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Colorado Family Care:

HIFA Waiver Report

prepared for the

Colorado General Assembly

July 01, 2005

"The mission of the Department of Health Care Policy & Financing is to purchase cost-effective health care for qualified, low-income Coloradans."

http://www.state.co.us/gov_dir/chcpf/index.html

Medicaid and CHP+ Streamlining Initiative

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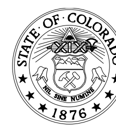

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Colorado Family Care
Concept Paper

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I. EXECUTIVE SUMMARY

The State of Colorado proposes to create a new program, named Colorado Family Care, which will serve low-income non-disabled children, pregnant women, and families eligible for Medicaid or CHP+ using the waiver process in a streamlined, comprehensive health insurance program. The Colorado Family Care program, a unified package of eligibility expansions, benefit enhancements, and purchasing reform, is proposed as Amendment 2[1] of Colorado's section 1115 Health Insurance Flexibility and Accountability (HIFA) demonstration program. The Colorado Family Care program reduces the number of low-income uninsured individuals in the state while building on the successes of the State Children's Health Insurance Program (SCHIP) known in Colorado as the Children's Basic Health Plan (dba CHP+). While state plan strategies might be available for some of the proposed changes, a streamlined health insurance approach for insurable populations will better serve children and families and improve the efficiency and effectiveness of the programs. In so doing, the State will be able to serve additional low-income children and families. The ultimate goal is to improve health outcomes for Colorado's low-income children and families. This will be accomplished through a public private partnership that uses private sector best practices while supporting and strengthening the safety net.

A key benefit of the Colorado Family Care model is that members will be able to move back and forth seamlessly between Medicaid and CHP+ as their eligibility changes while still remaining within the same care delivery system. This new integrated program will serve both Medicaid and CHP+ members by contracting with one group of health plans. *Consolidating these programs into Colorado Family Care will enable the State to purchase health services more effectively so that the State can enhance services to children and take a leadership role in addressing key developmental issues that, if left unrecognized, may prevent Colorado's children from maximizing their potential.*

While this program is a comprehensive program for low income families and children eligible for Medicaid and CHP+, Under Colorado Family Care, the State will expand eligibility for the following groups:

- Children with incomes from 185 to 200% of the FPL;
- Parents with incomes from 36 to 60% of the FPL;
- To the extent of available funds, parents with incomes from 61% to 100% of the FPL; and
- SCHIP pregnant women will continue to have coverage through the HIFA waiver option.

Under this waiver Colorado will also continue the coverage of pregnant women with incomes between 133 and 185% of poverty that began with a HIFA waiver in 2002 and the extension of coverage to pregnant women with incomes from 185 to 200% of poverty that is occurring with an amendment to that waiver in 2005. Since this previous HIFA waiver is set to expire shortly after the requested start date of the new waiver, Colorado is seeking a single combined HIFA waiver that incorporates the provisions of the previous waiver for prenatal care.

In addition to the eligibility expansions, there will be three important benefit enhancements under the demonstration:

[1] CHP's first HIFA waiver was approved and enabled the Colorado CHP+ program to cover pregnant women between 134 and 185% of Federal Poverty Level (FPL). Amendment 1 has been submitted.

- Low-income parents will receive the package of preventive health services included in the Core benefits;
- SCHIP children will receive enhanced treatment benefits through a wrap-around benefit as described below; and
- Medicaid children will have access to an outpatient substance abuse benefit.

In addition, as part of the initiative, Colorado will eliminate the current Medicaid asset test for low-income parents and children. The asset test will be removed beginning October 1, 2005. The intent is for current CHP+ members who become eligible for Medicaid due to the removal of the asset test to remain in the CHP+ delivery system until the implementation of the HIFA waiver on July 1, 2006 pending federal approval.

In addition to providing a benefit enhancement for CHP+ children, the initiative will also represent a restructuring of the way benefits are provided to poverty-level children.
Colorado Family Care will build on the state's public/private partnership that has proven successful for the CHP+ program. It will employ a private sector-inspired best practice business model. Colorado will purchase care coordination from contracted health plans and retain the full range of benefits currently available to Medicaid and CHP+ members in the state. Through a competitive request for proposals (RFP) process, Colorado will obtain better value for its health care dollars by contracting with a limited number of health plans that demonstrate an ability and long-term commitment to meet the special needs of low-income children and families enrolled in Medicaid and CHP+. A key component of the purchasing strategy will be the use of contractual health plan performance standards and incentives to expand access to timely primary care and reduce preventable emergency room visits and hospitalizations for Medicaid and CHP+ members called value based purchasing (VBP). In addition, Colorado will negotiate quantifiable annual quality improvement goals with each health plan.

The full range of benefits for children will consist of a Core package of services that represents the services most commonly used by children and wrap-around benefits identified as Core Plus that would be available as an integrated program to Medicaid and CHP+ children. Adults will receive the Core benefit package. Enrolled children who require more extensive services beyond the limits described in the Core benefit package would receive Core Plus benefits.

The SCHIP delivery system and value-based purchasing have been proven to effectively deliver health services to Colorado's children. Empirical evidence in support of the assertion is documented in the February 2005 peer reviewed journal, *Pediatrics*, which concluded that,

> Families who where newly enrolled into CHP+ perceived dramatic increases in access to all types of care and decreases in unmet medical needs, no increases in utilization of emergency department or hospitalization services, and improved overall quality of care in the year after enrollment into CHP+[2].

The benefit package design reflects extensive data analysis that concluded the CHP+ benefit limits were not exceeded in the comparable Medicaid children's population to any large degree. The Medicaid and CHP+ enrollees considered for the streamlined program are predominantly low-risk and their health care needs generally include: preventive services, acute services for typical childhood illnesses and injuries; management of developmental, school-related psychosocial, and emotional problems; and the occasional use of specialty, emergency, or

[2] Kempe, Allison et al. "Changes in Access, Utilization, and Quality of Care After Enrollment In to a State Child Health Insurance Plan", *Pediatrics.* February 2005, p.364.

inpatient care. Core benefits closely mirror the CHP+ benefit package. The Core and Core Plus benefits, when taken together, match the full Medicaid benefit package, including early and periodic screening, diagnosis and treatment (EPSDT) services for children.

Under the Colorado Family Care program, managed care organizations (MCOs) will be held accountable for the provisions and management of the full range of Core and Core Plus benefits, for children and Core benefits for adults. Core benefits closely resemble Colorado's small group basic and standard health benefits commonly in use by insurers for the small group market and meet the SCHIP actuarial requirements. They are essentially those benefits which lend themselves to an insurance model. The Core benefit package features broad categories of covered benefits currently provided in both Medicaid and CHP+ and reflects each program's reliance on both the American Academy of Pediatrics periodicity schedule outlining the recommended age-appropriate clinician visits and the Advisory Committee on Immunization Practices (ACIP) recommended pediatric vaccines[3]. Core Plus benefits complete the benefit package for children and meets EPSDT requirements. As has occurred in the past with managed care, Medicaid children in the demonstration will no longer need to change providers to access the full range of EPSDT services, and the full range of benefits will continue to be managed and coordinated by the MCO. This will enhance their ability to provide and coordinate comprehensive care for children. As reported in a previous paper commissioned by the State,

> Having the health plan administer both Core and wrap-around benefits also means that the clients can access the same provider network when seeking …. benefits. This facilitates the streamlining project objective of 'seamlessness' and maintains child-provider relationships. Thus, integrating the administration of Core and wrap-around benefits has the potential to simplify access, result in prompt referrals and improve coordination of care[4].

A value-based purchasing approach will structure the relationship between the State and the health plans. This will be built upon the following four components:

1. Purchasing specifications that clearly define the value that the State seeks to obtain from Colorado Family Care contractors, both in terms of process and outcome measures;
2. Measurement systems and data reporting structures to assess whether the State is obtaining the value that it seeks;
3. A process for working with Colorado Family Care contractors to identify opportunities for improvement and to collaborate on joint quality improvement activities; and
4. The application of rewards and penalties to provide contractors with clear consequences related to their performance based on contract specifications.

Because Medicaid and CHP+ children will be eligible for the same set of services and will be enrolled in the same set of plans, there will be no disruption in care when eligibility bouncing (eligibility changes between Medicaid and CHP+ due to fluctuations in income) occurs. The addition of Core Plus to the SCHIP benefit package represents an important benefit enhancement for the few children who develop special health care needs that cannot currently be met by the SCHIP benefits.

The proposed reform builds upon the CHP+ model and is structured to leverage the purchasing power of the State using a private insurance model. Foster care children, those receiving

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[3] Policy Studies, Inc, "Benefit Design for Streamlined Program for Children Enrolled in the Medicaid and CHP+ Program", available at http://www.chcpf.state.co.us/HCPF/titlexxi/StatePlan.

[4] Health Policy Solutions, Inc., "Purchasing Models for Children with Special Health Care Needs" Streamlining Project Policy Options", available at http://www.chcpf.state.co.us/HCPF/titlexxi/StatePlan

adoption services, supplemental security income (SSI) children, and children receiving home and community-based services (HCBS), or institutional care will not be included in the demonstration, and thus will not see any changes in the way their benefits are provided. The above-listed categories do not lend themselves to a private insurance purchasing model, because of the intense nature of their special needs, and therefore, will not be included.

Poverty level children, pregnant women, and parents, including American Indians and Alaskan Natives (as required by federal law), will receive their Medicaid and SCHIP benefits through MCOs. One of the key elements of the Colorado Family Care initiative is that for the first time, the populations included in the program will receive their services through a uniform set of MCOs, regardless of whether they are enrolled in Medicaid or CHP+. This means members will be able to move back and forth seamlessly between Medicaid and CHP+ as their eligibility changes while still remaining within the same care delivery system. The uniform set of MCOs will be chosen through a competitive bidding process. A non-risk based MCO will be available to those areas of the State in which a capitated MCO is not available. MCO rates will be developed using actuarial data based on the actual utilization of the children and adults enrolled in the program and will strive to develop more parity in the rates between private sector and safety net providers. The results of the research undertaken by the State clearly demonstrate the impact on utilization of services by having a more robust primary care network of providers available to the children enrolled in the program. The State is also proposing a limited, voluntary pilot program to examine the feasibility of a premium assistance program through employer sponsored insurance (ESI). This is described in more detail below.

One goal of the value-based purchasing initiative is to secure an optimal number of MCOs in each geographic area of Colorado, based on the "critical mass" of covered lives that is needed to provide assurances that MCOs will have sufficient resources to build an appropriate network and meet quality of care standards. This is based on the SCHIP model, which allows states to mandatorily enroll eligible children in a limited number of MCOs. Colorado has found that it is not practical to offer a choice of at least two health plans in certain areas of the state. Health plans will be chosen in a competitive process and there will be minimum standards for geographic coverage depending upon which region(s) of the state a plan is proposing to serve.

It is Colorado's expectation that by combining the resources of Medicaid and CHP+ in a value-based purchasing initiative, the managed care presence in Colorado can be strengthened for both programs. This should result in higher quality care for the beneficiaries served in Medicaid and SCHIP. In addition, the demonstration could form the foundation of a streamlined managed care product that could potentially be attractive to other purchasers, including higher income uninsured adults who could "buy in" to coverage, and uninsured businesses that could purchase coverage for their workers.

The coverage expansion and the addition of preventive benefits for low-income parents will be financed with the proceeds of Colorado's new tobacco tax (HB05-1262). Core Plus benefits for children in the CHP+ program and some other limited benefit expansions to the CHP+ benefits will be financed through the anticipated savings in the streamlined program. Savings are available through changes in utilization patterns from a more robust primary care network and the use of managed care throughout the program. These are described in more detail in the Actuarial Feasibility Study, Appendix A. The program design, including the integration of the MCOs for Medicaid and CHP+, and the Core Plus benefit structure, is the result of extensive data and policy analysis and deliberation. The multiple studies undertaken under the auspices of the Department of Health and Human Services Health Resources and Services Administration (HRSA) grant and generous funding from the Rose Community Foundation in Colorado are available on the

Department of Health Care Policy and Financing web site www.chcpf.state.co.us. These have been made available to the community throughout the process as they have been completed and have formed the basis for many of the public input processes described in Appendix B. It is the State's intention not only to fund increased coverage with the proceeds of the tobacco tax, but also to seize upon the opportunity to incorporate key elements of HIFA and the lessons learned from the success of CHP+ to improve the way services are delivered to current beneficiaries.

II. BACKGROUND

Colorado Medicaid Program

The Colorado Medicaid program covers low-income residents of Colorado who fit into one of the following categories: children, parents, pregnant women, the elderly and the disabled. Each group has specific income eligibility rules. For children ages 0-5 to be eligible for Medicaid their family's income must be less than 133% of the federal poverty level (FPL). Children 6-19 must come from families with an income less than 100% of the FPL to be eligible[5]. For parents to qualify for Medicaid they must have an income less than 36% of the FPL if they are not working and less than 39% of the FPL if they are working. Pregnant women are eligible for Medicaid if their income is less than 133% of the FPL[6]. The elderly and disabled who receive Supplemental Security Income (SSI) are also eligible for Medicaid if their income is less than 74% of the FPL[7]. Colorado does not have a Medically Needy program.

As of June 2003, approximately 340,000 Colorado residents were enrolled in Medicaid. This number represents a 10% increase in the number of enrollees over the previous year (in June 2002 there were approximately 309,000 people enrolled in Medicaid)[8]. The majority of people covered by Medicaid are children. In fiscal year 2001, 53.3% of Medicaid enrollees were children. The enrollment for other groups was as follows: adults (19.3%), the blind and disabled (15.7%), and the elderly (11.6%)[9].

In state fiscal year 2003, 18.3% of Colorado's state general fund expenditures, or $933 million[10], were Medicaid related. To put this number in perspective, Colorado's other state general fund expenditures include $2.3 billion on elementary and secondary schools, $754 million on higher education and $455 million on corrections[11]. Total state Medicaid expenditure for state fiscal year 2003 was $1.15 billion[12]. The federal matching rate for Colorado is currently 50%[13].

Colorado SCHIP Program

In the late 1990s the number of children in the United States without health insurance was growing. In 1997 Congress addressed this problem by enacting the State Children's Health Insurance Program (SCHIP) as Title XXI of the Social Security Act. SCHIP's goal was to provide health insurance for children whose family income was too high to be eligible for

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[5] The Henry J. Kaiser Family Foundation, "Colorado: Income Eligibility Levels for Children Under Medicaid, as a Percent of Federal Poverty Level (FPL), 2004", available at: http://statehealthfacts.org.
[6] Ibid.
[7] Ibid.
[8] Ellis, Eileen R, Smith, Vern K, and Rousseau, David M. "Medicaid Enrollment in 50 States: June 2003 Update," The Kaiser Commission on Medicaid and the Uninsured, available at http://www.kff.org/medicaid/upload/50178_1.pdf
[9] The Henry J. Kaiser Family Foundation, "Colorado: Distribution of Medicaid Enrollees by Enrollment Group, FY2001," available at http://statehealthfacts.org.
[10] The Henry J. Kaiser Family Foundation, "Distribution of State General Fund Expenditures, SFY2003," available at http://statehealth facts.org.
[11] Ibid.
[12] The Henry J. Kaiser Family Foundation, "Colorado: State Medicaid Expenditures SFY2003," available at http://statehealthfacts.org.
[13] The Henry J. Kaiser Family Foundation, "Colorado: Federal Matching Rate (FMAP) for Medicaid," available at http://statehealthfacts.org.

Medicaid, but not enough to make private insurance affordable. SCHIP offered states three ways to expand their health insurance coverage for children:

1. Expand Medicaid eligibility to children who previously did not qualify for the program;
2. Design a children's health insurance program entirely separate from Medicaid; or,
3. Combine the Medicaid and separate program options[14].

On October 14, 1997 Colorado submitted a Title XXI State Plan aimed at creating an insurance program separate from Medicaid. The plan proposed to expand on our existing state child health insurance program, the Colorado Child Health Plan (CCHP), to create an enhanced version of CCHP, called CHP+. CCHP was a health care reimbursement plan covering outpatient services only for low income Coloradans. CHP+ built on the infrastructure of CCHP, utilizing the statewide provider network established by CCHP to provide comprehensive health insurance for children ages 0-17 in families with incomes at or below 185% of the FPL. CHP+ expanded on CCHP to cover inpatient and outpatient hospitalization, physician services, prescription drugs and mental health care services. To be eligible for CHP+ children must not qualify for Medicaid.

Colorado's CHP+ program was approved on February 18, 1998. This made Colorado the third state to have its SCHIP program approved. Additionally, the approval of CHP+ marked the beginning of the first SCHIP program that was completely separate from Medicaid. Colorado's State Plan became effective on April 22, 1998.

Since the initial plan was approved there have been some important amendments to the Colorado State Plan. The first amendment was submitted on January 19, 1999 and expanded CHP+ to cover children up to age 19. On December 20, 2000 the second amendment was submitted. It eliminated premiums and implemented an annual enrollment fee for families with incomes between 151 and 185% of the FPL. Currently, these fees are $25 for one child and $35 for two or more children. The third amendment was submitted on December 27, 2000, to more accurately represent the manner in which benefits are delivered through the State's Managed Care Network and the Managed Care Organizations. Dental benefits were added to CHP+ with the fourth amendment, which became effective on February 1, 2002. Finally, Colorado submitted its fifth amendment on December 10, 2003. This amendment gave Colorado the authority to implement and revoke an enrollment freeze. On November 1, 2003, an enrollment freeze was put into place. It was lifted on July 1, 2004.

CHP+ enrollment grew rapidly in the first years after its implementation. During state fiscal year 1999 the average monthly enrollment (AME) in Colorado was 12,825 children. AME nearly doubled the following year, reaching 22,935 children. The average monthly enrollment of Colorado children in CHP+ continued to rise in each subsequent fiscal year, in which enrollment was capped at 52,965 due to budgetary constraints. The freeze was lifted on July 1, 2004 and the number of enrollees in fiscal year 2004 reflected the drop in enrollment due to attrition during the enrollment freeze[15].

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[14] Center for Medicare &Medicaid Services, "SCHIP Summary," available at http://www.cms.hhs.gov/schip/about-SCHIP.asp.
[15] Center for Medicare & Medicaid Services, "SCHIP Enrollment Reports", available at http://www.cms.hhs.gov/schip/enrollment/.

The expenditures on CHP+ for fiscal year 2003 totaled approximately $62.5 million. The enhanced federal matching rate is 65%, thus the breakdown of the state share and federal share was approximately $21.9 million and $40.6 million, respectively[16].

Another addition to the CHP+ program was the CHP+ Prenatal Care Program. With the approval of phase 1 of the HIFA waiver on September 27, 2002, Colorado added a program to CHP+ that provided health insurance to pregnant women. The CHP+ Prenatal Care Program extended Colorado's SCHIP program to cover prenatal and postnatal care for women ages 19 and over with incomes at or below 185% of the FPL. As with children, pregnant women must not qualify for Medicaid to be eligible for the CHP+ Prenatal Care Program. The program covers a variety of benefits including (but not limited to) all prenatal care, prescribed medication, labor and delivery, physicals and mental health services. If a woman is found to be eligible for the CHP+ Prenatal Care Program coverage begins once the application is completed and ends sixty days after birth. A HIFA Waiver amendment has been submitted to CMS to change the eligibility criteria for pregnant women under SCHIP to 200% FPL.

