process, including assignment to an HMO. Several application assistors we spoke with said that they would

welcome this change, as it would allow them to tell applicants on the spot whether they have been approved for CHP+ coverage, but some advocates expressed concern that reducing the number of SED sites would further limit access to application assistance, which they feel is already too limited in some areas.

Like many states, Colorado has begun to focus on improving SCHIP renewal rates. Currently, 62 percent of CHP+ enrollees renew on time. Although some children are disenrolled for cause (for example, the 2000 state evaluation reported that a sizeable percentage of disenrollees had obtained other insurance), 41 percent of survey respondents whose children had been disenrolled at redetermination said that they had simply "forgot/procrastinated/misplaced the application" (Colorado Department of Health Care Policy & Financing 2001). Response rates have improved since CHA implemented the new reminder mechanisms: 80 to 90 percent of families return the renewal form now, compared with 50 to 60 percent earlier. CHA also plans to begin working more with the health plans to improve renewal rates; some currently send reminder notices to their enrollees. Some respondents pointed out that the state's renewal rate is better than it appears, as many families reapply after their coverage lapses.

V. CROWD OUT

A. POLICY DEVELOPMENT

Concerns about substitution of public for private coverage prompted the legislature to restrict eligibility in CHP+ to children who have not "currently nor in the three months prior to application been insured by a comparable health plan through an employer, with the employer contributing at least fifty percent of the premium cost" (H.B. 97-1304). Colorado is the only state with a waiting period that takes into account the amount of the employer contribution, although other states also consider the affordability of employer-based coverage—for example, by setting a dollar limit for the employee share (CMS 2001).

B. PROGRAM CHARACTERISTICS

The three-month waiting period called for by the legislature remains in effect, and applicants are asked to report whether their children had coverage in the past three months as well as how much the employer and family each paid. Additional crowd-out prevention measures cited by the state in its 2000 evaluation include the cost-sharing structure and design of the CHP+ benefit package, both of which were designed to resemble features of commercial insurance and thus remove the incentive for families to drop their existing coverage.

C. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

Many respondents stated that crowd out would not be an issue in Colorado with or without a waiting period because families with incomes below 185 percent of the FPL are not likely to have employer-subsidized dependent coverage. The state does not have data to assess whether the waiting period has deterred CHP+-eligible families from dropping their coverage, but state staff reported that the percentage of applicants who are denied CHP+ coverage because they had

other coverage during the waiting period is very small. Advocates and application assistors said that families who have dropped private insurance coverage have done so because the cost of that coverage has risen, not because of CHP+. Despite this assessment, concerns about crowd out have influenced efforts to market CHP+ through employers. To avoid any suggestion that CHP+ promotions are encouraging employers or employees to drop coverage, both CHA and Covering Kids have restricted their employer outreach efforts to businesses that do not provide dependent coverage.

VI. BENEFITS

A. POLICY DEVELOPMENT

The legislation that established CHP+ stipulated that HCPF develop a schedule of benefits for the program similar to that offered in the Colorado Standard and Basic Health Benefit Plans, which are required for use in Colorado's small employer market. Several people we interviewed said that there was a common perception among legislators and providers that the Medicaid benefit package was "too rich" or, as one legislator put it, the "Cadillac treatment." Legislators reportedly felt that a package that mirrored the coverage offered in the employer market would help familiarize families with the kind of insurance coverage they might eventually be offered in the workforce. It was also thought that this structure would facilitate future implementation of a premium assistance program within CHP+, because benefit packages offered by employers would be likely to match or exceed the CHP+ benefit package, thus obviating the need for the state to offer wraparound coverage to CHP+ enrollees covered under an employer plan.

B. BENEFIT PACKAGE CHARACTERISTICS

CHP+ offers more generous coverage than the small-employer commercial plans on which it was modeled, and the actuarial value of the CHP+ package exceeds that of all the Title XXI benchmarks. However, at the time of our visit, CHP+ was one of only two Title XXI programs nationwide that did not currently offer dental benefits. The state added a dental benefit to the CHP+ package as of February 1, 2002, using funds from Colorado's share of the federal tobacco settlement. Delta Dental of Colorado will deliver dental care to CHP+ enrollees through commercial providers and essential community providers throughout the state.