Although it was estimated that 3,400 women would be eligible for the program, during 2003 fiscal year the CHP+ Prenatal Care Program served only 600 women. This low enrollment reflected the fact that the program experienced a slow start-up and was suspended because of budget constraints. The benefit cost for the women in the CHP+ Prenatal Care Program was reported to be approximately $3 million in fiscal year 2003[17].

Program Issues

Colorado's health insurance programs for low-income families and children currently suffers from the following problems:

- Frequent changes in eligibility that result in movement back and forth from Medicaid to CHP+, and resulting discontinuities and inefficiencies in care;
- Unacceptably high utilization of emergency room and inpatient hospitalization services among Medicaid enrollees versus comparable CHP+ enrollees, even when adjusted for population differences; and
- Inability to secure an adequate number of Medicaid managed care plans

The bouncing in eligibility between Medicaid and CHP+ is considerable, and results in a high cost not only to the State but also to enrollees. The bouncing occurs because small variations in income will result in a change in eligibility between Medicaid and CHP+. Since many of these children are in families with hourly workers, their family's income is highly variable over the course of the year. Many of these wage earners are employed in temporary or seasonal jobs, and many are self employed at jobs with variable income. CHP+ has twelve month guaranteed eligibility while Medicaid has month to month eligibility. This exacerbates the bouncing as shown in a recent analysis of eligibility data. The report showed that in a recent 30-month period, there were 30,000 eligibility changes from SCHIP to Medicaid.

Historically, when a child became ineligible for either Medicaid or CHP+, and potentially eligible for the other, the family was notified that they were ineligible for their current program. The family would then have to apply for the other program, providing all relevant documentation, this process leads to gaps in coverage. With the implementation of the Colorado Benefits Management System, all eligibility determinations are in the same management information

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[16] "Children's Basic Health Plan Annual Report State Fiscal Year 2003", available at http://www.chcpf.state.co.us/HCPF/titlexxi/cbhpAddindex.asp
[17] Ibid.

system. As a child's eligibility changes, they are automatically screened for the other program, Medicaid or CHP+ respectively. However, as their eligibility changes, they are moved into a different delivery system, from CHP+ managed care, to Medicaid fee for service, to Medicaid managed care, and potentially, back into CHP+ managed care.

Even after coverage is secured under the other program for which they are eligible, the child is not assured of being enrolled in the same MCO or having the same providers available. If the child is receiving ongoing treatment for a medical condition, the treatment can be disrupted and he or she may need to start again with a new provider. Lastly, the benefit package is not the same between Medicaid and CHP+, so the child may have been receiving benefits for which he or she is no longer eligible. This creates a tremendous amount of confusion and disruption, not only for enrollees but also for providers.

Nationally, research on emergency room (ER) use reveals that children insured through Medicaid are more likely to visit the ER than privately-insured children. Studies have shown that much of this ER use by Medicaid children – 75% in one study -- is for routine care or "non-emergent" issues[18]. Additionally, other studies suggest that even some of the truly "emergent" cases could have been prevented, if children had had adequate access to primary care services[19]. Research has repeatedly shown that using the ER as a regular source of care results in poorer health outcomes, because it designed to handle emergencies and not chronic conditions. Because ER and inpatient settings are so costly and inefficient relative to primary care settings, payers around the country have experimented with strategies, programs and incentives to enhance primary care access and reduce unnecessary ER and inpatient use, with varying success[20,21,22].

To better understand the utilization patterns of Colorado Medicaid and CHP+ enrollees, the state commissioned a study by JEN Associates to compare health service use among low-risk children (e.g., children, ages 1-19, who do not have an SSI-eligible diagnosis) in both programs. The study controlled for income, health status, urban/rural residence, age of the child, and other factors in order to isolate how much of the observed utilization trends were attributable to Medicaid and CHP+ *program* differences versus underlying differences in the enrolled populations. Even after controlling for these factors, the study concludes that Medicaid children in fee-for-service programs show higher rates of ER use and inpatient acute care days, as compared to children enrolled in the CHP+ program. Currently, more than half of the Medicaid population is enrolled in a fee-for-service program.

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[18] Science Blog (May 2002) from University of Michigan Health System at: http://www.scienceblog.com/community/older/2002/B/20026248.html. Academic citation: Dombkowski KJ, Stanley R, Clark SJ. Influence of Medicaid managed care enrollment on emergency department utilization by children. Arch Pediatr Adolesc Med. 2004 Jan; 158(1):17-21.

[19] Falik M, Needleman J, Wells BL, Korb J. Ambulatory care sensitive hospitalizations and emergency visits: experiences of Medicaid patients using federally qualified health centers. Med Care. 2001 Jun; 39(6):551-61.

[20] Bindman AB, Chattopadhyay A, Osmond DH, Huen W, Bacchetti P. The impact of Medicaid managed care on hospitalizations for ambulatory care sensitive conditions. Health Serv Res. 2005 Feb; 40(1):19-38.

[21] Gadomski A, Jenkins P, Nichols M. Impact of a Medicaid primary care provider and preventive care on pediatric hospitalization. Pediatrics. 1998 Mar; 101(3):E1.

[22] Alessandrini EA, Shaw KN, Bilker WB, Perry KA, Baker MD, Schwarz DF. Effects of Medicaid managed care on health care use: infant emergency department and ambulatory services. Pediatrics. 2001 Jul; 108(1):103-10.

The JEN study also found that low-risk CHP+ children are more likely to have a visit with a general practitioner or a pediatrician, as compared to low-risk Medicaid children [23]. Although the study did not assess appropriateness of services in either program, the pattern of low primary care utilization and high ER and inpatient use among Medicaid clients is consistent with the national literature. In Colorado, this difference in utilization results in per member per month costs that are almost 17% lower in the CHP+ program relative to fee-for-service Medicaid for comparable children[24], despite the fact that provider payments rates in CHP+ are higher than in Medicaid. To the extent that some of this 17% difference in costs may be due to unnecessary ER and inpatient use, it creates an opportunity to both reduce costs and improve health, by improving access to primary care services.

Another historical issue the demonstration will address is Colorado's experience with managed care in the Medicaid program. Unlike the CHP+ program, Colorado Medicaid has been unable to secure a robust managed care presence in the Medicaid program. There are a number of reasons for this, including the inability of the State to provide an adequate volume of enrollees to many of the plans in order to spread the risk. Under the demonstration, a single set of MCOs will be competitively procured to serve CHP+ and the poverty-level parents, pregnant women, and children in Medicaid. By combining resources with CHP+, the Medicaid program will be able to reap the benefits of managed care at the same time that children in the two programs are assured of continuity of care when their eligibility situation changes.

The Department of Health Care Policy and Financing (HCPF) has spent the past two years researching the best way to design a seamless health insurance program for poverty-level children and families within Medicaid and CHP+ that will address the issues noted above. As a result of this research, the State is proposing to purchase health care services for these individuals from health plans using a business model well tested in the private sector and receiving acceptance among many publicly purchased state health care programs. This proposed approach will better serve children and families and improve the efficiency and effectiveness of the programs. The State will be able to serve additional low-income children and families through this initiative. The program is also intended to incorporate the HIFA initiative priorities of reducing the number of low-income Americans who lack health insurance while beginning to incorporate employer sponsored insurance (ESI) as a coverage vehicle.

[23] JEN Associates, Inc., *Comparative Analysis of Colorado Children Enrolled in the CHP+ and Medicaid Programs,* June 2004, p. 11.
[24] JEN Associates, Inc., *Comparative Analysis of Colorado Children Enrolled in the CHP+ and Medicaid Programs,* June 2004, p. 1.

III. DISCUSSION

This section provides details on Colorado's proposal and is organized into the following subsections:

- Eligibility, including populations included and excluded, and eligibility expansions
- Benefits, including a discussion of medical necessity and EPSDT services
- Cost Sharing
- Service Delivery System, including a discussion of value-based purchasing and employer sponsored insurance
- Grievances and Appeals
- Financing
- Timing/Phase-in
- Waiver and Demonstration Authorities
- Evaluation Plan

The intent of this section is to provide a discussion of the key components of the program and to be responsive to the specific questions raised by the Colorado General Assembly in the recently enacted SB05-221 (Appendix C).

Eligibility

Included Populations

The populations included in the restructuring initiative, Colorado Family Care, will include new eligibles and current eligibles in the following groups:

- Poverty-level Medicaid children;
- Pregnant women in Medicaid and CHP+;
- Children in CHP+; and
- Families eligible for Medicaid or CHP+[25].

Colorado Family Care will exclude the participation of foster care, adoption, SSI or children's waiver populations. It will also exclude income-eligible children who require institutional care.

Expansion Populations

Under Colorado Family Care, the State will expand eligibility for the following groups:

- Children with incomes from 185 to 200% of the FPL;
- Parents with incomes from 36 to 60% of the FPL, and
- To the extent of available funds, parents with incomes from 61% to 100% of the FPL.

Under this waiver Colorado will also continue the coverage of pregnant women with incomes between 133 and 185% of poverty that began with a HIFA waiver in 2002 and the extension of coverage to pregnant women with incomes from 185 to 200% of poverty that is occurring with an amendment to that waiver in 2005. Since this previous HIFA waiver is set to expire shortly after the requested start date of the new waiver, Colorado is seeking a single combined HIFA waiver that incorporates the provisions of the previous waiver for prenatal care.

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[25] In all cases, American Indians and Alaskan Native members of these eligibility groups are included in the initiative.

In the interest of expanding coverage as quickly as possible, coverage for the children is scheduled to begin July 1, 2005 via State Plan Amendments (SPA). Coverage for parents will begin under the demonstration on July 1, 2006. Coverage for pregnant women, with incomes from 186 to 200% FPL, has been requested from CMS through Amendment 1 of the above referenced 1115 HIA Waiver.

In addition, Medicaid eligibility for parents and children will be expanded with the removal of the asset test. The removal of the asset test will take effect October 1, 2005. The intent is for current CHP+ members who become eligible for Medicaid due to the removal of the asset test to remain in the CHP+ delivery system until the implementation of the HIFA waiver on July 1, 2006 (pending Federal approval).

Benefits

Definition of Medical Necessity

There is considerable variation from state to state as to how Medicaid and SCHIP programs define "medically necessary." A review of contracts between state Medicaid agencies and managed care organizations showed no two definitions of "medically necessary" that were exactly alike. The Medicaid Act's definition of medical necessity for EPSDT is much broader than that used by private insurance. Under EPSDT, state Medicaid programs must cover "necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services."

Colorado proposes to continue to use the Medicaid definition of "medical necessity" as outlined in the Code of Colorado Regulations Department of Health Care Policy and Financing Medical Services Board, Medical Assistance 8.205.11. Definitions (10 CCR Medical Assistance 8.205.11) as follows:

> "A covered service shall be deemed medically necessary if, in a manner consistent with accepted standards of medical practice, it:
>
> 1. Is found to be an equally effective treatment among other, less conservative or more costly treatment options, and
> 2. Meets at least one of the following criteria:
>   a. The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability or secondary disability;
>   b. The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental, cognitive or developmental effects of an illness, injury or disability;
>   c. The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability;
>   d. The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing Activities of Daily Living."

The use of this definition will serve to promote uniform and consistent administration of a streamlined program. The seamless nature and ease of administration have been stated goals in developing the operational framework for the streamlined program. Regardless of the way "medical necessity" is defined, it must be managed in such a way that is both effective and efficient so that enrollees can access appropriate health care services. Benefit administration can be significantly simplified by the development of a clear, quality-driven, cost-effective benefit

package. The impact of the recommended benefit design will decrease the need to continually manage a definition of "medical necessity" that is subject to variations in interpretation.

Benefit Enhancements

In addition to the eligibility expansions described above, there will be two important benefit enhancements under the demonstration:

- SCHIP children will receive enhanced treatment benefits, making the SCHIP benefit package more comparable to the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit; and
- Low-income parents will receive a package of preventive health services included in the Core benefits.

The benefit package for children is described below in the Benefit Restructuring subsection. Parents will receive the Core benefit package.

All eligibles in the various categories will receive the same benefits as other members of their group, regardless of whether they become eligible under the previous rules or the newly expanded eligibility rules. All benefit enhancements will take place after July 1, 2006 as the value-based purchasing initiative is phased in.

Benefit Restructuring

The cornerstone of the benefit design in the Colorado Family Care program is the classification of benefits for children into Core and Core Plus. Colorado is proposing that the program include a streamlined benefit package consisting of the sum of a Core benefit package and wrap-around benefits identified as Core Plus that would be available as an integrated program to income-eligible Medicaid and CHP+ children. The Core benefit package, which corresponds closely to CHP+ benefits, includes a set of services sufficiently comprehensive for all children and ensures access to appropriate health care services. Enrollees who require more extensive services beyond the limits described in the Core benefit package would receive Core Plus benefits.

The benefit package design reflects extensive data analysis which concluded that the CHP+ benefit limits were not exceeded in the comparable Medicaid population to any large degree[26]. The proposed Core benefit package also accounts for the exclusion of certain Medicaid members who qualify for services on the basis of their disability (SSI, children's waivers) or involvement with the foster care system (foster care, foster-adopt, IV-4E adoption) who will continue to receive services under the existing Medicaid health care purchasing model. The Medicaid and CHP+ enrollees considered for the streamlined program are predominantly low-risk and their health care needs generally include: preventive services, acute services for typical childhood illnesses and injuries; management of developmental, school-related psychosocial, and emotional problems; and the occasional use of specialty, emergency, or inpatient care. The Core benefit package features the following broad categories of covered benefits currently provided in both Medicaid and CHP+ and reflects each program's reliance on both the American Academy of Pediatrics periodicity schedule outlining the recommended age-appropriate clinician visits and the Advisory Committee on Immunization Practices (ACIP) recommended pediatric vaccines.

- Routine medical office visits

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[26] JEN Associates, Inc., "Comparative Analysis Colorado Children Enrolled in the CHP+ and Medicaid Programs", available at http://www.chcpf.state.co.us/HCPF/titlexxi/StatePlan.

- Preventive care (includes periodic and inter-periodic exams, immunizations, screening services)
- Maternity (prenatal care, delivery, post-partum care & inpatient well baby care)
- Prescription drugs
- Inpatient hospital
- Outpatient/ambulatory surgery
- Diagnostics, including 1) laboratory and x-ray and 2) MRI, nuclear medicine and other high tech services
- Emergency care
- Ambulance
- Urgent, non-routine after hours care
- Biologically-based mental illness care
- Other mental health care (inpatient – 45 full or 90 partial days per benefit year; outpatient – 20 visits per benefit year)
- Alcohol and substance abuse (limited to 20 outpatient rehabilitation days)
- Physical, occupational, and speech therapy (limited to 30 visits)
- Durable medical equipment (coverage limited to $2,000 maximum per benefit year, except for prosthetic devices, oxygen and insulin pumps and supplies, which are not subject to the maximum payment, but which do reduce the maximum payment of $2,000)
- Oxygen (not subject to a maximum payment but does reduce the maximum payment of $2,000 per benefit year for durable medical equipment)
- Organ transplants
- Home health care
- Hospice care
- Skilled nursing facility care
- Dental care
- Vision care
- Audiology services
- Kidney dialysis
- Intractable pain care
- Autism coverage
- Dietary counseling/nutritional services
- Case management

A more detailed description of the benefit package is included as Appendix D1 (physical health benefits) and D2 (oral health benefits). The matrix specifies the amount, duration and scope for selected categories of covered services. When the streamlined program is implemented, the Evidence of Coverage (EOC) will reflect the amount, duration and scope for all covered services including any utilization controls on services. For example, the EOC will address prior authorization requirements for treatment services as well as any tentative limits on services and the process that allows the child to go beyond the limits. Additionally, the EOC will describe those excluded services, such as those considered unsafe or experimental.

Oral Health

Oral health will be carved out and competitively bid on a statewide basis. All children in Colorado Family Care will access oral health benefits through the managed dental vendor. The oral health Core benefit will match the current CHP+ benefit for the inclusion in the waiver. Core Plus will include those additional medically necessary oral health services. The oral health Core benefit may be enhanced as final actuarial rates become available and in negotiation with

the oral health managed care organization. The results of an external evaluation of oral health Core benefits is available on the web site *http://www.chcpf.state.co.us*. The CHP+ benefit has a benefit maximum of $500 per calendar year. The report recommends that the final benefit maximum be determined after more extensive actuarial analysis but it does not recommend any substantive changes to the actual benefits. Colorado also recommends that once the benefit maximum is established, it have a cost of living adjustment built in to the benefit design to assure that the purchasing power of the benefit remain constant.

Behavioral Health

Under Colorado Medicaid, behavioral health services are carved out of the acute care program. All Medicaid recipients receive behavioral health services through a behavioral health organization (BHO) program that operates under Section 1915(b) authority. For adults, this will continue under the new program. However, some changes for children to more appropriately integrate medical and behavioral health care services will take place.

Colorado proposes to maintain the Core and Core Plus approach for children that is described throughout this waiver application. Children with special health care needs who meet the contractual requirements of the BHO program will access services through the BHO's. However, Colorado is committed to finding creative ways for meeting the unique developmental needs of children. Therefore, Colorado is proposing to add an early childhood developmental screening and triage component to the delivery system. Colorado proposes to work collaboratively with key members of the behavioral health, early childhood and public health provider and consumer communities to phase in this work over the next year as the waiver is being further analyzed and the operational plan developed.

Minimizing Barriers to Access

There are three important ways in which the demonstration will reduce barriers to access that are inherent in the current system.

First, the issue of eligibility bouncing between Medicaid and CHP+ creates access issues for children because they often experience:

- Gaps in coverage;
- Changes in health plans;
- Changes in providers; and
- Different benefit packages.

Colorado Family Care will offer children and families a seamless approach to health care delivery. Families will be enrolled continually in one program with the selected MCO and primary care provider. Children will be able to access a medical home consistently throughout the course of their coverage, minimizing disruptions in care that result from eligibility changes.

Secondly, the Medicaid managed care purchasing structure has been reported to exacerbate certain access barriers. The MCO's do not provide all benefits for which Medicaid children are eligible, potentially resulting in the family or provider having to negotiate the health care delivery system to receive the complete set of benefits. In Colorado Family Care, the MCO is responsible for arranging and managing both the Core and Core Plus benefit packages. In the paper by Johnson, the "rationale for implementing the streamlining project through a wrap-around model

includes purchasing, delivery system stability, primary care access, benefit management and operational considerations." Johnson recommends a series of operational requirements including

- Administering wrap-around benefits as a "package";
- Contracting for the administration of wrap-around services with the same plans that provide Core benefits; and
- Define clear boundaries between the Core benefit package and the wrap-around package[27].

The State has incorporated these recommendations in the program design and looks forward to working collaboratively with MCO's and providers to implement the most effective program which results in comprehensive care for children and early identification of children with special health care needs.

Finally, with the addition of Core Plus benefits to the CHP+ benefit package, children enrolled in SCHIP will have access to services that were previously not covered.