Currently, CHP+ offers full coverage for emergency care and transportation; hospital services; medical offices visits; diagnostic services; preventative, routine and family planning

services, including immunizations and well-child visits; maternity care; mental health care; outpatient substance abuse treatment; physical, speech and occupational therapy; durable medical equipment; transplants; home health care; hospice care, and prescriptions. CHP+ coverage is more generous than that offered in the Colorado Standard and Basic Health Benefit Plans, in that CHP+ sets higher service limits for medical equipment, and vision care than the basic plans, charges lower co-payments and imposes no deductibles. Some of these benefits were added to meet Title XXI requirements, but the CHP+ benefit package also exceeds the actuarial value of all of the Title XXI benchmarks, including the Federal Employee Health Benefit Plan (FEHBP). Two HMOs, Colorado Access and Denver Health Medical Plan, offer benefits beyond those in the basic CHP+ package, by including ten additional therapy and mental health visits per year, and setting higher service limits on glasses and/or contact lenses ($150 per year versus $50) and hearing aids ($1200 per year versus $800).

There are two major differences between the CHP+ and Medicaid benefit packages. CHP+ offers substance abuse treatment (outpatient only) that Medicaid does not; and CHP+ limits mental health treatment and certain therapies, while Medicaid does not. (Under CHP+, treatment for non-neurobiologically-based mental illness is limited to 45 inpatient days and 20 outpatient visits, and physical, speech and occupational therapy is limited to 30 visits per diagnosis per year.)

C. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

CHA administrators said that designing the package to resemble a commercial HMO package has helped with the public image of the program and facilitated employer-based outreach, because "employers understand the package." Community partners, advocates, and state agency staff believe the CHP+ benefit package is adequate in comparison with commercial plans, but respondents agreed that the addition of a dental benefit will enormously improve the

CHP+ benefit package and provide an additional incentive for parents to enroll their children in CHP+.

A common concern among providers, advocates and community agencies was that the limits on therapies and durable medical equipment are too stringent for children with special health care needs (CSHCN). (For example, coverage for durable medical equipment benefit is limited to $2,000 per year, while the cost of a typical power wheelchair covered by Medicare is $5,000.) However, as stated by one CHA administrator, "no package will be adequate for this [CSHCN] population." The state is working with the Title V, Maternal Child Health, and Health Care Program for Children with Special Health Care Needs (HCP) to develop a strategy to address the needs of these of these children.

Several respondents critiqued the limits on behavioral health care. State staff said that they are not aware of children bumping up against the service limits, but acknowledged that they have no hard data yet. Providers and advocates stated that HMOs control utilization of mental health services by serving only children who are severely emotionally disturbed. One advocate stated that the school system and HCPF are struggling over the issue of whether special education programs or CHP+ will be responsible for providing mental health services to the CHP+ population and added that services available to children through community mental health centers are inadequate because the division for children's mental health that was recently established within the Department of Public Health and Environment was not adequately funded.

VII. SERVICE DELIVERY AND PAYMENT ARRANGEMENTS

A. POLICY DEVELOPMENT

The CHP+ delivery system has been molded by the state's geography and a frontier philosophy that favors privatization of public services. In the statute that established CHP+, the legislature mandated a "strong managed care direction" for the program. Declaring that "the use of managed health care systems has significant potential to reduce the growth of health care costs incurred by the people of this state," the legislature directed HCPF to provide services through managed care organizations where possible and, in areas of the state that are not served by HMOs, to contract directly with other providers "using a managed care model." The legislation also authorized the agency to establish a competitive bidding process to select HMOs and stipulated that plans participating in CHP+ must also participate in Medicaid.

With the vast majority of the state's population concentrated on the Front Range, most HMOs have shown little interest in expanding over the mountains and into the more rural areas of the state. As a result, the state has somewhat reluctantly maintained the statewide network of providers that was established under the state's pre-CHP+ program in order to meet the legislative mandate to pursue a "strong managed care direction" in the program.

The rural provider network established for the pre-CHP+ program formed the kernel for the managed care model called for by the legislature. The Colorado Child Health Plan (CCHP), the limited-benefit plan that preceded CHP+, was structured as a managed care program. Members received care from over 3,300 providers, 58 hospitals, and two home health care/durable medical equipment agencies statewide. Primary care providers in the CCHP network served as gatekeepers and were capitated for routine office visits and well-child care. Specialists were reimbursed on a fee-for-service basis. (As noted, only ambulatory surgery and hospital

observation (23-hour) services were covered under CCHP. For hospital stays exceeding 24 hours, members relief on the Colorado Indigent Care Program for coverage.) By the time the state's Title XXI plan was approved, this network (now known as the CHP+ Network) had been expanded statewide and included hospitals contracted to provide inpatient care.

Although the legislature envisioned the CHP+ Network operating only in areas that were not served by HMOs, advocates fought to maintain the "pre-HMO" role for the network under CHP+ so that enrollees would have a medical home during the one- to two-month period before they are enrolled in an HMO. Accordingly, all enrollees are linked to a primary care provider in the CHP+ Network as soon as their application is approved. In many cases, families can remain with the primary care provider who served them during this period, as most PCPs who contract with the CHP+ Network in counties served by HMOs also contract with the HMOs.

B. SERVICE DELIVERY SYSTEM

Currently, the state contracts with six HMOs to provide services to CHP+ enrollees in 38 of the state's 64 counties (as of February 2002). The 38 HMO counties are the most populous in the state and home to approximately 85 percent of CHP+ eligibles. Of the 38, 24 are called "choice counties," because enrollees can choose between an HMO and the CHP+ Network or among multiple HMOs, while in the other 14 counties, CHP+ enrollees must enroll in the single HMO that operates in their county. CHP+ enrollees in 25 rural counties are served only by the CHP+ Network.

Two-thirds of children in CHP+ are enrolled in HMOs. About half of these children are enrolled in Colorado Access, a nonprofit health plan established in 1994 by The Children's Hospital, University Hospital, Denver Health and the Colorado Community Health Network (the state association of community health centers). The remaining enrollees are split between the other five HMOs (United Healthcare, Kaiser Permanente, Community Health Plan of the

Rockies, Rocky Mountain HMO, and Denver Health Medical Plan), with each serving between 3 and 9 percent of enrollees. A seventh plan, HMO Colorado, pulled out of the program after the first year. Just over one-third of CHP+ enrollees receive services through the CHP+ Network.

Colorado Access is the only one of the six HMOs that serves enrollees outside of the Front Range (the eastern foothills area of the state, dominated by the cities of Fort Collins, Boulder, Denver, Colorado Springs and Pueblo) or the Western Slope (the Grand Junction, Meeker and Steamboat Springs area). Licensed to operate in all but a few Colorado counties, Colorado Access is planning to expand into areas currently served only by the CHP+ Network. Community health centers (CHCs) form the backbone of the Colorado Access network. A key player in the network is Denver Health's Community Health Services Program, the largest and the second oldest federally funded CHC in the country, with 11 primary care clinics and 12 school-based clinics. Another major provider is Valley Wide Medical Services, with 14 primary care clinics, two school-based clinics, and three dental clinics in 10 counties in the San Luis Valley (south central Colorado). Statewide, Colorado's 14 CHCs and 96 clinic sites serve as the medical home for one-quarter of all CHP+ enrollees, as well as one-quarter of all Medicaid recipients and one-third of all uninsured children in the state (Colorado Community Health Network 2001).

In accordance with state statute, all of the plans that serve CHP+ enrollees also serve Medicaid enrollees. According to HCPF staff, the provider networks offered by the plans to CHP+ and Medicaid enrollees are basically the same. CHA staff agreed this is the case in most parts of the state but contended that in rural areas, more providers participate in CHP+ than Medicaid.

C. PAYMENT ARRANGEMENTS

The combination of a public-private partnership and the managed care delivery system mandated by the legislature has resulted in a complex administrative structure for CHP+ (as illustrated in Figure II.1). Contracting and payment arrangements differ for the CHP+ Network and HMOs.

HCPF was authorized by the legislature to seek competitive bids from HMOs, but the state instead established capitation rates, which are adjusted for age and income. (There are nine rate cells). This year, the state decreased rates for two-to-six year olds and increased rates for seven-to-eighteen year olds, as the older group had proved more expensive than anticipated. (Infants are the most expensive group.) The state has considered developing risk-adjusted rates but does not as yet have the data to calculate them. Initially, to protect HMOs from adverse selection, the state established a risk pool to compensate plans for costs (individual or aggregate) that rose substantially above the capitation rate. However, the pool was never used and has since been legislatively removed.

HMOs' reimbursement arrangements with providers vary. For example, Metro Community Health Provider Network, a Denver CHC, has partial risk contracts with Colorado Access and Community Health Plan of the Rockies, but a fee-for-service contract with United HealthCare. Staff of Colorado Access reported that providers' patient volume determines whether they are offered a capitated arrangement by the plan and that very few are.

The state pays CHA global capitation to manage the CHP+ Network, which includes over 3,000 providers statewide. CHA, in turn, pays the primary care providers (PCPs) who contract with the network a modified capitation payment that covers routine office visits and well-child care. PCPs bill Anthem Blue Cross and Blue Shield (the state's third-party administrator) for lab work, immunizations and other services that are not covered under capitation, including care

provided during the "pre-HMO" period. Anthem also handles claims from specialists, who are reimbursed on a fee-for-service basis, and hospitals, which are paid discounted charges. CHA also contracts with Horizon Behavioral Health Services to provide mental health care to children served by the network. Fee-for-service rates in the CHP+ Network are about 80 percent of Medicare rates and/or 120 percent of Medicaid rates. Blue Cross/Blue Shield of Colorado (now Anthem) processed CCHP claims for free for six years. With the advent of CHP+ and the availability of federal matching funds, Blue Cross began charging the state for claims processing. In fiscal year 2000, the Blues charged $6 per member per month (PMPM). The rate rose to $10 PMPM in 2001 and to $14.75 PMPM in 2002.