Early and Periodic Screening, Diagnosis and Treatment

As explained elsewhere, not only will Medicaid children continue to receive all early and periodic screening, diagnosis and treatment (EPSDT) services through the Core and Core Plus structure, but SCHIP children will also receive the equivalent of the full EPSDT services with the addition of Core Plus to the CHP+ benefit package. Please see description of the ESI component for a discussion of benefits for that limited program.

Cost Sharing

Colorado is not proposing any changes with respect to cost sharing for Medicaid or SCHIP direct coverage. However, in instances where families choose to receive their coverage through employer sponsored insurance (ESI) with premium assistance in a pilot program, the cost-sharing rules of the ESI coverage will apply. It is important to note that families will be given informed choice, including information about their potential cost-sharing liability, and they will be able to revert to direct coverage in the event the ESI policy no longer meets their needs (see below).

Service Delivery System

Value-based Purchasing

With the Colorado Family Care program, Colorado seeks to improve the state's procurement and management of its Medicaid and CHP+ managed care programs by implementing a strategy known as value-based purchasing (VBP). This approach to purchasing managed care and other services was first developed by large corporate purchasers of health insurance, but has now been used by public sector purchasers for several years.

The value-based purchasing circle on the next page depicts the ongoing, seven-step cycle that begins with the procurement of services and continues throughout the term of the contract.

Value-based purchasing requires a fundamental shift away from traditional state management of Medicaid fee-for-service programs, which historically focused on claims payment and processing.

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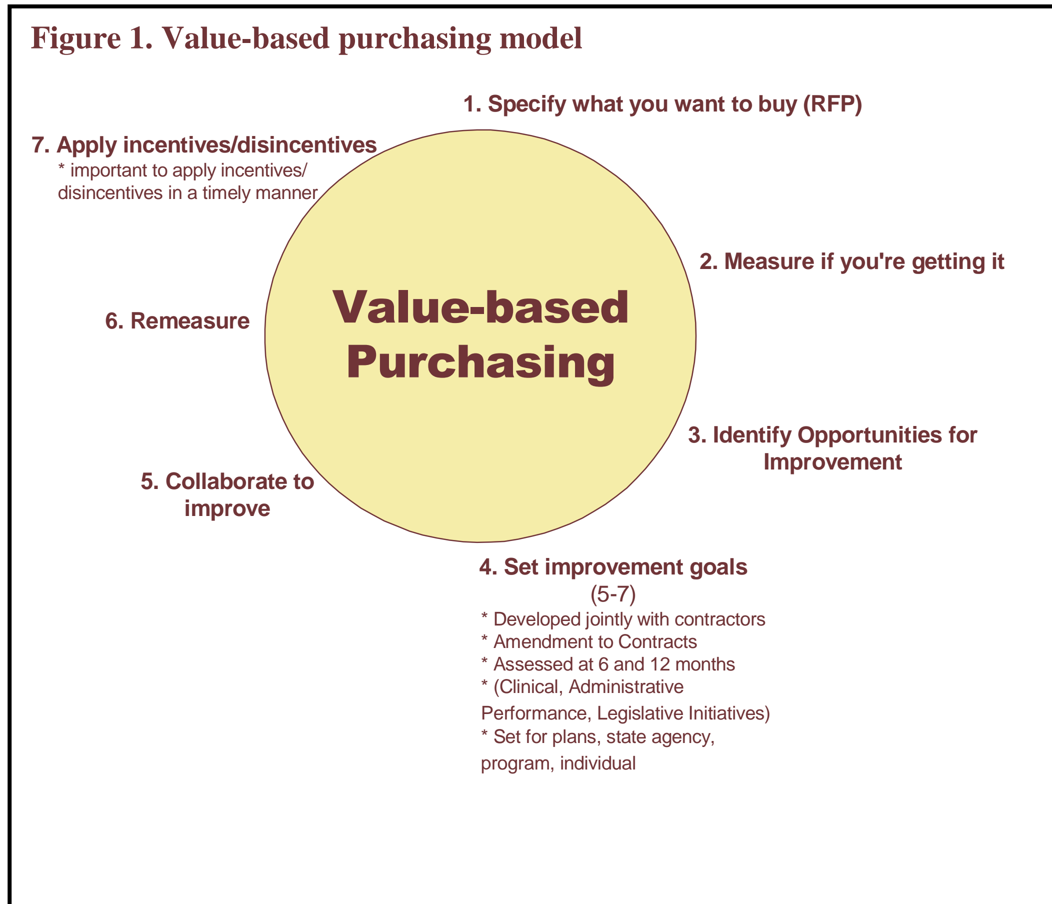
[27] Health Policy Solutions, Inc., "Purchasing Models for Children with Special Health Care Needs Streamlining Project Policy Options", available at http://www.chcpf.state.co.us/HCPF/titlexxi/StatePlan.

The new approach emphasizes a more strategic, focused approach to specifying data-based performance requirements, and to identifying clear consequences for both performances that exceeds expectations and sub-standard performance by contractors.

Contractors are held accountable not only for standard performance requirements, but also for performance improvements identified and achieved through a collaborative business relationship with the State.

Figure 1. Value-based purchasing model



Value-based purchasing also creates a strategic, clearly defined, improved and streamlined analytic approach to contract management. The Colorado Family Care procurement document, the evaluation criteria, the health plan contract, and the contract monitoring approach will be interconnected and based on the following four value-based purchasing components:

1. Purchasing specifications that clearly define the value that the State seeks to obtain from its Family Care contractors, both in terms of process and outcome measures;
2. Measurement systems and data reporting structures to assess whether the State is obtaining the value that it seeks;
3. A process for working with MCOs to identify opportunities for improvement and to collaborate on joint quality improvement activities; and
4. The application of rewards and penalties to provide contractors with clear consequences related to their performance to contract specifications.

The objectives of the State's value-based purchasing initiative in the Colorado Family Care program are as follows:

- Decrease the number of uninsured people in Colorado by expanding eligibility in a manner that provides better quality, and more cost-effective care to members;
- Support the development of a statewide, seamless health care system for non-disabled, children, pregnant women, and families participating in the Colorado Family Care program to eliminate disruptions in care when an individual's eligibility changes from Medicaid to CHP+ or vice versa;
- Promote access to quality primary and preventive care by providing Colorado Family Care members with a medical home and a choice of primary care providers; and by using a provider reimbursement methodology that encourages the provision and use of primary and preventive care services;
- Promote access to quality behavioral health care through an integrated medical and behavioral health model that meets the needs of Colorado Family Care members;
- Create efficiencies for the State and contracted health plans by streamlining and coordinating Medicaid and CHP+ managed care program administration
- Partner with safety-net providers and health plans to create stable relationships and provider networks that will meet the needs of Medicaid and CHP+ members now and in the future;
- Create better, data-based measurement and accountability on key health plan and program performance dimensions most important to the state and the members served by Colorado Family Care;
- Accelerate performance improvement by contracted health plans; and
- Recognize and reward excellence and improvement among contracted health plans, and apply disincentives when there is poor performance.

Managed Care Organization Procurement

In order to implement the streamlining initiative, Colorado will issue a request for proposal (RFP) for MCOs to serve the program population. One decision to be made is how to provide the greatest geographic coverage possible given the characteristics of the state. The size of the anticipated Colorado Family Care population (approximately 350,000 statewide) is relatively small compared to other state Medicaid and CHP+ managed care programs. The population in Colorado is highly concentrated with approximately half of the total state population in the greater Denver area and 84% in the eleven most-populous counties.

In light of these facts, Colorado will focus its capitated managed care purchasing strategy on the most populous counties. The state will include seven Core Service Areas (CSAs) for Colorado Family Care MCOs as follows:

- Denver (Denver, Adams, Jefferson, Arapahoe, Douglas);
- Boulder (Boulder, Broomfield);
- Larimer (Larimer);
- Weld (Weld);
- El Paso (El Paso, Teller);
- Pueblo (Pueblo); and
- Mesa (Mesa, Delta, Montrose).

To be considered as a potential bidder in the Denver CSA, Colorado will require bidders to bid on at least two service areas in addition to the Denver service area. The RFP evaluation criteria will favor bidders on the Denver CSA that are determined by the evaluation team to be qualified to serve two or more CSAs, other than the Denver CSA.

Colorado will allow for an exception to the minimum service area requirement for health plans that propose to operate solely in Denver county and are owned or operated by public hospitals in which at least 50% percent of patient admissions are uninsured or medically indigent patients or patients who are enrolled in Medicaid or CHP+. Colorado has consistently expressed its support for the safety net and its intent to develop Colorado Family Care in a way that strengthens safety net providers. Adding insured enrollees to safety net providers adds a consistent income stream.

In addition, Colorado will allow health plans to bid on any counties that are not included in a Core Service Area as Optional Service Areas (OSAs). Health plans will be restricted to bidding only on OSAs that are contiguous to a Core Service Area or to another OSA that the bidder is also proposing to serve.

Encouraging the Participation of New Managed Care Organizations

One of the goals of the streamlining initiative is to leverage the combined purchasing power of the Medicaid and CHP+ programs to strengthen the managed care presence in both programs. As part of the study process for the Colorado Family Care program, the State engaged a consulting firm to interview potential entrants to the managed care marketplace. One theme that emerged from the interviews is the need for an MCO to have at least 30,000 covered lives in order to assure success in the program. The service areas have been designed with this goal in mind. It is Colorado's hope that the combined purchasing strategy will prove successful in attracting new managed care plans to the State.

Network Adequacy

One key element of success is a robust provider network. Colorado is confident that the purchasing strategy to be employed under the demonstration will make is easier for individuals MCOs to secure appropriate provider networks to serve their enrollees. The following subsections on rates and provider burden also speak to program design elements that should foster the MCOs' ability to enlist a sufficient number of providers.

Dr. Steven Poole, MD, Executive Director of the Colorado Children's Healthcare Access Program ("A Medical Home for Every Child" Program) has recently completed two surveys of Colorado pediatricians, followed by focus groups and review by an expert panel to determine major reasons Colorado pediatricians are reluctant to provide care for Medicaid and CHP+ children. While the number one reason identified was poor reimbursement, the remaining eight reasons focused on the need for administrative simplification and clarity for the medical offices and psycho-social support for the families, including the availability of social workers, nurse educators/case managers and 24 hour telephone triage. The initial survey and planning process and the resultant development of sustainable models within private practices is being funded locally by the Piton Foundation and the Community Child Health Foundation.

Provider Reimbursement Rates

As explained in the background section, analysis has shown that the cost per child per month for low-risk children in Medicaid is 17% higher than in CHP+, despite higher physician rates in the CHP+ program. When the streamlining initiative is phased in, the proposed actuarial analysis will be performed for the entire group enrolled in Colorado Family Care, using common actuarial approaches to controlling for demographic differences (age and sex, for example) and the most

current financial data. The initial actuarial analysis completed for the waiver amendment and included in Appendix A used the CHP+ outpatient and physician approach to provider rates and projected that for the state's network. The State does not have access to the specific rates paid by MCO's to providers, due to the proprietary nature of the information. However, since the MCO medical costs are higher than Colorado's network, it can be hypothesized that there is adequate room in the rates for the MCO's to offer enhanced rates to physicians as a way to encourage changes in utilization patterns. The network hospital rates were projected using the Medicaid approach of reimbursing on a diagnosis related group (DRG) basis, as opposed to the current CHP+ approach of percent of charges. More specific information on the rate development is included in both the attached actuarial analysis and the budget development for the waiver (Attachment G, Appendix A).

Minimizing Burden on Providers

As noted in the background section, the eligibility bouncing between Medicaid and CHP+, coupled with the different structures of the program, creates situations where continuity of care is disrupted. In addition to the impact on beneficiaries, there is a huge impact on providers. The State has included primary care providers in the private and public sector in the planning for Colorado Family Care to assess the key issues that they are facing. They have supported the State's work to provide uniform benefits across the low income children and families categories and providing continuous enrollment in one delivery system for a specified period of time. Both of these approaches will minimize the administrative burden on provider's offices and their staffs. In conversations, they have also supported providing Core and Core Plus benefits through one administrative entity which enables the primary care physician to provide ongoing case management for the child as they move through various levels of treatment.

The State also intends to include in both the MCO RFP and contracts the requirement that MCOs meet specific administrative and medical care quality goals. A "Performance Indicator Dashboard" that identifies the key aspects of performance that will be monitored to ensure MCO accountability will enable the State to contract for specific performance and measure it consistently over time (Appendix E). The Dashboard is not an all-inclusive set of performance measures. Rather, the Dashboard assembles the performance indicators that assess many of the most important dimensions of MCO performance and identifies measures that when publicly shared will also serve to incentivize Colorado Family Care and health plan excellence.

Employer Sponsored Insurance

When Colorado legislators created the Child Health Plan Plus (CHP+) program to provide health insurance for low-income uninsured children, they intended the program to support employment-based health insurance in Colorado. The original CHP+ legislation, therefore, authorized the CHP+ program to create an employer buy-in option for eligible children. An employer buy-in program would allow eligible children with access to an employer health insurance plan to receive coverage through their employer plan instead of through CHP+ directly. In 2000, CHP+ administrators and stakeholders decided to evaluate the ability of an employer buy-in program to increase CHP+ enrollment and reduce program expenditures. Under grants from the Rose Community Foundation and the Robert Wood Johnson Foundation, the CHP+ Employer Buy-In

Feasibility Study was conducted to estimate the enrollment, administrative costs and savings that would be generated by an employer sponsored insurance (ESI) program[28].

The feasibility study analyzed Colorado household and employer survey data to estimate enrollment and savings of a CHP+ employer buy-in program. In addition, budget data from employer buy-in programs in other states were used to estimate administrative costs.

The study found that few CHP+ eligibles would be eligible for an employer buy-in program and that the administrative costs of the program would be high. Even if applicable federal regulations, at that time, were eliminated, a CHP+ employer buy-in program would enroll only 4,500 children and would require an annual administrative budget of over $1 million per year.

Colorado has committed to the Centers for Medicare & Medicaid Services (CMS) in the first phase of the HIFA waiver that it would develop an ESI program as one component of Phase II. Many of the burdens that were identified by Schulte in the 2001 paper still exist in Colorado. However, CMS has more recently approved ESI programs with fundamentally different configurations from that described in the earlier study. The State has worked with several of the currently contracted MCOs to determine the level of interest and the ability to provide an ESI program. At this point, the consultants hired to develop this component have proposed a small pilot program that would work with one or two large employers and two Colorado MCOs to develop an ESI program. A description of the pilot is attached (Appendix F).

While the pilot is still in the early states of development, there are some components that have been recommended:

- Under the pilot, approximately 200 individuals per year will receive premium assistance to pay for the employee share of an ESI premium;
- In order to qualify, the employer's plan must meet the minimum requirements of the Colorado Division of Insurance Standard Benefits package for small group coverage;
- The State will work with health plans and employers to develop a plan to attract parents of low-income children to enroll in premium assistance. Prior to developing the outreach materials, the State may hold focus groups with members of the target populations in order to better understand the challenges, barriers, and opportunities inherent in this effort;
- Eligible individuals will be given an informed choice between ESI and direct coverage so that they understand the implications in terms of benefits and cost sharing;
- No wraparound will be provided for either benefits or cost sharing, i.e., the family would choose to participate in the employers insurance program as it is available to any other worker within the participating company; and
- Colorado is requesting the necessary waivers to implement the program without wraparound. Beneficiaries will always have the option to return to direct coverage.

Grievances and Appeals

Eligibility

Colorado proposes to utilize the current Medicaid grievance and appeals process for the Colorado Family Care program. This would expand the appeals process for SCHIP (CHP+) recipients by making it consistent with the Medicaid requirements.

[28] Schulte, Sarah and Yondorf, Barbara, "Establishing a Colorado Health Insurance Employer Buy-in Program for Kids: Issues and Options A White Paper", Colorado Division of Insurance & Department of Health Care Policy and Finanicng, August 1999.

Benefits

Colorado proposes to utilize the current Medicaid grievance and appeals process for benefits with one modification: Consistent with federal law, Colorado will allow Colorado Family Care members to request a State Fair Hearing after exhausting the internal appeal process used by the MCO. Colorado's MCOs are regulated by the Colorado Division of Insurance (DOI) which has in place a grievance and appeal process. The Colorado Family Care program will require by contract that managed care organizations include the Division of Insurance grievance and appeal process for Colorado Family Care members. This component of the process is currently in place for the Colorado SCHIP program and has worked effectively as the initial steps in the appeal process. For CHP+ members the Colorado Family Care program will expand the appeal process to include a Fair Hearing after the DOI process has been exhausted.

Financing

Budget Assumptions for SCHIP

SCHIP Caseloads

The SCHIP budget assumes a significant caseload increase in the year prior to the waiver and in the first year of the waiver due to marketing of Colorado's SCHIP program (the Child Health Plan Plus, or CBH+) and expansion of eligibility from 185% of poverty to 200% of poverty for children and low-income pregnant women.

Children with incomes below 185% of poverty: Colorado has assumed that the planned marketing program will result in an increase in base SCHIP program enrollment of children with incomes below 185% of poverty of 24% in state fiscal year 2007, the first year of the waiver, and an increase of 7% in state fiscal year 2008, the second year of the waiver. For the last three years of the waiver, the waiver budgets assume an annual caseload increase of 4.5%.

Children that meet Medicaid income levels but not current Medicaid asset tests: Colorado is submitting a Medicaid state plan amendment to remove the Medicaid asset test for low-income children as of October 1, 2005. Current eligibility data indicate that 39.48% of current Colorado SCHIP enrollees meet Medicaid income tests, but not the Medicaid asset test. The SCHIP allotment neutrality budget assumes that by the beginning of the first year of the waiver, all of the children eligible for Medicaid under the current income thresholds will have moved from SCHIP to Medicaid funding.

Children with incomes between 185% and 200% of poverty: Colorado has amended its SCHIP State Plan to increase the SCHIP income threshold for children to 200% of poverty as of July 1, 2005. The SCHIP budget includes an estimate that an average of 4,462 children in this income group will be enrolled in SCHIP in state fiscal year 2007, the first year of the waiver, and an increase of 7% in state fiscal year 2008, the second year of the waiver. For the last three years of the waiver, the waiver budgets assume an annual caseload increase of 4.5%.

Pregnant Women between 133% and 185% of poverty: This waiver requests extension of eligibility for this group through June 30, 2011. Enrollment in this component of the Colorado SCHIP program has recently been re-opened. As a result, Colorado fiscal staff estimates an increase of 150% in the number of member months for prenatal care and the number of SCHIP-funded deliveries in the fiscal year prior to the waiver and a 30% increase in the first year of the

waiver. For last four fiscal years of the waiver, the budget assumes an annual caseload increase of 4.5%.

Pregnant Women between 185% and 200% of poverty: The existing SCHIP HIFA Waiver is being amended to extend eligibility to this group as of July 1, 2005. The Colorado Family Care waiver request includes an extension of eligibility for this population through June 30, 2011. The SCHIP budget assumes 349 deliveries and 3,127 month of prenatal care for the first year of this new coverage. The budget assumes an enrollment increase of 30% for the first year of the waiver and an annual caseload increase of 4.5% for the remaining four years of the waiver period.

SCHIP Cost Factors

Administration: The SCHIP budget assumes a 2.37% inflation factor for administrative costs for the base program. The budget also assumes that an evaluation of the waiver program with a total cost of $1.5 million will be split between Medicaid and SCHIP based on enrollment. About 12% of the total number of children enrolled in the streamlining initiative will be in the SCHIP component.