Comparisons between Medicaid and CHP+ reimbursement are difficult to make because of the differences in benefit packages and populations served, but Medicaid staff believe the capitation rates for the two programs are comparable given those differences. They also believe that plans vary the rates they pay providers for services under Medicaid and CHP+ only insofar as the services covered differ.

D. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

In general, access is perceived to be good for most CHP+ enrollees, although some respondents pointed out some "glaring exceptions" to the rule. CHA staff attributed some provider shortages to rapid population growth and said that CHP+ enrollees face no worse access issues than children with commercial coverage. (During the 1990s, Colorado's population grew at an average rate of almost 2.5 percent annually, over twice the national average.) But others believe that the situation is worse for CHP+ enrollees than for children with commercial coverage, particularly in the state's resort mountain communities and in El Paso County, because some providers are unwilling to accept CHP+ rates. Ambivalence about the role of the CHP+ Network has affected access to care in some areas, according to CHA staff. With an uncertain

commitment from the state to maintain its management contract, CHA has been loath to invest in building the network, and it has accordingly deteriorated over time, particularly in areas where it competes with an HMO. HCPF staff disputed this characterization of access for CHP+ enrollees and noted that geomapping has shown the CHP+ network to be as good as commercial networks in most areas.

CHA staff believe access is very good in counties served by multiple HMOs or by the CHP+ Network alone and less good in counties served by both the network and Colorado Access, where shortages of certain specialty care (particularly orthopedics) exist. But even in areas served by multiple HMOs, there are problem spots. El Paso County was cited by several respondents as one such area, with the situation in Colorado Springs described as "abysmal." Physicians in the county are reportedly hostile to managed care, and only one pediatrician contracts with any of the CHP+ plans. Specialty care is reportedly in short supply in even more areas, particularly the more rural parts of the state, such as the San Luis Valley.

Although we were not able to obtain definitive data, access appears to be better for CHP+ enrollees than Medicaid enrollees. As noted, respondents differed as to whether the HMO networks and, by extension, access, are the same for CHP+ and Medicaid. In parts of the state not served by HMOs, comparability of access between the two programs varies by the county. Access is reportedly comparable in the San Luis Valley but much better for CHP+ enrollees than for Medicaid enrollees in Larimer and Morgan counties.

HMOs seem generally satisfied with the capitation rates paid by the state, and all but one plan turned a profit last year. HCPF staff noted that CHP+ coverage is probably less costly for plans to administer than Medicaid coverage because the CHP+ benefits are similar to those offered by the plans in their commercial lines. Some providers, particularly some specialists (for example, anesthesiologists) complain that their reimbursement from the plans is inadequate. One

pediatrician reported that HMOs pay Medicaid rates, which in Colorado are about 67 percent of Medicare rates and 58 percent of commercial rates. As his overhead, not counting physician salary, is 70 percent of commercial rates, "not only am I giving away my professional time for free, but I am actually paying for the privilege of caring for these patients."

In contrast, safety net providers who were serving these same children for thirty cents on the dollar when they were covered only by the indigent care program consider anything more than that generous, according to the executive director of the state CHC association. Shifts in the health care market have also favored CHP+. CHA staff reported that as other payers have ratcheted down reimbursement, providers who once refused to participate in the CHP+ Network are now viewing network rates more favorably. ("What was once abysmal is now pretty damn good," as one respondent put it.)

Providers voiced few complaints about billing procedures or the timeliness of payment. However, some said that the "pre-HMO" period causes confusion as to which entity (CHA or an HMO) services should be charged. If a service is improperly billed to the CHP+ Network after the child has been enrolled in an HMO, Anthem Blue Cross will deny the claim, which must then be forwarded to the appropriate HMO through a claims adjudication process handled by CHA.

VIII. COST SHARING

A. INTRODUCTION/POLICY DEVELOPMENT

The state's premium policy generated a spate of negative publicity before it was abandoned in fall 2000, but program administrators and others with whom we spoke during our visit disagreed about whether premiums are inherently problematic in an insurance program for low-income families. The legislature's intent in requiring premiums in CHP+ was to model the plan after commercial insurance coverage and to reinforce the value of the services. "Personal responsibility was the buzzword," said one HCPF administrator. Premiums were also reportedly deemed necessary to support the program financially when it was originally conceived as a Medicaid waiver program. (CCHP used an annual fee structure.)

By state law, HCPF was required to design and implement a structure of "periodic premiums" and copayments for CHP+. (Notably, the legislature did not require that premiums be collected monthly.) In consultation with the policy board, HCPF established a schedule of monthly premiums based on family income as follows:

- Below 101 percent of the FPL: $0
- 101-150 percent of the FPL: $9 for one child, $15 for two or more
- 151-170 percent of the FPL: $15 for one child, $25 for two or more
- 171-185 percent of the FPL: $20 for one child, $30 for two or more

Neither the CHP+ legislation nor HCPF rules addressed the issue of nonpayment, and CHA took no action against families who failed to pay. (Families were sent increasingly aggressive letters demanding payment but, as one CHA manager put it, the threat was only "pay up or something might happen.") By May 2000, 53 percent of the 9,100 families who were required to pay premiums were at least 30 days in arrears. Then, in July 2000, the state controller ruled that,

by state law, all overdue accounts must be turned over to collections. "No one wanted to send families to collections," said one member of the policy board, but faced with the state controller's ruling, the board instituted a new policy calling for families whose payments were more than 60 days past due to be disenrolled and then "locked out" of the program for three months, and for overdue accounts to be turned over to collections. Persuaded that the policy board did not have the authority to eliminate the premium requirement, board members lobbied the legislature to do so. In late August, the governor stepped in and asked the legislature to declare a "premium holiday," suspending premium payments through the end of the year and canceling any outstanding payments. The governor also recommended that the state eliminate monthly premiums for CHP+ and charge only those families with incomes above 150 percent of the FPL an annual enrollment fee of $25 for one child and $35 for two or more children.

B. PROGRAM CHARACTERISTICS

Since January 2001, CHP+ has charged the annual enrollment fees recommended by the governor in fall 2000 and the copayments that were established by HCPF and the policy board at the start of the program (Table VIII.1). Families are billed for the enrollment fee after their application has been approved and children are not enrolled until payment is made. Copayments are based on family income and range from $1 to $5 for prescription drugs, from $2 to $5 for office visits, and from $5 to $15 for emergency room care. The state uses the "shoebox" method to track aggregate out-of-pocket expenditures for medical care—that is, families are required to collect their receipts and notify the state when their expenditures for covered services have reached 5 percent of their income (the limit mandated by Title XXI). If a family reaches the limit, which none has to date, a sticker will be placed on the child(ren)'s card to indicate that enrolled family members are exempt from further co-payments.

TABLE VIII.1

COST-SHARING POLICIES

Policy	SCHIP
Enrollment fee[a]	Yes
< 150% FPL	$0
151-185% FPL	$25 annually for 1 child
	$35 annually for 2 or more children
Premiums[b]	No
Co-payments[c]	Yes
Emergency Care	
<100% FPL	$0
101-150% FPL	$5
151-185% FPL	$15
Medical Office Visits	
<100% FPL	$0
101-150% FPL	$2
151-185% FPL	$5
Prescription Drugs	
<100% FPL	$0
101-150% FPL	$1
151-185% FPL	$3-5
Deductibles	No

SOURCE: Centers for Medicare and Medicaid Services (CMS), *Colorado XXI Program Fact Sheet.* CMS web site http://www.hcfa.gov/init/chpfsco.htm

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI)

[a]Implemented 1/01.
[b]Eliminated 10/00.
[c]Fee schedule was revised as of 10/00 due to passage of Amendment 2.

C. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

Most respondents agreed that the state's premium policy undermined enrollment efforts but cited slightly different reasons. Advocates said that the "rumor of collections" was a major threat and frightened families away from the program. A larger problem, according to CHA staff, was that many community partners who were involved in outreach disliked the premium policy and were consequently reluctant to promote the program, particularly when talk of collections arose. At that time, the monthly rate of enrollment growth dropped from 3 percent to 0.6 percent, and according to one CHA administrator, it has taken a full year for the program to regain its momentum. Denver Health Community Voices, a W.C. Kellogg Foundation health care initiative, is currently studying how the elimination of premiums and introduction of an enrollment fee has affected enrollment.

Many respondents said that premium levels—which were based on those tested but later reduced in Florida—were too high. This reaction, however, may be due in part to the availability of a potentially lower-cost alternative: the Colorado Indigent Care Program. Two-thirds of the parents surveyed by the Colorado Community Health Network in Denver said CHP+ premiums were too high and that they would prefer that their children be covered by the indigent care program, despite the higher copayments (Sonn 2000). In an earlier visit to the state, an Urban Institute research team found that reactions to premiums varied sharply by region, with respondents in areas where the indigent care program operates much more likely than their counterparts in areas where the program does not operate to report that CHP+ premium levels were too high (Hill forthcoming).