Baseline Benefit Costs: Both the Medicaid and SCHIP budgets are based on an assumption of annual increases in capitation rates of 8.4%. This represents the average annual increase in premiums for the Colorado Children's Basic Health Plan for the last five years, and is documented as an attachment to the SCHIP waiver budget.

Streamlining initiative: One aspect of the streamlining initiative is a single set of capitation rates for both Medicaid and SCHIP enrollees. While the streamlining initiative results in significant savings overall, the result is SCHIP rates that are on average 12.4% higher than the rates that would have existed without the streamlining initiative.

SCHIP Allotment

The SCHIP allotment neutrality document shows that with Colorado's current SCHIP allotments and carry-forward allotments from the last two years, there is sufficient funding for the SCHIP portion of the Colorado Family Care waiver through state fiscal year 2011, and sufficient allotment for the children's SCHIP program through the end of federal fiscal year 2011. The documents also show sufficient allotment surplus to enable Colorado to continue funding low-income pregnant women and to fund the streamlining initiative through the end of federal fiscal year 2011, which is three months beyond the end of the requested five-year waiver period.
The HIFA waiver does not allow Colorado to assume that there will be any redistribution of SCHIP allotments from other states during the entire five-year period of the waiver. Should expenses exceed the current estimates, Colorado will work with CMS to ensure that the total cost of the waiver does not exceed the available funding, including enrollment caps if necessary.
The SCHIP allotment neutrality document also demonstrates that the Colorado SCHIP program will have administrative costs, even with the waiver, that are significantly below the 10% federal cap on matchable administrative costs. In addition to the standard SCHIP allotment neutrality template, Colorado has provided support data on the caseload and cost assumptions included in the allotment neutrality calculations.

The five-year cost of the SCHIP component of this HIFA waiver is $42,014,813 for the streamlining initiative and $147,119,241 for coverage of pregnant women from 133 to 200% of the federal poverty level, for a total cost of $189,134,054.

Medicaid Budget Neutrality

Medicaid Caseload Assumptions

Since all of the Medicaid expansion groups are optional Medicaid eligible populations, the Medicaid budget for the Colorado Family Care waiver includes all of the new Medicaid enrollees in both the waiver budget and the estimated costs without the waiver.

Mandatory Low-Income Children: The waiver does not include children enrolled in SSI, Foster Care, or other special needs categories. The waiver budget assumes a 7.1% growth in the number of children enrolled in mandatory groups in the first year of the waiver. Enrollment is projected to increase by 8% per year for the last four years of the waiver due in part to the impact of outreach initiatives.

Children that meet mandatory Medicaid income levels but not current Medicaid asset tests: As noted above, Colorado is submitting a Medicaid state plan amendment to remove the Medicaid asset test for low-income children as of October 1, 2005. Current eligibility data indicate that 39.48% of current Colorado SCHIP enrollees meet Medicaid income tests, but not the Medicaid asset test. The Medicaid waiver budget assumes that by the end of the first year of the waiver, 22,187 children eligible for Medicaid under the current income thresholds will have moved from SCHIP to Medicaid funding. For the last four years of the waiver an annual enrollment increase of 8% is projected.

Parents with incomes between 36% and 60% of poverty: The Medicaid portion of the waiver budget assumes an annual increase in the penetration rate for low-income parent groups from 34% of eligibles in the first year of the waiver to 70% in the fifth year of the waiver. By the fifth year of the waiver the estimate for this group is 6,186 parents. The total state and federal cost of adding this group over the five years of the waiver is $88.3 million, of which the state share is 50%.

Parents with incomes between 61% and 100% of poverty: The Medicaid portion of the waiver budget assumes an annual increase in the penetration rate for low-income parent groups from 34% of eligibles in the first year of the waiver to 70% in the fifth year of the waiver. By the fifth year of the waiver the estimate for this group is 11,660 parents. The total state and federal cost of adding this group over the five years of the waiver is $166.4 million, of which the state share is 50%. The waiver includes a request that Colorado be able to cap enrollment in this group if enrollment exceeds available state revenues.

Medicaid Inflation Factors

Administration: The waiver budget also assumes that an evaluation of the waiver program with a total cost of $1.5 million will be split between Medicaid and SCHIP based on enrollment ratios for the streamlining initiative. The estimate is that about 88% of the children in the initiative will be Medicaid enrollees. In addition, the Medicaid portion of the waiver budget includes $2.5 million in the first year of the waiver for the cost of necessary information technology improvements. An additional administrative cost is the cost of contracted plan administration for the Self-Funded Managed Care component of the initiative. This cost is estimated at $15 per member per month and is included in the benefit costs as illustrated in the supporting data on the impact of streamlining. In addition to anticipated savings in medical costs due to plan

management, the budget assumes a savings from base administrative costs at 2.5% of medical costs for those children that would have been enrolled in fee-for-service Medicaid.

Baseline Benefit Costs: As noted above, both the Medicaid and SCHIP budgets are based on an assumption of annual increases in capitation rates of 8.4%, based on the trend in capitation rates for the last five years for the Children's Basic Health Plan.

Streamlining initiative: One aspect of the streamlining initiative is a single set of capitation rates for both Medicaid and SCHIP enrollees. The actuarial estimates for the streamlining initiative indicate significant savings to the Medicaid program, as shown on page 1 of the Medicaid budget neutrality document. The Medicaid savings for five years from the streamlining initiative total $132,098,036.

Medicaid Budget Neutrality Documents

Page 1 of the Medicaid budget neutrality document shows the total cost of physical and mental health care services for the waiver period for all of the groups that are part of the waiver. Page 1 indicates that the waiver will include substantial savings due to implementation of the streamlining initiative. By fiscal year 2011 the annual Medicaid savings are $36.1 million, of which the federal share is 50%.

Page 2 of the Medicaid budget neutrality document shows the Medicaid costs for the current and proposed optional Medicaid eligible groups without the streamlining initiative.

The Medicaid budget neutrality document also includes supporting data that was used to develop the waiver model and a summary of the impact of the streamlining initiative on per capita rates.

The total cost of the Medicaid component of the Colorado Family Health Care waiver for the five-year waiver period is estimated at $3,304,850,386, as shown on page 1 of the Medicaid budget neutrality document. The federal share of this amount is 50%.

When the Medicaid and SCHIP funds are combined, the total cost of the portions of the Colorado Medicaid and SCHIP programs that are included in the waiver cost in Colorado is $3,493,984,440. By the fifth year of the waiver, an average of 441,278 individuals will be enrolled in either the Medicaid or SCHIP component of the waiver.

Timing/Phase-in

The demonstration will be phased in as follows:

July 2005

- Children's expansion up to and including 200% FPL
- Pregnant women expansion up to and including 200% FLP

October 2005

- Removal of asset test (Medicaid SPA)

July 2006

- Parent eligibility expansion (Medicaid waiver)
- Add preventive benefits for parents (Medicaid waiver)
- Integration of the Medicaid and CHP+ MCOs
- Add Core Plus benefits to CHP+ (SCHIP waiver)
- Implement Core/Core Plus policies (procurement process)
- Mandatory enrollment of American Indians and Alaskan Natives (Medicaid waiver)
- Begin phase-in of ESI pilot (Medicaid and SCHIP waivers)

Waiver and Expenditure Authorities

In order to implement the demonstration, Colorado is requesting a number of following waiver and expenditure (also known as "costs not otherwise matchable") authorities. Waivers of certain provisions are permitted under section 1115(a) (1), while expenditure authority is granted under section 1115(a) (2).

The authorities that are being requested are organized below according to the various elements of the initiative to which they correspond.

Eligibility Expansion for Pregnant Women

- Expenditure authority for costs associated with providing coverage to individuals not otherwise eligible under a State child health plan (to the extent necessary to cover pregnant women with incomes from 185 to 200% of the FPL).

Benefit Enhancements (Preventive Services) for Low-Income Parents

- *Waiver of 1902(a) (10) (B) (Amount, Duration and Scope):* To the extent necessary to add a package of preventive services for low-income parents enrolled in Medicaid.

Benefit Enhancements (Core Plus) for Children Enrolled in CHP+

- *Waiver of 2103 (Benefit Package Requirements):* To the extent necessary to offer Core Plus benefits to SCHIP children, since this represents an enhancement of the benchmark equivalent package approved under the SCHIP State Plan.

Managed Care Streamlining

- *Waiver of 1902(a) (23) (Freedom of Choice):* To the extent necessary to mandate enrollment of American Indians and Alaskan Natives in MCOs.
- Expenditure authority for payments to managed care organizations that would not otherwise be allowable under Section 1903 because the requirement for choice of managed care organizations in Section 1932(a) (3) (A).

Employer-Sponsored Insurance Initiative

- *1902(a) (10) (B) (Amount, Duration and Scope):* To the extent necessary to allow for a choice between ESI and direct coverage for low-income adults and children in Medicaid with no wrap-around.
- *1902(a) (43) (A) (EPSDT):* To the extent necessary to permit voluntary enrollment of children in ESI plans that do not offer the full EPSDT benefit.
- *2103 (Benefit Package Requirements):* To the extent necessary to permit enrollment of children in ESI plans that do not meet the benefit package requirements of Title XXI with no wrap-around.
- *2103(e) (Cost Sharing Requirements):* To the extent necessary to permit voluntary enrollment of SCHIP children in ESI policies whose cost-sharing requirements exceed the Title XXI limits
- Expenditure authority under Medicaid for costs associated with providing premium assistance to Medicaid eligibles that voluntarily enroll in ESI plans that exceed the cost-sharing limits of the Medicaid program.

Evaluation Plan

Under SB05-221, the state legislation directing the Department of Health Care Policy and Financing to seek approval for the demonstration, the State Auditor's Office will conduct an independent evaluation of the demonstration.

The goal of the evaluation will be to quantitatively measure the effects of the program, and to determine whether changes should be made. Examples of the effects to be measured include:

- The number of new recipients in Medicaid and CHP+ who would not have been eligible for benefits in the absence of the demonstration;
- The length of time recipients in the demonstration remain enrolled in medical assistance, compared to recipients not included in the demonstration;
- Utilization of primary and preventive care, emergency department, and inpatient hospital services amongst demonstration participants;
- EPSDT utilization and procedures for making beneficiaries aware of the availability of these services;
- The rate of provider participation and reasons for any increase or decrease in participation;
- Access to care in all geographic areas of the State;
- Patient and provider satisfaction with respect to behavioral health services in the five BHO regions of the State;
- Availability and utilization of grievance and appeal procedures for beneficiaries included in the demonstration as well as those excluded from the demonstration;
- Any changes in health outcomes for demonstration participants; and
- The impact of the premium assistance pilot on beneficiaries' ability to access services.

STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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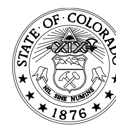

Bill Owens
Governor

Karen Reinertson
Executive Director

Health Insurance Flexibility and Accountability (HIFA) 1115 Demonstration

Proposal Application

July 01, 2005

"The mission of the Department of Health Care Policy & Financing is to purchase cost-effective health care for qualified, low-income Coloradans."

http://www.state.co.us/gov_dir/chcpf/index.html

Application Template for Health Insurance Flexibility and Accountability (HIFA) §1115 Demonstration Proposal

The State of Colorado Department of Health Care Policy and Financing proposes a section 1115 demonstration entitled Colorado Family Care, which will increase the number of individuals with health insurance coverage and provide enhanced benefits to State Children's Health Insurance Program (SCHIP) children and low-income parents of Medicaid and SCHIP children.

I. General Description of Program

The Colorado Family Care program, which is scheduled to begin on July 1, 2006, will provide health insurance coverage to an additional 21,240 residents of the State of Colorado with incomes at or below 200% of the Federal poverty level in year five of the demonstration. The increased coverage will be funded with both Medicaid and SCHIP funds.

II. Definitions

Income: In the context of the HIFA demonstration, income limits for coverage expansions are expressed in terms of gross income, excluding sources of income that cannot be counted pursuant to other statutes (such as Agent Orange payments.)

Mandatory Populations: Refers to those eligibility groups that a State must cover in its Medicaid State Plan, as specified in Section 1902(a)(10) and described at 42 CFR Part 435, Subpart B. For example, States currently must cover children under age 6 and pregnant women up to 133 percent of poverty.

Optional Populations: Refers to eligibility groups that can be covered under a Medicaid or SCHIP State Plan, i.e., those that do not require a section 1115 demonstration to receive coverage and who have incomes above the mandatory population poverty levels. Groups are considered optional if they can be included in the State Plan, regardless of whether they are included. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C. Examples include children covered in Medicaid above the mandatory levels, children covered under SCHIP, and parents covered under Medicaid. For purposes of the HIFA demonstrations, Section 1902(r)(2) and Section 1931 expansions constitute optional populations.

Expansion Populations: Refers to any individuals who cannot be covered in an eligibility group under Title XIX or Title XXI and who can only be covered under Medicaid or SCHIP through the section 1115 waiver authority. Examples include childless non-disabled adults under Medicaid.

Private health insurance coverage: This term refers to both group health plan coverage and health insurance coverage as defined in section 2791 of the Public Health Service Act.

III. HIFA Demonstration Standard Features

Please place a check mark beside each feature to acknowledge agreement with the standard features.

__X__ The HIFA demonstration will be subject to Special Terms and Conditions (STCs).

__X__ Federal financial participation (FFP) will not be claimed for any existing State-funded program. If the State is seeking to expand participation or benefits in a State-funded program, a maintenance of effort requirement will apply.

__X__ Any eligibility expansion will be statewide, even if other features of the demonstration are being phased-in.

__X__ HIFA demonstrations will not result in changes to the rate for Federal matching payments for program expenditures. If individuals are enrolled in both Medicaid and SCHIP programs under a HIFA demonstration, the Medicaid match rate will apply to FFP for Medicaid eligibles, and the SCHIP enhanced match rate will apply to SCHIP eligibles.

__X__ Premium collections and other offsets will be used to reduce overall program expenditures before the State claims Federal match. Federal financial payments will not be provided for expenditures financed by collections in the form of pharmacy rebates, third party liability or premium and cost sharing contributions made by or on behalf of program participants.

__X__ The State has utilized a public process to allow beneficiaries and other interested stakeholders to comment on its proposed HIFA demonstration.

IV. State Specific Elements

A. Upper income limit

The upper income limit for the eligibility expansion under the demonstration is 200 percent of the FPL. Colorado will utilize income disregards currently in place for Medicaid and SCHIP as approved in their respective State Plans.

If the upper income limit is above 200 percent of the FPL, the State will demonstrate that focusing resources on populations below 200 percent of the FPL is unnecessary because the State already has high coverage rates in this income range, and covering individuals

above 200 percent of the FPL under the demonstration will not induce individuals with private health insurance coverage to drop their current coverage. (Please include a detailed description of your approach as Attachment A to the proposal.)

B. Eligibility

Please indicate with check marks which populations you are proposing to include in your HIFA demonstration.

Mandatory Populations (as specified in Title XIX.)

__X__ Section 1931 Families

_____ Blind and Disabled

_____ Aged

__X__ Poverty-related Children and Pregnant Women

Optional Populations (included in the existing Medicaid State Plan)

Categorical

__X__ Children and pregnant women covered in Medicaid above the mandatory level

__X__ Parents covered under Medicaid

_____ Children covered under SCHIP

_____ Parents covered under SCHIP

_____ Other (please specify)

Medically Needy

_____ TANF Related

_____ Blind and Disabled

_____ Aged

__X__ Title XXI children (Separate SCHIP Program)

_____ Title XXI parents (Separate SCHIP Program)

Additional Optional Populations (not included in the existing Medicaid or SCHIP State Plan.) If the demonstration includes optional populations not previously included in the State Plan, the optional eligibility expansion must be statewide in order for the State to include the cost of the expansion in determining the annual budget limit for the demonstration.)

Populations that can be covered under a Medicaid or SCHIP State Plan

_____ Children above the income level specified in the State Plan
This category will include children from _____percent of the FPL through _____percent of the FPL.

_____ Pregnant women above the income level specified in the State Plan
This category will include individuals from _____percent of the FPL through _____percent of the FPL.

__X__ Parents above the current level specified in the State Plan
This category will include individuals from 32 percent of FPL to at least 60 percent of the FPL.

Existing Expansion Populations

Populations that are not defined as an eligibility group under Title XIX or Title XXI, but are already receiving coverage in the State by virtue of an existing section 1115 demonstration.

_____ Childless Adults (This category will include individuals from _____percent of the FPL through _____percent of the FPL.)

__X__ Pregnant Women in SCHIP (This category will include individuals from __134_percent of the FPL through _200__percent of the FPL.)

______ Other. Please specify:____
____
____
____

(If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

New Expansion Populations

Populations that are not defined as an eligibility group under Title XIX or Title XXI, and will be covered only as a result of the new HIFA demonstration.

_____ Childless Adults (This category will include individuals from _____percent of the FPL through _____percent of the FPL.)

_____ Pregnant Women in SCHIP (This category will include individuals from _____percent of the FPL through _____percent of the FPL.)

______ Other. Please specify: ____
____
____
____

(If additional space is needed, please include a detailed discussion as Attachment B to your proposal and specify the upper income limits.)

C. Enrollment/Expenditure Cap

_____ No

__X__ Yes

(If Yes) Number of participants ________or dollar limit of demonstration _______(Express dollar limit in terms of total computable program costs.)

The parent expansion group above 60% of FPL will be capped based on available state appropriations.

Note: While there will not be a hard dollar cap on available federal funds for the demonstration, the number of parents with incomes above 60% of the FPL may need to be capped based on available state appropriations.

D. Phase-in

Please indicate below whether the demonstration will be implemented at once or phased in.

_____ The HIFA demonstration will be implemented at once.

__X__ The HIFA demonstration will be phased-in.

If applicable, please provide a brief description of the State's phase-in approach (including a timeline):

Because the streamlining initiative will be connected to a competitive procurement, this element of the demonstration will be phased in according to the procurement schedule. In addition, the ESI pilot will be phased in.

E. Benefit Package

Please use check marks to indicate which benefit packages you are proposing to provide to the various populations included in your HIFA demonstration.

1. Mandatory Populations

__X__ The benefit package specified in the Medicaid State Plan as of the date of the HIFA application. *In addition, poverty-level parents covered under the Medicaid State Plan will receive an enhanced package of preventive benefits.*

2. Optional populations included in the existing Medicaid State Plan

__X__ The same coverage provided under the State's approved Medicaid State plan *(plus enhancement).*

______ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State

_____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))

_____ A health benefits coverage plan that is offered and generally available to State employees

_____ A benefit package that is actuarially equivalent to one of those listed above

_____ Secretary approved coverage. (The proposed benefit package is described in Attachment D.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

3. SCHIP populations, if they are to be included in the HIFA demonstration

States with approved SCHIP plans may provide the benefit package specified in Medicaid State plan, or may choose another option specified in Title XXI. (If the State is proposing to change its existing SCHIP State Plan as part of implementing a HIFA demonstration, a corresponding plan amendment must be submitted.) SCHIP coverage will consist of:

_____ The same coverage provided under the State's approved Medicaid State plan.
______ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
_____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
_____ A health benefits coverage plan that is offered and generally available to State employees
__X__ A benefit package that is actuarially equivalent to one of those listed above *(plus enhanced benefits.*
_____ Secretary approved coverage.

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

2. New optional populations to be covered as a result of the HIFA demonstration

__X__ The same coverage provided under the State's approved Medicaid State plan
(plus enhanced preventive benefits).
______ The benefit package for the health insurance plan this is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State
_____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
_____ A health benefits coverage plan that is offered and generally available to State employees
_____ A benefit package that is actuarially equivalent to one of those listed above
_____ Secretary approved coverage. (The proposed benefit package is described in Attachment D.)

Note: For Secretary approved coverage, benefit packages must include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

5. Expansion Populations – States have flexibility in designing the benefit package, however, the benefit package must be comprehensive enough to be consistent with the goal of increasing the number of insured persons in the State. The benefit package for this population must include a basic primary care package, which means health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician. With this definition states have flexibility to tailor the individual definition to adapt to the demonstration intervention and may establish limits on the types of providers and the types of services. Please check the services to be included.

_____ Inpatient

_____ Outpatient

_____ Physician's Surgical and Medical Services

_____ Laboratory and X-ray Services

_____ Pharmacy

_____ Other (please specify)

Please include a detailed description of any Secretary approved coverage or flexible expansion benefit package as Attachment C to your proposal. Please include a discussion of whether different benefit packages will be available to different expansion populations.

F. Coverage Vehicle

Please check the coverage vehicle(s) for all applicable eligibility categories in the chart below (check multiple boxes if more than one coverage vehicle will be used within a category):

Eligibility Category	Fee-For-Service	Medicaid or SCHIP Managed Care	Private health insurance coverage	Group health plan coverage	Other (specify)
Mandatory		X	X		
Optional – Existing		X	X		
Optional – Expansion		X	X		
Title XXI – Medicaid Expansion					
Title XXI – Separate SCHIP		X	X		
Existing section 1115 expansion					
New HIFA Expansion (existing)		X			

Please include a detailed description of any private health insurance coverage options as Attachment D to your proposal.

G. Private health insurance coverage options

Coordination with private health insurance coverage is an important feature of a HIFA demonstration. One way to achieve this goal is by providing premium assistance or "buying into" employer-sponsored insurance policies. Description of additional activities may be provided in Attachment D to the State's application for a HIFA demonstration. If the State is employing premium assistance, please use the section below to provide details.

__X__ As part of the demonstration the State will be providing premium assistance for private health insurance coverage under the demonstration. Provide the information below for the relevant demonstration population(s):

The State elects to provide the following coverage in its premium assistance program: (Check all applicable, and describe benefits and wraparound arrangements, if applicable, in Attachment D to the proposal if necessary. If the State is offering different arrangements to different populations, please explain in Attachment D.)

____ The same coverage provided under the State's approved Medicaid plan.

____ The same coverage provided under the State's approved SCHIP plan.

____ The benefit package for the health insurance plan that is offered by an HMO, and has the largest commercial, non-Medicaid enrollment in the State.

____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))

____ A health benefits coverage plan that is offered and generally available to State employees.

____ A benefit package that is actuarially equivalent to one of those listed above (please specify).

__X__ Secretary-Approved coverage.

____ Other coverage defined by the State. (A copy of the benefits description must be included in Attachment D.)

__X__ The State assures that it will monitor aggregate costs for enrollees in the premium assistance program for private health insurance coverage to ensure that costs are not

significantly higher than costs would be for coverage in the direct coverage program. (A description of the Monitoring Plan will be included in Attachment D.)

__X__ The State assures that it will monitor changes in employer contribution levels or the degree of substitution of coverage and be prepared to make modifications in its premium assistance program. (Description will be included as part of the Monitoring Plan.)

H. Cost Sharing

Please check the cost sharing rules for all applicable eligibility categories in the chart below:

Eligibility Category	Nominal Amounts Per Regulation	Up to 5 Percent of Family Income	State Defined
Mandatory	X		
Optional – Existing (Children)	X		
Optional – Existing (Adults)	X		
Optional – Expansion (Children)	X		
Optional – Expansion (Adults)	X		
Title XXI – Medicaid Expansion			
Title XXI – Separate SCHIP		X	
Existing section 1115 Expansion			
New HIFA Expansion			

Cost-sharing for children
Only those cost-sharing amounts that can be attributed directly to the child (i.e. co-payments for the child's physician visits or prescription drugs) must be counted against the cap of up to five percent of family income. Cost-sharing amounts that are assessed to a family group that includes adults, such as family premiums, do not need to be counted as 'child cost-sharing' for the purposes of the up to five percent cost-sharing limit. A premium covering only the children in a family must be counted against the cap.

Below, please provide a brief description of the methodology that will be used to monitor child-only cost-sharing expenses when the child is covered as part of the entire family and how those expenses will be limited to up to five percent of the family's income.

Any State defined cost sharing must be described in Attachment E. In addition, if cost sharing limits will differ for participants in a premium assistance program or other private health insurance coverage option, the limits must be specified in detail in Attachment E to your proposal.

V. Accountability and Monitoring

Please provide information on the following areas:

1. Insurance Coverage

The rate of uninsurance in your State as of 2001 for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project.

Current Status of Health Insurance Coverage
The current status of access to health insurance coverage in the State.

Colorado is a study in contrasts. Each of the state's geographic regions faces unique challenges in insuring its residents. Although Colorado is a very rural state, with 31 of its 64 counties classified as frontier (five or fewer people per square mile), 85% of the state's population lives in the metropolitan areas along the Front Range. Colorado's mountain communities employ seasonal and part-time workers who live just above the federal poverty level. Colorado's eastern plains of farmland and prairie merge into the more densely populated Front Range metropolitan area at the base of the Rocky Mountains. Substantial pockets of poverty remain on the Front Range, where there are 12 federally designated Enterprise Communities. The western slope and southern counties are home to the majority of the state's ranches and fruit orchards that employ seasonal and part-time workers.

Access to health insurance varies dramatically across Colorado depending on where one lives; family income level; the nature of one's work; and the size of one's employer. Among Colorado workers, the highest rates of uninsurance are in the construction industry (33.3%), followed by personal services/entertainment 29%; retail/wholesale trade 21.8%; business/repair services 16.3%; mining/manufacturing 15.8%; professional services 10%; transportation/ communications/utilities 9.7%; finance/insurance/real estate 9.4%; and government 3.1%.[1]

The current structure and composition of the health insurance market in Colorado presents challenges and opportunities for the state for increasing access to coverage. Specific key characteristics and trends in Colorado are:

- A strong skew towards small groups, with an average group size of 10.
- Significant contraction in the marketplace. For example:
  - The number of groups decreased 15% between December 2001 and December 2002 from 65,590 to 55,607, representing 43,308 people.
  - A wave of mergers, consolidations and carriers exiting the state

[1] Colorado Coalition for the Medially Underserved. 2001 Colorado Health Data Book.

has left only 10 carriers serving 92% of the market.
  - Five carriers dropped out of the small-group market, reducing the number of carriers from 30 to 25 between 2001 and 2002.
- Preferred provider plans (PPO) make up 45% of the market and are increasing their enrollment.
- Health maintenance organizations (HMO) make up 53% of the market, and their enrollment is decreasing. From the end of 2001 through June 2003, Colorado HMOs lost 22% of their membership.2 Only two HMOs serve the state's Medicaid program, and one of those is on a full-risk basis. By contrast, as late as 2002, five health plans were serving Medicaid.
- Increase in self-insuring large groups.
- A decreased presence of the Small Group Market Basic and Standard health benefit plans from 2001 to 2002. 77% of small employers chose plans other than basic or standard plans.

The current rate of uninsurance and a description of the State's uninsured.

Compared to other states, Colorado has among the highest rates of uninsurance for its low-income, non-elderly population (37.4% versus 34.2% nationally).[3] Nearly 700,000 Coloradans are uninsured (15.8% of the population).[4] Children represent 23.7% of the state's uninsured population with working adults representing 76%.[5] It is estimated that between 11% and 14% of Colorado children (those under 18 years) are uninsured.[6] Colorado's Hispanic population is disproportionately uninsured: One in four Latino people lack coverage.[7] Hispanic children account for nearly 30% of all uninsured children.[8]

More than two-thirds of Coloradans rely on the private insurance market for health insurance coverage.[9] Yet three-quarters of the uninsured live in families where there is at least one full-time worker. The major reason Coloradans don't have health insurance is because they can't afford it. Studies show that Coloradans generally cannot afford coverage until their incomes approach 250% of the federal poverty level.[10] The average monthly cost for employee-only coverage under the Colorado Standard Health Benefit Plan for a 36-year-old Denver employee was $163 for HMO coverage and $243 for PPO coverage as of September 2000.[11] To control costs, many employers have increased

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[2] Fletcher, Amy. "Employers battle ever-rising cost of health care." *Denver Business Journal*, December 29, 2003.
[3] Hoffman, Catherine and Mary Pohl, "Health Insurance Coverage in America-1999 Data Update," The Kaiser Commission on Medicaid and the Uninsured, Table 15, December 2000.
[4] Colorado Coalition for the Medically Underserved, (2003). *Moving Towards Substantial Reform: Health Care Coverage for All Coloradans*. February 2003.
[5] Ibid at 1.
[6] Ibid at 1.
[7] Ibid at 1.
[8] Ibid at 1.
[9] Ibid at 1.
[10] Glazner, J. (2000). *Prices and Affordability of Health Insurance for Colorado's Uninsured Population*. Colorado Coalition for the Medically Underserved. July 2000.
[11] 2000 Small Group Health Insurance Premiums for Colorado, Colorado Division of Insurance, 2001. Website: http://www.dora.state.co.us/Insurance/consumer.

employee contributions for coverage, and raised deductible, coinsurance or copay amounts. High rates of uninsurance exist among full-time employees that work for small businesses. Twenty-six percent of people working for a Colorado business with fewer than 25 employees are uninsured.[12]

The cost of health insurance in Colorado is rising faster than in other parts of the country.[13] This marks the fifth consecutive year in which a majority of Colorado members in the National Federation of Independent Business (membership is comprised of 60% of Colorado's small business) has had 20% increases in their insurance premiums.

Eligibility requirements to participate in employer plans are also limiting access. While 90% of full-time, private-sector workers in Colorado have an employer who offers coverage, only 79.1% of those employees are actually eligible for their employer's plan. Thus, just 71.9% of full-time workers have access to coverage through their employer. Employer coverage for part-time employees is extremely limited: Only 23.4% of part-time, private-sector employees in Colorado work for an employer who offers health coverage.

About 30% of Coloradans whose incomes are under 200% of the federal poverty level get coverage through public insurance programs[14]. One in eight (12.8%) Colorado children are covered under a public health insurance program.

The coverage rates in your State for the insurance categories for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project -

Private Health Insurance Coverage Under a Group Health Plan _
See above discussion.______________________________________

Other Private Health Insurance Coverage ________________________

Medicaid (please separately identify enrollment in any section 1906 or section 1115 premium assistance)

____

____

SCHIP (please separately identify any premium assistance)

____

[12] Ibid at 1.

[13] Fletcher, Amy, *Employers "*Battle ever-risking cost of health care". *Denver Business Journal*, December 29, 2003.

[14] "*Profile of the Uninsured in Colorado*" November 2004. Colorado Health Institute

Medicare ____

Other Insurance ____

Indicate the data source used to collect the insurance information presented above (the State may use different data sources for different categories of coverage, as appropriate):

__X__ The Current Population Survey

_____ Other National Survey (please specify_____)

_____ State Survey (please specify_____)

_____ Administrative records (please specify_____)

_____ Other (please specify_____)

Adjustments were made to the Current Population Survey or another national survey.

_____ Yes _____ No

If yes, a description of the adjustments must be included in Attachment F.

A State survey was used.

_____ Yes _____ No

If yes, provide further details regarding the sample size of the survey and other important design features in Attachment F.

If a State survey is used, it must continue to be administered through the life of the demonstration so that the State will be able to evaluate the impact of the demonstration on coverage using comparable data.

2. State Coverage Goals and State Progress Reports

The goal of the HIFA demonstration is to reduce the uninsured rate. For example, if a State was providing Medicaid coverage to families, a coverage goal could be that the State expects the uninsured rate for families to decrease by 5 percent. Please specify the State's goal for reducing the uninsured rate:

To provide coverage to an additional 21,240 residents of the State of Colorado with incomes at/or below 200% of the Federal poverty level.

Attachment F must include the State's Plan to track changes in the uninsured rate and trends in sources of insurance as listed above. States should monitor whether there are unintended consequences of the demonstration such as high levels of substitution of private coverage and major decreases in employer contribution levels. (See the attached Special Terms and Conditions.)

__X__ Annual progress reports will be submitted to CMS six months after the end of each demonstration year which provide the information described in this plan for monitoring the uninsured rate and trends in sources of insurance coverage.

States are encouraged to develop performance measures related to issues such as access to care, quality of services provided, preventative care, and enrollee satisfaction. The performance plan must be provided in Attachment F.

VI. PROGRAM COSTS

A requirement of HIFA demonstrations is that they not result in an increase in federal costs compared to costs in the absence of the demonstration. Please submit expenditure data as Attachment G to your proposal. For your convenience, a sample worksheet for submission of base year data is included as part of the application packet.

The base year will be trended forward according to one of the growth rates specified below. Please designate the preferred option:

_____ Medical Care Consumer Price Index, published by the Bureau of Labor Statistics. (Available at http://stats.bls.gov.) The Medical Care Consumer Price Index will only be offered to States proposing statewide demonstrations under the HIFA initiative. If the State chooses this option, it will not need to submit detailed historical data.

__X__ Medicaid-specific growth rate. States choosing this option should submit five years of historical data for the eligibility groups included in the demonstration proposal for assessment by CMS staff, with quantified explanations of trend anomalies. A sample worksheet for submission of this information is included with this application package. The policy for trend rates in HIFA demonstrations is that trend rates are the lower of State specific history or the President's Budget Medicaid baseline for the eligibility groups covered by a State's proposal. This option will lengthen the review time for a State's HIFA

proposal because of the data generation and assessment required to establish a State specific trend factor.

The State estimates the cost of this program will be $ 3,493,984,440.00 over its five-year approval period.

VII. WAIVERS AND EXPENDITURE AUTHORITY REQUESTED

A. Waivers

The following waivers are requested pursuant to the authority of section 1115(a)(1) of the Social Security Act (Please check all applicable):

Title XIX:

____ **Statewideness 1902(a)(1)**

To enable the State to phase in the operation of the demonstration.

__X__ **Amount, Duration, and Scope 1902(a)(10)(B)**

To permit the provision of different benefit packages to different populations in the demonstration. Benefits (i.e., amount, duration and scope) may vary by individual based on eligibility category.

To the extent necessary to add preventive health services for low-income parents, and to allow eligible individuals to choose employer-sponsored insurance instead of direct coverage and to restrict benefits to the Employer Sponsored Insurance (ESI) package.

__X__ **Freedom of Choice 1902(a)(23)**

To enable the State to restrict the choice of provider.

To the extent necessary to mandatorily enroll Native American and Alaskan Native members of the demonstration eligibles to enroll in MCOs

Title XXI:

__X__ **Benefit Package Requirements 2103**

To permit the State to offer a benefit package that does not meet the requirements of section 2103.

To the extent necessary to permit voluntary enrollment in ESI coverage that does not meet SCHIP benefit requirements, and to provide enhanced benefits to SCHIP children.

__X__ **Cost Sharing Requirements 2103(e)**

To permit the State to impose cost sharing in excess of statutory limits.

To the extent necessary to permit voluntary enrollment in ESI coverage that does not meet SCHIP cost-sharingrequirements.

B. Expenditure Authority

Expenditure authority is requested under Section 1115(a)(2) of the Social Security Act to allow the following expenditures (which are not otherwise included as expenditures

under Section 1903 or Section 2105) to be regarded as expenditures under the State's Title XIX or Title XXI plan.

Note: Checking the appropriate box(es) will allow the State to claim Federal Financial Participation for expenditures that otherwise would not be eligible for Federal match.

_____ Expenditures to provide services to populations not otherwise eligible to be covered under the Medicaid State Plan.

Expenditures related to providing _____________ months of guaranteed eligibility to demonstration participants.

__X__ Expenditures related to coverage of individuals for whom cost-sharing rules not otherwise allowable in the Medicaid program apply.

To the extent necessary to permit voluntary enrollment in ESI coverage that does not meet Medicaid cost-sharing requirements.

Title XXI:

_____ Expenditures to provide services to populations not otherwise eligible under a State child health plan.

_____ Expenditures related to providing __________ months of guaranteed eligibility to demonstration participants.

_____ Expenditures that would not be payable because of the operation of the limitations at 2105(c)(2) because they are not for targeted low-income children.

If additional waivers or expenditure authority are desired, please include a detailed request and justification as Attachment H to the proposal.

Additional Waiver:

EPSDT Section 1902(a)(43)(A)
To the extent necessary to permit voluntary enrollment in ESI coverage that does not provide the full EPSDT benefit package.

Additional Expenditure Authority:

Payments to managed care organizations that would not otherwise be allowable under Section 1903 because the requirement for choice of managed care organizations in Section 1932(a)(3)(A).

VIII. ATTACHMENTS

Please see attached concept paper for discussion of these issues.

Place check marks beside the attachments you are including with your application.

_____ Attachment A: Discussion of how the State will ensure that covering individuals above 200 percent of poverty under the waiver will not induce individuals with private health insurance coverage to drop their current coverage.

__ __ Attachment B: Detailed description of expansion populations included in the demonstration.

__ __ Attachment C: Benefit package description.
See Appendices D1 Physical Health and D2 Oral Health.

_____ Attachment D: Detailed description of private health insurance coverage options, including premium assistance if applicable.

__ __ Attachment E: Detailed discussion of cost sharing limits.
See Colorado Family Care Concept paper.

_____ Attachment F: Additional detail regarding measuring progress toward reducing the rate of uninsurance.

__X__ Attachment G: Budget worksheets.

_____ Attachment H: Additional waivers or expenditure authority request and justification.

IX. SIGNATURE

__________ ____

Date Name of Authorizing State Official (Typed)

____

Signature of Authorizing State Official

ATTACHMENT G – BUDGET DOCUMENTS

Introduction

The Colorado Family Care program, a unified package of eligibility expansions, benefit enhancements, and purchasing reform, will be implemented as Phase 2 of Colorado's section 1115 Health Insurance Flexibility and Accountability (HIFA) demonstration program. The program includes eligibility expansions for parents, children and pregnant women, and will streamline the service delivery system in an initiative that builds on the successes of the State Children's Health Insurance Program (SCHIP) known in Colorado as Child Health Plan Plus (CHP+).

The attached budget sheets provide the financial detail required for federal review of the package of waiver requests. The purpose of this introduction is to provide context for these budget sheets.

Under Colorado Family Care, the state will expand eligibility for the following groups:

- Children with incomes from 185 to 200% of the FPL;
- Parents with incomes from 36 to 60% of the FPL, and
- To the extent of available funds, parents with incomes from 61% to 100% of the FPL.