One CHA administrator theorized that the lack of compliance in Colorado was largely due to lack of enforcement and noted that, from the time enforcement was first proposed to the time the governor called the premium holiday, the rate of voluntary compliance rose from about 35

percent to about 70 or 80 percent. But a HCPF staff member noted that regardless of level at which premiums are set, a monthly premium structure may hurt enrollment because it requires people to make 12 decisions a year to purchase insurance when their commitment or ability to do so may vary from month to month.

The cost of premium collection was another consideration raised in the debate. In the July 2000 report, the state auditor noted that collecting premiums might have cost the state more than it gained in revenue and that pursuing families who were delinquent would only raise costs further. Moreover, because premium revenues must be deducted from benefit costs, they effectively decreased the amount against which the 10 percent administrative limit was calculated and thus the amount of administrative spending for which federal matching funds could be obtained.

Views of the new enrollment fee and the copayment structure in CHP+ were generally positive. According to one state Covering Kids staff member, "families are happy to pay the enrollment fee and copays. It gives them a sense of dignity." Although some CHA staff worried that the program may lose children because of the way the fee is collected (families are billed after they are deemed eligible but children are not actually enrolled until payment is made), they acknowledged that the obvious alternative (collecting the fee upfront and having to reimburse families who are subsequently found ineligible) was no better. During the second quarter of 2001, 200 families, or 15 percent of those applying, were denied coverage because they failed to pay the enrollment fee.

Providers and plan representatives reported no difficulty collecting copayments from families, and one noted that many families with children in CHP+ are used to copayments because of their experience with the indigent care program.

IX. DEMONSTRATIONS AND WAIVERS

In its original state plan submission, HCPF anticipated that the second phase of Colorado's Title XXI program might include a premium assistance program. The state has continued to explore this possibility, and in 2000 obtained a grant from a community foundation to study the issue. However, in the state evaluation submitted to CMS in March 2000, the state concluded that, "given existing federal regulations, Colorado does not believe that implementing this program will be feasible. The Department strongly recommends that HCFA reevaluate its approach to premium assistance programs to encourage states to work with employers who currently provide some limited coverage to their employees, which does not meet the high standards proposed in the revised federal regulations for CHIP programs."

X. FINANCING

Colorado implemented its Title XXI program in April 1998 and in the five months of federal fiscal year (FFY) 1998 reported only $1 million in expenditures (Table X.1). Spending accelerated the next year, as enrollment grew by more than 50 percent. By the end of the three-year period of availability, Colorado had spent 57 percent of its 1998 allotment, the median amount spent nationwide. At 65 percent, Colorado's enhanced federal matching rate for SCHIP, like that of 13 other states, is at the minimum level established by the SCHIP legislation.

State funding for the program is appropriated by the General Assembly each year and enrollment is capped at the level the state appropriation can support. However, until this year, CHP+ enrollment has not even approached the statutory limit. According to HCPF staff, the program's slower-than-anticipated growth is partly attributable to the 10 percent limit on federal financial participation for SCHIP program administration, including outreach**.** As HCPF noted in the state evaluation submitted to CMS in March 2000, "The 10 percent cap places severe strictures on design, development and growth of the CHIP program. While [it] may ultimately be a reasonable level for mature programs, it does not allow state sufficient funding for effective program start up."

Colorado appears to be one of the few states whose administrative spending under Title XXI has exceeded the 10 percent limit over a period of several years. In July 2000, the state auditor estimated that administrative costs for the year would amount to about 37 percent of health care service costs and 27 percent of total costs. The auditor attributed these high costs to the combination of an overly complex administrative structure, the relatively small number of children enrolled, and the high cost of starting a new program. A very different picture of CHP+ administrative costs emerges from the 2001/2002 budget briefing of the Joint Budget Committee

TABLE X.1

SCHIP ALLOTMENTS AND EXPENDITURES,
IN MILLIONS, 1998-2000

FFY	Federal Allotment	Expenditures	Expenditures as Percentage of Allotment for the Year	Percentage of Year's Allotment Spent by End of FFY 2000	Redistributed Amount
1998	$ 41.8	$ 1.0	2	57	
1999	$ 41.6	$ 9.0	22	0	
2000	$ 46.9	$13.9	30	0	NA

SOURCE: Centers for Medicare and Medicaid Services (CMS), Memo from Center for Medicaid and State Operations to State, January 25, 2000; Federal Register Notice, June 21, 2001; Kenney et al., *Three Years into SCHIP: What States Are and Are Not Spending.* Urban Institute: September 2000.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI); FFY=federal fiscal year.