Under this waiver Colorado will also continue the coverage of pregnant women with incomes between 133 and 185% of poverty that began with a HIFA waiver in 2002 and the extension of coverage to pregnant women with incomes from 185 to 200% of poverty that is occurring with an amendment to that waiver in 2005. Since this previous HIFA waiver is set to expire shortly after the requested start date of the new waiver, Colorado is seeking a single combined HIFA waiver that incorporates the provisions of the previous waiver for prenatal care.

In addition to the eligibility expansions, there will be three important benefit enhancements under the demonstration:

- Low-income parents will receive additional preventive health services that correspond to the Core benefits for children;
- SCHIP children will receive enhanced treatment benefits through a wrap-around benefit; and
- Medicaid children will have access to an outpatient substance abuse benefit.

In addition, as part of the initiative, Colorado will eliminate the current Medicaid asset test for low-income parents and children.

The service delivery streamlining initiative will enable Medicaid and CHP+ enrollees to move seamlessly between the two programs as their eligibility changes. This new integrated program will include one group of health plans for both programs. Consolidating the Medicaid and SCHIP delivery systems into Colorado Family Care will enable the State to purchase health services more effectively so that the State can enhance services to children and take a leadership role in addressing key developmental issues

that, if left unrecognized, may prevent Colorado's children from maximizing their potential.

Although the Colorado Family Care program will affect a number of eligibility categories, the federal budget documents present cost projections only for selected groups consistent with the federal requirements associated with section 1115 waiver requests. Because of the need to demonstrate federal budget neutrality, Colorado has presented detailed information on:

- The groups added solely because of waiver authority (including by the fifth year of the waiver an estimated 3,394 pregnant women with incomes between 133% and 200% of poverty);
- The groups with benefit changes that require waiver authority (including all low income children in Medicaid and SCHIP),
- The groups for which other program provisions are facilitated by waiver authority (an estimated 17,846 parents of Medicaid children with incomes between 36% and 100% of poverty for whom the waiver enables Colorado to place a cap on enrollment if necessary), and
- The program changes under the waiver that generate savings to be used in demonstrating budget neutrality, including the streamlining initiative.

Financing

Since the Colorado Family Care program includes both Medicaid and SCHIP components, the Colorado Department of Health Care Policy and Financing is submitting both Medicaid budget neutrality documentation and SCHIP allotment neutrality documentation. Because the waiver includes both existing and new populations, the state share of the total costs of the waiver include both existing state funds and new funds made available from an allocation of a portion of Colorado's recently enacted tobacco tax.

While most of the Colorado Family Care program changes could be accomplished with State Plan amendments and the expanded funding available through Colorado's recently enacted tobacco tax, the program is being submitted as an integrated package. While the tobacco tax legislation enabled funding of adults with incomes from 36% to 60% of the FPL and expanded access for children and pregnant women to 200% of poverty, these initiatives would not be sustainable without the waiver savings. Since the streamlining initiative for children does require waivers of Medicaid and SCHIP provisions, the fiscal implications of the streamlining initiative are identified as Medicaid savings and SCHIP costs associated with the waiver.

Budget Assumptions for SCHIP

SCHIP Caseloads

The SCHIP budget assumes a significant caseload increase in the year prior to the waiver and in the first year of the waiver due to marketing of Colorado's SCHIP program (the

Child Health Plan Plus, or CBH+) and expansion of eligibility from 185% of poverty to 200% of poverty for children and low-income pregnant women.

Children with incomes below 185% of poverty: Colorado has assumed that the planned marketing program will result in an increase in base SCHIP program enrollment of children with incomes below 185% of poverty of 24% in state fiscal year 2007, the first year of the waiver, and an increase of 7% in state fiscal year 2008, the second year of the waiver. For the last three years of the waiver, the waiver budgets assume an annual caseload increase of 4.5%.

Children that meet Medicaid income levels but not current Medicaid asset tests: Colorado is submitting a Medicaid state plan amendment to remove the Medicaid asset test for low-income children as of October 1, 2005. Current eligibility data indicate that 39.48% of current Colorado SCHIP enrollees meet Medicaid income tests, but not the Medicaid asset test. The SCHIP allotment neutrality budget assumes that by the beginning of the first year of the waiver, all of the children eligible for Medicaid under the current income thresholds will have moved from SCHIP to Medicaid funding.

Children with incomes between 185% and 200% of poverty: Colorado has amended its SCHIP State Plan to increase the SCHIP income threshold for children to 200% of poverty as of July 1, 2005. The SCHIP budget includes an estimate that an average of 4,462 children in this income group will be enrolled in SCHIP in state fiscal year 2007, the first year of the waiver, and an increase of 7% in state fiscal year 2008, the second year of the waiver. For the last three years of the waiver, the waiver budgets assume an annual caseload increase of 4.5%.

Pregnant Women between 133% and 185% of poverty: This waiver requests extension of eligibility for this group through June 30, 2011. Enrollment in this component of the Colorado SCHIP program has recently been re-opened. As a result, Colorado fiscal staff estimates an increase of 150% in the number of member months for prenatal care and the number of SCHIP-funded deliveries in the fiscal year prior to the waiver and a 30% increase in the first year of the waiver. For last four fiscal years of the waiver, the budget assumes an annual caseload increase of 4.5%.

Pregnant Women between 185% and 200% of poverty: The existing SCHIP HIFA Waiver is being amended to extend eligibility to this group as of July 1, 2005. The Colorado Family Care waiver request includes an extension of eligibility for this population through June 30, 2011. The SCHIP budget assumes 349 deliveries and 3,127 month of prenatal care for the first year of this new coverage. The budget assumes an enrollment increase of 30% for the first year of the waiver and an annual caseload increase of 4.5% for the remaining four years of the waiver period.

SCHIP Cost Factors

Administration: The SCHIP budget assumes a 2.37% inflation factor for administrative costs for the base program. The budget also assumes that an evaluation of the waiver program with a total cost of $1.5 million will be split between Medicaid and SCHIP based on enrollment. About 12% of the total number of children enrolled in the streamlining initiative will be in the SCHIP component.

Baseline Benefit Costs: Both the Medicaid and SCHIP budgets are based on an assumption of annual increases in capitation rates of 8.4%. This represents the average annual increase in premiums for the Colorado Children's Basic Health Plan for the last five years, and is documented as an attachment to the SCHIP waiver budget.

Streamlining initiative: One aspect of the streamlining initiative is a single set of capitation rates for both Medicaid and SCHIP enrollees. While the streamlining initiative results in significant savings overall, the result is SCHIP rates that are on average 12.4% higher than the rates that would have existed without the streamlining initiative.

SCHIP Allotment

The SCHIP allotment neutrality document shows that with Colorado's current SCHIP allotments and carry-forward allotments from the last two years, there is sufficient funding for the SCHIP portion of the Colorado Family Care waiver through state fiscal year 2011, and sufficient allotment for the children's SCHIP program through the end of federal fiscal year 2011. The documents also show sufficient allotment surplus to enable Colorado to continue funding low-income pregnant women and to fund the streamlining initiative through the end of federal fiscal year 2011, which is three months beyond the end of the requested five-year waiver period.

The HIFA waiver does not allow Colorado to assume that there will be any redistribution of SCHIP allotments from other states during the entire five-year period of the waiver. Should expenses exceed the current estimates, Colorado will work with CMS to ensure that the total cost of the waiver does not exceed the available funding, including enrollment caps if necessary.

The SCHIP allotment neutrality document also demonstrates that the Colorado SCHIP program will have administrative costs, even with the waiver, that are significantly below the 10% federal cap on matchable administrative costs. In addition to the standard SCHIP allotment neutrality template, Colorado has provided support data on the caseload and cost assumptions included in the allotment neutrality calculations.

The five-year cost of the SCHIP component of this HIFA waiver is $42,014,813 for the streamlining initiative and $147,119,241 for coverage of pregnant women from 133 to 200% of the federal poverty level, for a total cost of $189,134,054.

Medicaid Budget Neutrality

Medicaid Caseload Assumptions

Since all of the Medicaid expansion groups are optional Medicaid eligible populations, the Medicaid budget for the Colorado Family Care waiver includes all of the new Medicaid enrollees in both the waiver budget and the estimated costs without the waiver.

Mandatory Low-Income Children: The waiver does not include children enrolled in SSI, Foster Care, or other special needs categories. The waiver budget assumes a 7.1% growth in the number of children enrolled in mandatory groups in the first year of the waiver. Enrollment is projected to increase by 8% per year for the last four years of the waiver due in part to the impact of outreach initiatives.

Children that meet mandatory Medicaid income levels but not current Medicaid asset tests: As noted above, Colorado is submitting a Medicaid state plan amendment to remove the Medicaid asset test for low-income children as of October 1, 2005. Current eligibility data indicate that 39.48% of current Colorado SCHIP enrollees meet Medicaid income tests, but not the Medicaid asset test. The Medicaid waiver budget assumes that by the end of the first year of the waiver, 22,187 children eligible for Medicaid under the current income thresholds will have moved from SCHIP to Medicaid funding. For the last four years of the waiver an annual enrollment increase of 8% is projected.

Parents with incomes between 36% and 60% of poverty: The Medicaid portion of the waiver budget assumes an annual increase in the penetration rate for low-income parent groups from 34% of eligibles in the first year of the waiver to 70% in the fifth year of the waiver. By the fifth year of the waiver the estimate for this group is 6,186 parents. The total state and federal cost of adding this group over the five years of the waiver is $88.3 million, of which the state share is 50%.

Parents with incomes between 61% and 100% of poverty: The Medicaid portion of the waiver budget assumes an annual increase in the penetration rate for low-income parent groups from 34% of eligibles in the first year of the waiver to 70% in the fifth year of the waiver. By the fifth year of the waiver the estimate for this group is 11,660 parents. The total state and federal cost of adding this group over the five years of the waiver is $166.4 million, of which the state share is 50%. The waiver includes a request that Colorado be able to cap enrollment in this group if enrollment exceeds available state revenues.

<u>Medicaid Inflation Factors</u>

Administration: The waiver budget also assumes that an evaluation of the waiver program with a total cost of $1.5 million will be split between Medicaid and SCHIP based on enrollment ratios for the streamlining initiative. The estimate is that about 88% of the children in the initiative will be Medicaid enrollees. In addition, the Medicaid portion of the waiver budget includes $2.5 million in the first year of the waiver for the cost of necessary information technology improvements. An additional administrative cost is the cost of contracted plan administration for the Self-Funded Managed Care component of the initiative. This cost is estimated at $15 per member per month and is included in the benefit costs as illustrated in the supporting data on the impact of streamlining. In addition to anticipated savings in medical costs due to plan management, the budget assumes a savings from base administrative costs at 2.5% of medical costs for those children that would have been enrolled in fee-for-service Medicaid.

Baseline Benefit Costs: As noted above, both the Medicaid and SCHIP budgets are based on an assumption of annual increases in capitation rates of 8.4%, based on the trend in capitation rates for the last five years for the Children's Basic Health Plan.

Streamlining initiative: One aspect of the streamlining initiative is a single set of capitation rates for both Medicaid and SCHIP enrollees. The actuarial estimates for the streamlining initiative indicate significant savings to the Medicaid program, as shown on page 1 of the Medicaid budget neutrality document. The Medicaid savings for five years from the streamlining initiative total $132,098,036.

Medicaid Budget Neutrality Documents

Page 1 of the Medicaid budget neutrality document shows the total cost of physical and mental health care services for the waiver period for all of the groups that are part of the waiver. Page 1 indicates that the waiver will include substantial savings due to implementation of the streamlining initiative. By fiscal year 2011 the annual Medicaid savings are $36.1 million, of which the federal share is 50%.

Page 2 of the Medicaid budget neutrality document shows the Medicaid costs for the current and proposed optional Medicaid eligible groups without the streamlining initiative.

The Medicaid budget neutrality document also includes supporting data that was used to develop the waiver model and a summary of the impact of the streamlining initiative on per capita rates.

The total cost of the Medicaid component of the Colorado Family Health Care waiver for the five-year waiver period is estimated at $3,304,850,386, as shown on page 1 of the Medicaid budget neutrality document. The federal share of this amount is 50%.

When the Medicaid and SCHIP funds are combined, the total cost of the portions of the Colorado Medicaid and SCHIP programs that are included in the waiver cost in Colorado is $3,493,984,440. By the fifth year of the waiver, an average of 441,278 individuals will be enrolled in either the Medicaid or SCHIP component of the waiver.

Attachment G: HIFA Demonstration Waiver Budget Template for States Using SCHIP Funds

	FFY 2006 (full year SCHIP, 3 mths demo.)	FFY 2007 (Demo Year 1 & 2)	FFY 2008 (Demo Year 2 & 3)	FFY 2009 (Demo Year 3 & 4)	FFY 2010 (Demo Year 4 & 5)	FFY 2011 (nine months demonstration)
State's Allotment	$46,771,241	$57,742,273	$57,742,273	$57,742,273	$57,742,273	$57,742,273
Funds Carried Over From Prior Year(s)	$100,132,644	$99,369,385	$96,842,499	$85,829,503	$66,030,140	$36,285,438
SUBTOTAL (Allotment + Funds Carried Over)	$146,903,885	$157,111,658	$154,584,772	$143,571,776	$123,772,413	$94,027,711
Reallocated Funds (Redistributed or Retained that are Currently Available)	$0					
TOTAL (Subtotal + Reallocated funds)	$146,903,885	$157,111,658	$154,584,772	$143,571,776	$123,772,413	$94,027,711
State's Enhanced FMAP Rate	65%	65%	65%	65%	65%	65%
Portion of Federal Fiscal Year						0.75
COST PROJECTIONS OF APPROVED SCHIP PLAN						
Benefit Costs						
Insurance payments						
Managed care						
per member/per month rate @ # of eligibles	$49,150,929	$57,951,124	$66,798,104	$75,685,141	$85,754,593	$94,035,729
Fee for Service						
Total Benefit Costs	**$49,150,929**	**$57,951,124**	**$66,798,104**	**$75,685,141**	**$85,754,593**	**$94,035,729**
(Offsetting beneficiary cost sharing payments)	0	0	0	0	0	0
Net Benefit Costs	**$49,150,929**	**$57,951,124**	**$66,798,104**	**$75,685,141**	**$85,754,593**	**$94,035,729**
Administration Costs						
Annual Admin. Increase		2.37%	2.37%	2.37%	2.37%	2.37%
Personnel	$668,100	$683,934	$700,143	$716,736	$733,723	$563,334
General administration	$17,523	$17,938	$18,363	$18,798	$19,244	$14,775
Contractors/Brokers (e.g., enrollment contractors)	$1,133,630	$1,160,497	$1,188,001	$1,216,157	$1,244,980	$955,865
Claims Processing	$0	$0	$0	$0	$0	$0
Outreach/marketing costs (77.3% of $1.3 million)	$1,004,900	$1,028,716	$1,053,097	$1,078,055	$1,103,605	$847,320
Other	$1,927,219	$1,972,894	$2,019,652	$2,067,517	$2,116,518	$2,166,679
Total Administration Costs	$4,751,372	$4,863,979	$4,979,255	$5,097,264	$5,218,070	$4,547,973
10% Administrative Cap	$4,915,093	$5,795,112	$6,679,810	$7,568,514	$8,575,459	$9,403,573
Federal Title XXI Share	$35,036,496	$40,829,817	$46,655,284	$52,508,563	$59,132,231	$64,079,406
State Share	$18,865,805	$21,985,286	$25,122,076	$28,273,842	$31,840,432	$34,504,296
TOTAL COSTS OF APPROVED SCHIP PLAN	**$53,902,301**	**$62,815,103**	**$71,777,359**	**$80,782,405**	**$90,972,663**	**$98,583,702**

COST PROJECTIONS OF HIFA DEMONSTRATION PROPOSAL - Rate Differential Due to Streamlining (savings occur in Medicaid)						
Benefit Costs for Demonstration Population #1 (Pregnant women with income to 200% FPL)						
Insurance payments						
Managed care - higher rates						
per member/per month rate @ # of eligibles	$17,654,456	$23,326,573	$26,423,893	$29,933,610	$33,908,713	$27,882,149
Fee for Service						
Total Benefit Costs for Waiver Population #1	**$17,654,456**	**$23,326,573**	**$26,423,893**	**$29,933,610**	**$33,908,713**	**$27,882,149**
Benefit Costs for Demonstration Population #2 (Streamlined managed care for ALL children with income to 200% FPL)						
Insurance payments						
Managed care - higher rates						
per member/per month rate @ # of eligibles	$1,573,244	$6,544,105	$7,540,085	$8,542,810	$9,677,970	$7,956,598
Fee for Service						
Total Benefit Costs for Waiver Population #2	$1,573,244	$6,544,105	$7,540,085	$8,542,810	$9,677,970	$7,956,598
Total Benefit Costs	**$19,227,700**	**$29,870,678**	**$33,963,978**	**$38,476,420**	**$43,586,683**	**$35,838,747**
(Offsetting beneficiary cost sharing payments)						
Net Benefit Costs	**$19,227,700**	**$29,870,678**	**$33,963,978**	**$38,476,420**	**$43,586,683**	**$35,838,747**
Administration Costs - SCHIP Share of Waiver Evaluation	$0	$36,000	$36,000	$36,000	$36,000	$36,000
10% Administrative Cap						
Federal Title XXI Share	$12,498,005	$19,439,341	$22,099,986	$25,033,073	$28,354,744	$23,318,586
State Share	$6,729,695	$10,467,337	$11,899,992	$13,479,347	$15,267,939	$12,556,162
TOTAL COSTS FOR DEMONSTRATION	**$19,227,700**	**$29,906,678**	**$33,999,978**	**$38,512,420**	**$43,622,683**	**$35,874,747**
TOTAL PROGRAM COSTS (State Plan + Demonstration)	$73,130,001	$92,721,782	$105,777,338	$119,294,825	$134,595,346	$134,458,449
Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	$146,903,885	$157,111,658	$154,584,772	$143,571,776	$123,772,413	$94,027,711
Total Federal Title XXI Program Costs (State Plan + Demonstration)	$47,534,500	$60,269,158	$68,755,270	$77,541,636	$87,486,975	$87,397,992
Unused Title XXI Funds Expiring (Allotment or Reallocated)						
Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	$99,369,385	$96,842,499	$85,829,503	$66,030,140	$36,285,438	$6,629,719

Notes:

1.) The waiver ends 9 months into FFY 2011. Title XXI funds would be sufficient to continue the demonstration through the end of the federal fiscal year.

2.) The Title XXI allotment assumptions are conservative.