of the Colorado General Assembly. Budget committee staff found that on a per-member-per-month basis, administrative costs in CHP+ were actually 17 percent lower than those in Medicaid ($13.60 versus $16.41). Moreover, the committee briefing noted that a proportion of CHP+ administration is actually related to Medicaid, because CHP+ outreach brings in many applications from Medicaid eligibles. A key reason for the differing perspectives on the CHP+ administrative costs is that the auditor's report was conducted at a time when the state was required by HCFA to consider management of the CHP+ Network an administrative cost. The state subsequently folded these costs into a capitated payment to CHA, which permits them to be considered health care service costs.

The state expects CHA to raise funds to support outreach activities. This requirement has raised thorny issues for the public-private partnership, in that donors, CHA and the state may be at odds over how donations will be spent. Last year, for example, CHA was fined $5,000 by the state for using donations to fund a grant proposal that the state did not approve. CHA staff believe that the possibility that the state may award the next contract for CHP+ administration to another organization has hindered CHA's fundraising efforts, because donors do not like the idea that their funds will simply be turned over to another organization without their approval.

Tobacco settlement monies will be used to support the addition of a dental benefit to the CHP+ package this year. Under Senate Bill 00-71, $10 million per year of the state's share of federal tobacco settlement funds will be earmarked for dental services. At the same time, the state may cap enrollment at 46,000 children. Because the taxpayers' bill of rights limits increases in state spending to 6 percent, funds to support enrollment beyond this cap would have to be taken out of the budget for some other state program. Consequently, although political support for the program appears strong, Senator Owens, a key sponsor of the bills that

established the state's Title XXI program, was unwilling to speculate about what the legislature will do if CHP+ enrollment reaches the limit established by law for the year.

XI. LESSONS LEARNED

Although Colorado was among the first states to implement its Title XXI program, as well as one of the few with an existing state-funded program to build upon, CHP+ has faced some unique challenges that have slowed program enrollment and eventually forced some significant changes in program structure. The legislature's call for a public-private partnership and "strong managed care direction" to the program presented the Medicaid agency and its lead contractor, CHA, with the dual challenges of developing collaborative relationships with each other, as well as with a newly constituted policy board, and of expanding a managed care delivery system in a large and geographically diverse state where one-fifth of the population resides in rural and/or frontier counties. As noted, lines of authority within the public-private partnership were not clearly delineated and, as a result, the partners have at some times been hesitant to act and at other times come into conflict with one another. Ambivalence and uncertainty about roles and lack of consensus about the future direction of the program has played out in many contexts, most notably the issue of premiums. Neither HCPF nor the policy board addressed how nonpayment was to be dealt with, and when the specter of collections arose, members of the policy board did not think they had the authority to eliminate the premium structure.

This year has been one of major change for the program, as monthly premiums were replaced by an annual enrollment fee, the policy board was disbanded, and the legislature approved both the addition of a dental benefit and the placement of three state FTEs at CHA to determine Medicaid eligibility. Both HCPF and CHA staff, as well as others with whom we spoke, believe that the program has turned a corner and that the partners have learned a great deal in the past two-and-a-half years about how to collaborate effectively with one another.

Other key findings from the site visit include the following:

- ***The choice of a separate program model for SCHIP was virtually a foregone conclusion in Colorado because the infrastructure was already in place, and anti-Medicaid sentiment was strong***. The state's five-year history of providing insurance coverage to low-income children through a state-funded program, coupled with powerful political resistance to any expansion of the Medicaid entitlement, paved the way for adoption of a separate program model under Title XXI. This model allowed the state legislature to pursue its goal of structuring CHP+ as a "bridge" to private coverage, in that it permitted the state to offer a benefit package that resembles small-group commercial coverage and allowed cost sharing above Medicaid limits.

- ***The legislature's strong interest in tapping the expertise of the private sector and insistence on a "strong managed care direction" for CHP+ resulted in a highly complex administrative structure***. Multiple entities are involved in outreach, enrollment, provider network development, benefit administration, and reimbursement for CHP+. In addition to contracting with HMOs to deliver benefits in the most populous areas of the state, HCPF contracts with CHA, to administer the CHP+ Network in more rural areas and to manage outreach and enrollment statewide—functions that would ordinarily be assumed by the state agency itself. A third entity handles fee-for-service claims from providers in the CHP+ Network, and yet another entity manages behavioral health care benefits for children served by the network. This complex structure has clearly presented some management challenges for HCPF, particularly since the nature of the public-private partnership envisioned by the legislature was not clearly defined.