Attachment G: SCHIP Program Support Data

State Fiscal Year (July 1 - June 30)	FY 04-05	FY 05-06	FY 06-07	FY 07-08	FY 08-09	FY 09-10	FY 10-11
Inflation Rate for Medical Expenses			8.40%	8.40%	8.40%	8.40%	8.40%
Kids Medical Premiums							
Kids Caseload Annual Growth				7.00%	4.50%	4.50%	4.50%
Base Average Kids Caseload for Medical Premiums	43,509	45,394	56,194				
Adjustment for Increase to 200% FPL (Exhibit 3)		3,604	4,462				
Adjustment to Remove the Asset Test (Exhibit 4)		(13,848)	(22,187)				
Average Kids Caseload for Medical Premiums	43,509	35,150	38,469	41,162	43,014	44,950	46,973
Cost Per Kid for Medical Premiums	$90.92	$101.44	$109.96	$119.20	$129.21	$140.06	$151.83
Premiums Kids Total Funds	$47,470,059	$42,787,392	$50,760,395	$58,878,125	$66,694,067	$75,548,364	$85,582,927
Less Annual Enrollment Fees	($138,359)	($163,386)	($186,224)	($199,224)	($208,188)	($217,558)	($227,349)
Kids Dental Premiums							
Average Kids Caseload Dental (87% of total caseload)	37,853	30,581	33,468	35,811	37,422	39,107	40,867
Cost Per Kid Dental	$11.31	$11.82	$12.81	$13.89	$15.06	$16.33	$17.70
Dental Kids Total Funds	$5,137,409	$4,337,609	$5,144,701	$5,968,977	$6,762,904	$7,663,408	$8,680,151
Subtotal - Base Program Medical Expenses	$52,469,109	$46,961,615	$55,718,872	$64,647,878	$73,248,783	$82,994,214	$94,035,729
Prenatal And Delivery Costs							
Prenatal & Delivery Caseload Growth Rate				4.50%	4.50%	4.50%	4.50%
Base Women's Member Months	6,604	16,476	21,426				
Adjustment for increase to 200% FPL (Exhibit 3)		3,127	4,067				
Women's Member Months	6,604	19,603	25,493	26,640	27,839	29,092	30,401
Monthly Rate	$345.30	$317.36	$344.02	$372.92	$404.25	$438.21	$475.02
Costs for Prenatal and Postpartum Care	$2,280,361	$6,221,208	$8,770,102	$9,934,589	$11,253,916	$12,748,405	$14,441,083
Base # Deliveries	670	1,839	2,392				
Adjustment for Increase to 200% FPL (Exhibit 3)		349	454				
# Deliveries	670	2,188	2,846	2,974	3,108	3,248	3,394
Cost Per Prenatal Delivery	$3,965.00	$4,475.47	$4,851.41	$5,258.93	$5,700.68	$6,179.54	$6,698.62
Cost for Deliveries	$2,658,331	$9,792,328	$13,807,113	$15,640,058	$17,717,713	$20,071,146	$22,735,116
Subtotal Prenatal and Delivery Costs	$4,938,692	$16,013,536	**$22,577,215**	**$25,574,647**	**$28,971,629**	**$32,819,551**	**$37,176,199**

Federal Fiscal Year (Oct - Sep)	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	FFY 2010	FFY 2011
Base Program Medical Expenses	$51,092,236	$49,150,929	$57,951,124	$66,798,104	$75,685,141	$85,754,593	$70,526,797
Prenatal Program Medical Expenses	$7,707,403	$17,654,456	$23,326,573	$26,423,893	$29,933,610	$33,908,713	$27,882,149
Administration							
Annual Admin. Increase		2.37%	2.37%	2.37%	2.37%	2.37%	2.37%
Personnel	$652,633	$668,100	$683,934	$700,143	$716,736	$733,723	$563,334
General Admin	$17,117	$17,523	$17,938	$18,363	$18,798	$19,244	$14,775
Contractors/Brokers	$1,107,385	$1,133,630	$1,160,497	$1,188,001	$1,216,157	$1,244,980	$955,865
Claims Processing	$0	$0	$0	$0	$0	$0	$0
Outreach/Marketing	$0	$1,004,900	$1,028,716	$1,053,097	$1,078,055	$1,103,605	$847,320
Other (see note 5 below)	$1,882,601	$1,927,219	$1,972,894	$2,019,652	$2,067,518	$2,116,518	$2,166,679
TOTAL	$3,659,736	$4,751,372	$4,863,979	$4,979,256	$5,097,264	$5,218,070	$4,547,973
Total Funds	$62,459,375	$71,556,757	$86,141,676	$98,201,253	$110,716,015	$124,881,376	$102,956,919
Federal Funds at 65%	$40,598,594	$46,511,892	$55,992,089	$63,830,814	$71,965,410	$81,172,894	$66,921,997

SCHIP Allotment from prior years	$82,779,951
Allotment for FFY 2005	$57,951,287
Carry-forward to FFY 2006	$100,132,644

Notes

1.) All rates and costs presented in support data are net of cost sharing other than enrollment fees.

2.) The inflation rate used for administrative expenses is a ten year average of Colorado CPI running from 1995 through 2004, where 2001 - 2004 were forecasted figures.

SCHIP Rate Support Data for Colorado Streamlined Initiative

Attachment G: SCHIP Rate Support Data for HIFA Demonstration

Base SCHIP **Streamlined Initiative** Rate estimates using data for State FY 2005

	pmpm	members distribution
SCHIP HMO	$ 107.37	65.846%
SCHIP SFMC	$ 107.93	34.154%
Composite	$ 107.56	100.000%

SCHIP Rate Increment for Streamlined Initiative

Medical Inflation Factor 8.40%

Change from base line	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
Streamlined SCHIP Rate	$ 107.56	$114.01	$123.59	$133.97	$145.23	$157.43	$170.65
SCHIP Medical baseline	$90.92	$101.44	$109.96	$119.20	$129.21	$140.06	$151.83
Difference	$16.64	$12.57	$13.63	$14.77	$16.02	$17.37	$18.82

Historical CBHP premium costs for children

	Blended PMPM	Growth
FY 01-02	73.48	
FY 02-03	80.74	9.9%
FY 03-04	87.65	8.6%
FY 04-05	90.92	3.7%
FY 05-06	101.44	11.6%
5 year Average Growth		**8.40%**

Attachment G Supporting SCHIP Data - Children's Basic Health Plan Children's Caseload Projection for FY 05-06

Total Enrollment Trend

	Historical Monthly Enrollment						Projection	Projection	Request
	FY 98-99	FY 99-00	FY 00-01	FY 01-02	FY 02-03	FY 03-04	FY 04-05[1]	FY 05-06	FY 06-07
Jul	8,263	19,233	25,221	35,741	44,618	51,846	37,159	43,655	35,073
Aug	8,956	20,397	25,489	36,711	45,864	51,844	41,477	44,627	35,690
Sep	9,649	20,889	25,826	37,284	46,857	51,626	41,355	45,598	36,308
Oct	10,347	21,906	26,431	38,344	48,177	52,484	35,840	29,528	36,925
Nov	11,082	22,698	27,383	38,977	48,734	50,882	38,115	30,144	37,543
Dec	11,704	22,944	27,958	39,247	49,258	49,001	39,098	30,760	38,160
Jan	12,649	23,652	28,887	40,052	50,492	47,156	39,206	31,376	38,778
Feb	13,798	23,997	30,528	40,324	50,930	44,976	41,229	31,991	39,395
Mar	15,074	24,491	31,795	41,646	51,192	42,979	42,974	32,608	40,012
Apr	16,603	24,801	33,073	42,690	51,511	41,353	43,493	33,223	40,630
May	17,341	25,015	34,163	43,351	51,399	39,111	41,045	33,840	41,247
Jun	18,436	25,196	34,907	43,745	51,564	37,069	40,018	34,455	41,865
Average Monthly Enrollment	12,825	22,935	29,305	39,843	49,216	46,694	40,084	35,150	38,469
Annual Growth[2]		36.7%	38.5%	25.3%	17.9%	-28.1%	8.0%	-13.9%	21.5%

[1]The FY 04-05 caseload includes projected retroactivity. The estimate does not include members who where not enrolled in MMIS due to CBMS implementation issues.

3,425 AME of Offline payments

[2]Annual Growth shown here is calculated as the growth from June to June.

43,509 Total estimated AME FY 04-05

		Adjustments from HB 05-1262					
FY 05-06	Base Caseload Projection	Marketing	Projection without the Asset Test Removal	Impact of Asset Test Removal	SubTotal with Asset Test Removed	CBHP to 200%	Final CBHP Caseload
July	40,444	-	40,444	-	40,444	3,211	43,655
August	40,870	474	41,344	-	41,344	3,283	44,627
September	41,296	948	42,244	-	42,244	3,354	45,598
October	41,722	1,422	43,144	(17,042)	26,102	3,426	29,528
November	42,148	1,896	44,044	(17,397)	26,647	3,497	30,144
December	42,574	2,370	44,944	(17,753)	27,191	3,569	30,760
January	43,000	2,844	45,844	(18,108)	27,736	3,640	31,376
February	43,426	3,318	46,744	(18,464)	28,280	3,711	31,991
March	43,852	3,792	47,644	(18,819)	28,825	3,783	32,608
April	44,278	4,266	48,544	(19,175)	29,369	3,854	33,223
May	44,704	4,740	49,444	(19,530)	29,914	3,926	33,840
June	45,130	5,214	50,344	(19,886)	30,458	3,997	34,455
	42,787	2,607	45,394	(13,848)	31,546	3,604	35,150

	Adjustments from HB 05-1262				
FY 06-07	Projection without the Asset Test Removal	Impact of Asset Test Removal	SubTotal with Asset Test Removed	CBHP to 200%	Final CBHP Caseload
July	51,244.0	(20,240)	31,004	4,069	35,073
August	52,144	(20,594)	31,550	4,140	35,690
September	53,044	(20,948)	32,096	4,212	36,308
October	53,944	(21,302)	32,642	4,283	36,925
November	54,844	(21,656)	33,188	4,355	37,543
December	55,744	(22,010)	33,734	4,426	38,160
January	56,644	(22,364)	34,280	4,498	38,778
February	57,544	(22,718)	34,826	4,569	39,395
March	58,444	(23,072)	35,372	4,640	40,012
April	59,344	(23,426)	35,918	4,712	40,630
May	60,244	(23,780)	36,464	4,783	41,247
June	61,144	(24,134)	37,010	4,855	41,865
	56,194	(22,187)	34,007	4,462	38,469

Attachment G: SCHIP Supporting Data = Prenatal Projection

CHP+ Prenatal and Delivery Program

Enrollment in the Prenatal and Delivery Program	FY 02-03 Actual	FY 03-04 Actual	FY 04-05 Estimate	FY 05-06 Projection	FY 06-07 Projection
July		409	-	961	1,786
August		335	185	1,036	1,786
September		250	260	1,111	1,786
October	190	175	300	1,186	1,786
November	388	124	405	1,261	1,786
December	506	81	543	1,336	1,786
January	580	40	649	1,411	1,786
February	631	14	773	1,486	1,786
March	678	-	831	1,561	1,786
April	753	-	880	1,636	1,786
May	586	-	893	1,711	1,786
June	467	-	886	1,786	1,786
Total Member Months (133% to 185% FPL)	**4,779**	**1,428**	**6,604**	**16,476**	**21,426**
Projected Increase from 186% to 200% FPL (HB 05-1262)	0.00%	0.00%	0.00%	18.98%	18.98%
Member Months from 186% to 200% FPL	-	-	-	3,127	4,067
Total Projected Member Months	**4,779**	**1,428**	**6,604**	**19,603**	**25,493**
Estimated Member months per delivery[1]				8.9579	8.9579
Estimated Deliveries Base				1,839	2,392
Estimated Deliveries to 200%				349	454
Estimated Deliveries Total				**2,188**	**2,846**

[1] The FY 05-06 appropriation for SB 05-209 assumed 19,170 member months and 2,140 deliveries for an average of 8.9579 member months per delivery.

Supporting Data for Attachment G: Medicaid Component of Colorado Family Care

Impact of Streamlining Initiative on Medicaid Rates

	State Fiscal Years						
Medicaid Costs for Children under the SI initiative	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09**	**FY 09-10**	**FY 10-11**
Growth Factor		**1.084**	**1.084**	**1.084**	**1.084**	**1.084**	**1.084**
SI HMO Medical Claims costs	$ 103.52	$ 112.22	$ 121.64	$ 131.86	$ 142.94	$ 154.94	$ 167.96
SI HMO plan administration	$ 8.29	$ 8.99	$ 9.74	$ 10.56	$ 11.45	$ 12.41	$ 13.45
SI HMO Total	$ 111.81	$ 121.20	$ 131.38	$ 142.42	$ 154.38	$ 167.35	$ 181.41
SI SFMC Medical Claims costs	$ 94.82	$ 102.78	$ 111.42	$ 120.78	$ 130.92	$ 141.92	$ 153.84
SI SFMC plan administration	$ 15.00	$ 16.26	$ 17.63	$ 19.11	$ 20.71	$ 22.45	$ 24.34
SI SFMC Total	N/A	$ 119.04	$ 129.04	$ 139.88	$ 151.63	$ 164.37	$ 178.18
Blended Total Costs (65% HMO - 35% SFMC)	N/A	$ 120.45	$ 130.56	$ 141.53	$ 153.42	$ 166.31	$ 180.28
	$ 3.48						

Children's Medicaid Costs w/o SI and Savings	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09**	**FY 09-10**	**FY 10-11**
Growth Factor		**1.084**	**1.084**	**1.084**	**1.084**	**1.084**	**1.084**
non- SI HMO Medical & Admin	$ 114.26	$ 123.86	$ 134.26	$ 145.54	$ 157.77	$ 171.02	$ 185.38
non- SI fee-for-service Medical Claims	$ 113.74	$ 123.29	$ 133.65	$ 144.88	$ 157.05	$ 170.24	$ 184.54
Non-SI fee-for-service plan administration (2.5% of medical costs)	$ 2.84	$ 3.08	$ 3.34	$ 3.62	$ 3.93	$ 4.26	$ 4.61
Non-SI fee-for-service plan Total	$ 116.58	$ 126.38	$ 136.99	$ 148.50	$ 160.97	$ 174.50	$ 189.15
Blended Without Waiver Rates (22% HMO)	$ 116.07	$ 125.82	$ 136.39	$ 147.85	$ 160.27	$ 173.73	$ 188.32
Blended savings	N/a	$ (5.37)	$ (5.83)	$ (6.32)	$ (6.85)	$ (7.42)	$ (8.04)

HMO Share without Streamlined Initiative 22%

DEMONSTRATION WITH WAIVER BUDGET PROJECTION

Current Mandatory Populations Included in the Waiver

TANF and Mandatory Low-Income Children *(after 10/1/05 removal of asset test)*	Waiver Year 1: SFY 2007	Waiver Year 2 SFY 2008	Waiver Year 3: SFY 2009	Waiver Year 4: SFY 2010	Waiver Year 5: SFY 2011
Caseload Member Months	3,320,496	3,586,140	3,873,036	4,182,876	4,517,508
Per Member Per Month (PMPM)	$130.56	$141.53	$153.42	$166.31	$180.28
Medical & Plan Administration Costs with Waiver	$433,523,958	$507,546,394	$594,201,183	$695,654,108	$814,416,342
PMPM Savings from Streamlining (incl. above)	-$5.83	-$6.32	-$6.85	-$7.42	-$8.04

New Optional Populations Included in The Waiver

Optional 1931 Adults to 60% FPL	Waiver Year 1: SFY 2007	Waiver Year 2 SFY 2008	Waiver Year 3: SFY 2009	Waiver Year 4: SFY 2010	Waiver Year 5: SFY 2011
Caseload Member Months	36,060	48,780	60,444	68,928	74,232
Per Member Per Month (PMPM)	$266.56	$282.90	$300.24	$318.66	$338.21
Costs with Waiver	$9,612,244	$13,799,740	$18,147,807	$21,964,539	$25,105,819

Optional 1931 Adults from 61% to 100% FPL	Waiver Year 1: SFY 2007	Waiver Year 2 SFY 2008	Waiver Year 3: SFY 2009	Waiver Year 4: SFY 2010	Waiver Year 5: SFY 2011
Caseload Member Months	67,956	91,944	113,940	129,924	139,920
Per Member Per Month (PMPM)	$266.56	$282.90	$300.24	$318.66	$338.21
Costs with Waiver	$18,114,521	$26,010,728	$34,209,536	$41,401,474	$47,321,993

Total Waiver Costs

Medical Costs	Waiver Year 1: SFY 2007	Waiver Year 2 SFY 2008	Waiver Year 3: SFY 2009	Waiver Year 4: SFY 2010	Waiver Year 5: SFY 2011
Waiver Caseload Member Months	3,424,512	3,726,864	4,047,420	4,381,728	4,731,660
Per Member Per Month (PMPM)	$134.69	$146.87	$159.75	$173.22	$187.43
Costs with Waiver	$461,250,723	$547,356,862	$646,558,526	$759,020,120	$886,844,155
Estimated Increases in Administration					
Additional MMIS Costs Under Waiver	$2,500,000	$0	$0	$0	$0
Medicaid Share of Waiver Evaluation	$264,000	$264,000	$264,000	$264,000	$264,000
Increase in Admin. Costs (Other than Plan Admin)	$2,764,000	$264,000	$264,000	$264,000	$264,000
Federal Obligation	$1,382,000	$132,000	$132,000	$132,000	$132,000
Total Waiver Costs	$464,014,723	$547,620,862	$646,822,526	$759,284,120	$887,108,155
Federal Obligation	$232,007,361	$273,810,431	$323,411,263	$379,642,060	$443,554,077

Net Waiver Costs/(Savings)

	Waiver Year 1	Waiver Year 2	Waiver Year 3	Waiver Year 4	Waiver Year 5
Medicaid Medical & Plan Admin. Waiver Savings	($19,363,514)	($22,658,736)	($26,521,320)	($31,037,744)	($36,336,722)
Increase in Other Administrative Costs	$2,764,000	$264,000	$264,000	$264,000	$264,000
Total Medicaid Cost/(Savings) from Waiver	($16,599,514)	($22,394,736)	($26,257,320)	($30,773,744)	($36,072,722)
Federal Obligation	($8,299,757)	($11,197,368)	($13,128,660)	($15,386,872)	($18,036,361)

Waiver Summary	**Total Funds**	**State Funds**
Five Year Medicaid Savings from Streamlining	**-$132,098,036**	-$66,049,018
Five Year SCHIP Cost of Streamlining	$42,014,813	$14,705,185
Five Year SCHIP Cost for Pregnant Women	$147,119,241	$51,491,734
Medicaid and SCHIP Impact of Waiver	$57,036,018	$147,901
Five Year Medicaid Cost of Low-Income Parents	$255,688,401	$127,844,200

Five Year Cost of Medicaid Services included in the Waiver	**3,304,850,386**
Five Year Cost of Medicaid and SCHIP Services included in the Waiver	**3,493,984,440**

Average Waiver Enrollment in Year 5 - Medicaid	394,305
Average Waiver Enrollment in Year 5 - SCHIP	46,973
Average Waiver Enrollment in Year 5 - Total	441,278

WITHOUT WAIVER BUDGET PROJECTION

Current Mandatory Populations Included in the Waiver

TANF and Mandatory Low-Income Children	Waiver Year 1: SFY 2007	Waiver Year 2 SFY 2008	Waiver Year 3: SFY 2009	Waiver Year 4: SFY 2010	Waiver Year 5: SFY 2011
Mandatory Caseload Member Months	3,320,496	3,586,140	3,873,036	4,182,876	4,517,508
Per Member Per Month (PMPM)	$136.39	$147.85	$160.27	$173.73	$188.32
Costs without Waiver	$452,887,472	$530,205,130	$620,722,503	$726,691,852	$850,753,064