- ***The abolition of the Child Health Benefit Plan Policy Board promises to give HCPF more authority over CHP+ and suggests that the legislature's antipathy toward the Medicaid entitlement does not extend to the Medicaid agency***. Since September 2001, oversight for CHP+ has been provided by the Medical Services Board, which also oversees the Medicaid program. HCPF's longstanding relationship with this board, as well as board members' familiarity with Medicaid rules and procedures, are expected to enhance HCPF's control over the program.

- ***The influence of TABOR, the Colorado taxpayers' bill of rights, has been felt throughout the development of the program***. As noted, the state's 6 percent cap on increases in program expenditures reportedly inclined the legislature to designate HCPF as the lead agency for CHP+, rather than create a quasi-governmental authority to manage the program. In addition to heightening fears about the effects of CHP+ outreach on Medicaid enrollment, TABOR restrictions led the legislature to set annual caps on CHP+ enrollment. These restrictions also limit HCPF's ability to increase reimbursement rates, particularly as enrollment approaches the limit set by the legislature, and may ultimately affect provider participation and access to care.

- ***The screen-and-enroll process in Colorado is complicated by the large county role in Medicaid eligibility determination, differences in Medicaid and CHP+ requirements and what some advocates described as a "cultural clash" between staff of the two programs***. Variations in policy across programs and counties create barriers to both Medicaid and CHP+ enrollment. The asset test used by Medicaid but not by CHP+ was cited by many respondents as a significant barrier. In addition, county offices reportedly vary in terms of the documentation they require and the

extent to which they follow up on applications forwarded by CHA for Medicaid eligibility determination. The state auditor concluded that significant numbers of Medicaid-or CHP+-eligible children have fallen through the cracks because of poor follow up by county office staff at initial application or renewal. The move to allow Medicaid eligibility workers to be placed at CHA is an important step toward streamlining the process, but given county offices' financial investment in Medicaid eligibility determination, further steps are unlikely to be taken soon.

- ***Providing application assistance through a broad network of community-based organizations may be less effective than providing assistance through a narrower network that can assume more responsibility for enrollment functions***. CHA cited cost considerations as the primary reason that the state is considering reducing the number of SED sites and delegating additional enrollment functions to those that remain. (The state is currently conducting a cost-benefit analysis to determine whether to reduce the number of sites.) Some advocates worry that access to application assistance is already too limited, but data from the SED sites suggest that many sites are completing very few applications.

- ***Crowd-out is not perceived to be an issue in Colorado***. Most respondents believe that families and employers who have dropped dependent coverage have done so because the cost of that coverage has risen, not because of CHP+. It is not clear whether the three-month waiting period has prevented crowd-out that might otherwise have occurred.

- ***Although the state legislature initially considered a standard commercial benefit package adequate coverage for the CHP+ population, legislators have since deemed dental benefits a necessary addition***. Three years into the program, legislators set aside their objective of providing under CHP+ a benefit package that mirrors the most readily available commercial coverage, in order to add a benefit widely considered critical for children. In this, as in the transfer of program oversight to the Medical Services Board, the legislature seems to be moving away from its earlier insistence on keeping CHP+ as separate and distinct from Medicaid and as close to commercial coverage as possible.

- ***Access to care for CHP+ enrollees is reportedly good despite some "glaring exceptions."*** The managed care structure of CHP+ assures that enrollees in even the most rural areas have a medical home. Many respondents reported gaps in the referral networks of both HMOs and the CHP+ Network, however, which have resulted in shortages of specialty care, particularly in areas where specialists are few. Hostility to managed care on the part of some providers has also contributed to access problems in some parts of the state.

- ***Colorado's efforts to collect monthly premiums were generally perceived as disastrous, but the problem may have been lack of enforcement and the availability of a potentially lower-cost alternative***. Respondents disagreed as to whether monthly premiums are inherently problematic in a public program, but generally agreed that they were set too high, particularly for the lowest-income families served by CHP+. Lack of clarity about the consequences of non-payment appears to have contributed to low rates of compliance. Families' continued access

to the indigent care program, which charges no premiums, undoubtedly helped fuel the feeling that CHP+ premiums were too high.

- ***The federal requirement that the benefit package provided to SCHIP enrollees meet benchmark standards discourages states from implementing premium assistance programs***. Colorado had planned to implement a premium assistance program but chose not to do so because of the difficulty of assuring that children covered under an employer plan receive benchmark-equivalent coverage.

- ***The 10 percent limit on federal financial participation for administrative costs reportedly slowed enrollment in Colorado***. CHA and state staff reported that the 10 percent cap limited investment in outreach, particularly in the first year of the program, with a predictable impact on enrollment.

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