New Optional Populations Included in the Waiver as Pass Through Groups

Optional 1931 Adults from 36% to 60% FPL	Waiver Year 1: SFY 2007	Waiver Year 2 FY 2008	Waiver Year 3: FY 2009	Waiver Year 4: FY 2010	Waiver Year 5: FY 2011
Optional Caseload Member Months	36,060	48,780	60,444	68,928	74,232
Per Member Per Month (PMPM)	$266.56	$282.90	$300.24	$318.66	$338.21
Costs without Waiver	$9,612,244	$13,799,740	$18,147,807	$21,964,539	$25,105,819

Optional 1931 Adults 61% to 100% FPL	Waiver Year 1: SFY 2007	Waiver Year 2 FY 2008	Waiver Year 3: FY 2009	Waiver Year 4: FY 2010	Waiver Year 5: FY 2011
Optional Caseload Member Months	67,956	91,944	113,940	129,924	139,920
Per Member Per Month (PMPM)	$266.56	$282.90	$300.24	$318.66	$338.21
Costs without Waiver	$18,114,521	$26,010,728	$34,209,536	$41,401,474	$47,321,993

Total Costs Without Waiver

Medical Costs	Waiver Year 1: SFY 2007	Waiver Year 2 SFY 2008	Waiver Year 3: SFY 2009	Waiver Year 4: SFY 2010	Waiver Year 5: SFY 2011
Waiver Caseload Member Months	3,424,512	3,726,864	4,047,420	4,381,728	4,731,660
Per Member Per Month (PMPM)	$140.35	$152.95	$166.30	$180.31	$195.11
Costs with Waiver	$480,614,237	$570,015,598	$673,079,846	$790,057,865	$923,180,876

Supporting Data for Attachment G: Medicaid Component of Colorado Family Care

Medicaid Caseload Estimates for Existing Mandatory Groups	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09**	**FY 09-10**	**FY 10-11**
Caseload Growth Factor - Children				*8.0%*	*8.0%*	*8.0%*	*8.0%*
Mandatory Children (includes impact from Marketing the CBHP program)	221,849	237,644	254,521	274,883	296,874	320,624	346,274
Medicaid Caseload Estimates for Optional Children (Begins October 1, 2005)							
Caseload Growth Factor				*8.0%*	*8.0%*	*8.0%*	*8.0%*
Kids from SCHIP due to removal of asset test		13,848	22,187	23,962	25,879	27,949	30,185
Medicaid Caseload Estimates for Optional Parents (Begins October 1, 2005)							
Caseload Growth Factor - parents added through the removal of the asset test			*70.0%*	*8.0%*	*8.0%*	*8.0%*	*8.0%*
1931 parents added through the removal of the asset test		3,440	5,849	6,317	6,822	7,368	7,957
Optional parents 36%-75%			4,886	6,610	8,191	9,340	10,059
Optional parents 36%-60% (61.5% of 36% to 75% group)			3,005	4,065	5,037	5,744	6,186
Optional parents 60%-75%			1,881	2,545	3,154	3,596	3,873
Optional parents 75%-100%			3,782	5,117	6,341	7,231	7,787
Caseload Growth Factor - Optional Parents				*35.3%*	*23.9%*	*14.0%*	*7.7%*
Total Optional parents 36%-100%			8,668	11,727	14,532	16,571	17,846
Penetration rate			34%	46%	57%	65%	70%
Total Mandatory & Optional Low-Income Children	221,849	251,492	276,708	298,845	322,753	348,573	376,459
Total Optional Low-Income Parents	-	3,440	14,517	18,044	21,354	23,939	25,803

Inflation Factor			8.4%				
Medicaid Costs for Existing Populations							
Medicaid - Mandatory Children - Annual per capita	$1,292.08	$1,351.33	$1,464.84	$1,587.89	$1,721.27	$1,865.86	$2,022.59
Medicaid - 1931 adults - Annual per capita	$3,703.86	$3,941.15	$4,272.21	$4,631.08	$5,020.09	$5,441.78	$5,898.89
Mental Health - Mandatory Children - PMPM	$11.74	$12.73	$13.80	$14.96	$16.22	$17.58	$19.06
Medicaid Costs for Optional Parents							
Medicaid Parents above 36% FPL - Annual per capita medical costs[1]		$2,899.74	$3,029.07	$3,210.81	$3,403.46	$3,607.67	$3,824.13
Mental health - Parents above 36% FPL - PMPM	$11.64	$13.04	$14.14	$15.33	$16.62	$18.02	$19.53

[1] The rate for parents above 36% FPL is estimated using the CELI Adult (1931) Medicaid Per Capita, but carving out all the costs associated with the Maternity and Delivery.

Supporting Data for Attachment G: Medicaid Component of Colorado Family Care

Impact of Streamlining Initiative on Medicaid Rates

			State Fiscal Years				
Medicaid Costs for Children under the SI initiative	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09**	**FY 09-10**	**FY 10-11**
Growth Factor		**1.084**	**1.084**	**1.084**	**1.084**	**1.084**	**1.084**
SI HMO Medical Claims costs	$ 103.52	$ 112.22	$ 121.64	$ 131.86	$ 142.94	$ 154.94	$ 167.96
SI HMO plan administration	$ 8.29	$ 8.99	$ 9.74	$ 10.56	$ 11.45	$ 12.41	$ 13.45
SI HMO Total	$ 111.81	$ 121.20	$ 131.38	$ 142.42	$ 154.38	$ 167.35	$ 181.41
SI SFMC Medical Claims costs	$ 94.82	$ 102.78	$ 111.42	$ 120.78	$ 130.92	$ 141.92	$ 153.84
SI SFMC plan administration	$ 15.00	$ 16.26	$ 17.63	$ 19.11	$ 20.71	$ 22.45	$ 24.34
SI SFMC Total	N/A	$ 119.04	$ 129.04	$ 139.88	$ 151.63	$ 164.37	$ 178.18
Blended Total Costs (65% HMO - 35% SFMC)	N/A	$ 120.45	$ 130.56	$ 141.53	$ 153.42	$ 166.31	$ 180.28
	$ 3.48						

Children's Medicaid Costs w/o SI and Savings	**FY 04-05**	**FY 05-06**	**FY 06-07**	**FY 07-08**	**FY 08-09**	**FY 09-10**	**FY 10-11**
Growth Factor		**1.084**	**1.084**	**1.084**	**1.084**	**1.084**	**1.084**
non- SI HMO Medical & Admin	$ 114.26	$ 123.86	$ 134.26	$ 145.54	$ 157.77	$ 171.02	$ 185.38
non- SI fee-for-service Medical Claims	$ 113.74	$ 123.29	$ 133.65	$ 144.88	$ 157.05	$ 170.24	$ 184.54
Non-SI fee-for-service plan administration (2.5% of medical costs)	$ 2.84	$ 3.08	$ 3.34	$ 3.62	$ 3.93	$ 4.26	$ 4.61
Non-SI fee-for-service plan Total	$ 116.58	$ 126.38	$ 136.99	$ 148.50	$ 160.97	$ 174.50	$ 189.15
Blended Without Waiver Rates (22% HMO)	$ 116.07	$ 125.82	$ 136.39	$ 147.85	$ 160.27	$ 173.73	$ 188.32
Blended savings	N/a	$ (5.37)	$ (5.83)	$ (6.32)	$ (6.85)	$ (7.42)	$ (8.04)

HMO Share without Streamlined Initiative 22%

STATE OF COLORADO

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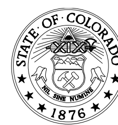

Bill Owens
Governor

Karen Reinertson
Executive Director

Appendix A:
Actuarial Feasibility Study
Medicaid and CHP+ Streamlining Initiative

July 01, 2005

"The mission of the Department of Health Care Policy & Financing is to purchase cost-effective health care for qualified, low-income Coloradans."
http://www.state.co.us/gov_dir/chcpf/index.html

CCRC
Actuaries, LLC

State of Colorado

Medicaid and CHP+ Streamlining Initiative

June 17, 2005

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Section I – Introduction of Colorado Medicaid and CHP+ Streamlining Initiative

The State of Colorado's Department of Health Care Policy and Financing (HCPF) is considering the streamlining of Medicaid children coverages, Child Health Plan Plus (CHP+), and the Colorado Indigent Care Program (CICP) into a single health care program that provides comprehensive benefits to all participants who are children, including an expansion of services to children who require more extensive care. This integrated plan would make it easier for families to receive consistent benefits while not switching between programs as their income fluctuates.

As a Federal requirement, this new program would look at expanding health care coverage to include target populations not currently served by Colorado's existing health care programs. This could include children with family incomes up to 200 percent of the Federal Poverty Level, and/or parents of CHP+ eligible children not enrolled in a current program and possibly identified within the indigent care program. It would also identify an appropriate group of CICP enrollees to receive full insurance benefits.

The streamlining project does not plan to require the participation of foster care, adoption, Supplemental Security Income (SSI), and children's waiver populations. These populations require much more intensive services than Medicaid clients, and they are much less likely to move between the Medicaid and CHP+ programs. However, a number of children with special health care needs (CSHCN) are income-eligible for Medicaid and CHP+ and would therefore be included in the project scope. They include children with chronic conditions, children with less-disabling conditions, and children who could potentially qualify for SSI. Disruptions in coverage due to switching from program to program can be particularly problematic for these children. Proper clinical management of asthma, juvenile diabetes, cerebral palsy, and teen pregnancy, for example, requires consistency in coverage and providers.

HCPF has engaged CCRC Actuaries, LLC (CCRC Actuaries) to perform an actuarial analysis of the proposed program based on enrollment and claim information available for review and to develop a projection of the proposed streamlining initiative. This report represents the first phase of this engagement, which was developing a model to project the expenses associated with the Core Benefits of the new Streamlining Initiative, as defined in Section V. This model can than be used to test prospective benefit and enrollment changes in the next phase of the analysis.

Using actuarial methodology, a baseline scenario was developed that assumes that the programs remain separate and unchanged from current operations. This scenario was performed to test the budget neutrality requirements established by the guidelines of the streamlining project. From this baseline scenario we developed the projection for the streamlining initiative. HCPF provided historical claim data, actuarial reports, provider reimbursement, and budget information that included projected enrollment numbers as well as claims that were the source of these projections. In addition, CCRC Actuaries utilized industry and governmental information as necessary to perform the calculations where credible information did not exist. It should be noted that the underlying claim experience for the managed care entities under the Medicaid program was not provided. In order to develop this information, CCRC Actuaries incorporated information available with respect to claims under the self-funded managed care (SFMC) coverages for Medicaid children, industry data with respect to experience for Medicaid children and claim assumptions developed from CHP+ experience.

STATEMENT OF ACTUARIAL OPINION

I, Dave Bond, Managing Partner of CCRC Actuaries, LLC hereby certify that I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I meet the actuarial qualification standards to render Statements of Actuarial Opinion for Children Health Insurance Programs and other self-insured entities. I have been retained by HCPF to render a Statement of Actuarial Opinion regarding the methods and underlying assumptions developed and used in this analysis.

This Statement of Actuarial Opinion was prepared in a manner consistent with the Code of Professional Conduct and Qualification Standards of the American Academy of Actuaries, and the Standards of Practice of the Actuarial Standards Board.

In preparing the plan, CCRC Actuaries utilized information concerning Medicaid and CHP+ prior experience, covered individuals, plan revenues, plan benefits, and other expenses. This information was developed and provided by HCPF, the plan's third party administrators and other consultants. National and industry experience was utilized where data was not specifically available for Colorado. In our review, we completely relied on the accuracy of this information and did not review or test the information in detail.

In the circumstances, and subject to the conditions described herein, based on our review, we believe the projections perform a reasonable basis under the assumption as set forth in each alternative and baseline presented.

The preparation of any estimate of future health costs requires consideration of a broad array of complex social and economic events. This report does not contemplate the financial impact of any changes in mandated benefits related to either the Medicaid or CHP+ program. Changes in reimbursement methodology, the emergence of new and expensive medical procedures and prescription drugs options, and the continuing evolution of the framework of the managed care options, increase the level of uncertainty of such estimates. As such, the estimate of governmental sponsored health program costs contains considerable uncertainty and variability and actual experience may not conform to the assumptions used.

In my opinion, the success of the Streamlining Initiative will largely depend on the successful development and reintroduction of managed care initiatives with meaningful utilization management techniques to the Medicaid population, as well as those variables such as enrollment changes, underlying medical trends and effective development of managed care capitations to managed care entities.

The chart on the following page summarizes the total program cost and the total state cost under the baseline scenario. The baseline scenario is assuming the current operations of both programs. This can be found in section VII.

Baseline Scenario			
	FY 2005	**FY 2006**	**FY 2007**
Total Program Cost	**$315,021,586**	**$354,718,488**	**$396,093,253**
Total State Cost	**$150,791,317**	**$169,483,010**	**$189,345,144**

The projection for the streamlining initiative has been provided analyzing the effect of mandatory enrollment and the unlimited capacity of the Health Maintenance Organization (HMO) operating in Colorado. We have not included potential savings associated with administrative expenses. The Streamlining Initiative assumes behavioral and mental health is provided as a separate capitation at the current Medicaid rates for both the SFMC and HMO populations. The use of the Medicaid rates is for the purpose of budgeting alone and not for negotiating. Any savings provided in behavioral and mental health could be utilized for expansion. The baseline scenario assumed current Medicaid HMO pricing at 95% of Medicaid Fee-For-Service. For the streamlining initiative, the current CHP+ efficiencies in HMO pricing are applied to the Medicaid population. Additionally, there are claims paid savings assumed in providing the Core benefits to the Medicaid population under the current CHP+ utilization review. Unified rates for the Streamlining Initiative were then developed from weighted average rates for Medicaid and CHP+.

Colorado will realize increased programmatic savings associated with utilization management and cost controls in combining Medicaid and CHP+. Colorado should realize additional cost savings in hospital claims by converting from a percent of charges system to paying claims based on Diagnosis-Related Groups (DRGs). ***Projected savings, not including administrative savings and any expansion scenarios, are approximately 4% of Total Program Costs.*** This does not include projected savings associated with adjusting how hospital charges are paid. The assumptions critical to this conclusion include HMO capacity in Colorado, the ability to adjust Medicaid HMO capitations and the ability to improve Medicaid SFMC utilization. As HMO enrollment increases, the risk associated with this group should approach the overall group, and capitations should be lowered as some of the anti-selection factors mitigate with wider coverage. It is our understanding that capitations are currently restricted to 95% of expected SFMC costs.

Currently, CHP+ pays physicians a capitation to provide certain services to children enrolled in the program. The PCP capitation has not been increased since the programs inception. The PCP capitation for the SFMC network may need to be increased to continue to get physicians to participate. A 10% increase in the PCP capitation would result in an additional $1,000,000 in claim costs for fiscal year 2005. Capitation works best with volume. Single physicians with a small Medicaid and CHP patient-load run the risk of sustaining a loss even though we show that the current PCP Capitation is in excess of the projected claim cost.

The following chart summarizes the total program cost, the total state cost, the total program savings, and the total state savings under our assumed assumptions. This can be found in Section VIII.

Streamlining Initiative			
	FY 2005	**FY 2006**	**FY 2007**
Total Program Cost	300,807,190	336,549,503	373,239,044
Total State Cost	141,856,026	158,228,949	175,476,845
Total Program Savings	14,214,396	18,168,985	22,854,209
Total State Savings	8,935,291	11,254,061	13,868,300

The projected claim costs for the SFMC network and HMO's for FY 2005 are shown in the following table.

Projected Fiscal Year 2004-2005 Costs for the HMO's (PMPM)

Age	< 100% FPL	100% to 133% FPL	> 133% FPL	Combined
< 1	$ 127.53	$ 127.35	$ 126.33	$ 127.07
1 thru 4	$ 94.84	$ 94.53	$ 93.10	$ 94.38
5 thru 9	$ 86.40	$ 85.93	$ 84.40	$ 85.86
10 thru 14	$ 95.38	$ 94.94	$ 93.43	$ 94.90
> 14	$ 134.13	$ 133.72	$ 132.17	$ 133.64
Combined	$ 102.94	$ 102.57	$ 101.14	$ 102.45

Projected Fiscal Year 2004-2005 Costs for the Self-Funded Managed Care Network (PMPM)

Age	< 100% FPL	100% to 133% FPL	> 133% FPL	Combined
<1	$ 109.21	$ 108.91	$ 106.80	$ 108.79
1 thru 4	$ 83.15	$ 82.85	$ 81.13	$ 82.79
5 thru 9	$ 75.82	$ 75.46	$ 73.68	$ 75.28
10 thru 14	$ 87.90	$ 87.48	$ 85.64	$ 87.52
> 14	$ 150.26	$ 149.84	$ 148.00	$ 149.89
Combined	$ 94.64	$ 94.30	$ 92.48	$ 94.23

The success of the Streamlining Initiative is contingent on the ability to negotiate with physicians and HMO's rates that are consistent with the current CHP benefit structure. The inability to successfully realize the current CHP reimbursement rates will adversely impact the projected savings. The results of our analysis are based on estimates of demographic and economic assumptions of the most likely outcome. Considerable uncertainty and variability are inherent in such estimates. Accordingly, the subsequent emergence of actual enrollees and actual expenses may not conform to the assumptions used in our analysis. Consequently, the subsequent development of these items may vary considerably from expected results. Future developments should be scrutinized, which may cause the program costs to vary significantly.

Dave Bond

Dave Bond
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June 17, 2005

Section II – Background of Children Health Plan Plus

On October 14, 1997, Colorado submitted a Title XXI State Plan to expand children's access to health coverage by building on the experience and infrastructure of the Colorado Child Health Plan (CCHP), an existing State-only program providing basic medical services to low-income children, and established Child Health Plan Plus (CHP+), a separate child health program.

Initially, coverage was provided to children through age 17 with family incomes at or below 185 percent of the Federal Poverty Level (FPL). Effective April 22, 1998, Colorado amended the Plan to expand coverage to children through age 18. The second amendment submission occurred on December 20, 2000, resulting in elimination of monthly premiums and an implementation of an annual enrollment fee for families with incomes between 151 and 185 percent of the FPL. Only 7 days later, a third revision was proposed to make changes in the Plan's application and enrollment process and in its service delivery system. Colorado submitted its fourth amendment on June 28, 2002, to update and amend its SCHIP State Plan to indicate compliance with the final SCHIP regulations and to add dental benefits for children. The addition of the dental benefit was effective February 1, 2002. The fifth amendment arising on December 10, 2003, provided Colorado with the authority to implement and to subsequently revoke an enrollment freeze, as the State budget allows. A freeze on enrollment for children became effective on November 1, 2003, and remained in place through June 30, 2004.

CHP+ includes health insurance coverage for low-income children under the age of 19. It provides medical benefits including inpatient and outpatient hospital, physician, prescription drugs, dental health care, and mental health care. CHP+ works to improve the health status of Colorado children by improving access to appropriate medical care and to reduce overall health care costs. The following table is a summary of CHP+ benefits:

Service	Available Benefits
Emergency Room and Urgent / After-hours Care	Covered after copay for a life or limb emergency.
Emergency Transport / Ambulance Services	Covered in full for a life or limb emergency.
Inpatient Hospital Stay	Covered in full.
Skilled Nursing Facility	Covered in full.
Outpatient / Ambulatory Surgery	Covered in full.
Laboratory, X-ray and Diagnostic Services	Covered in full.
Medical Office Visit	Primary Care Provider (PCP) visits (other than preventive) and specialty visits covered.
Preventive Care	Covered in full when provided by the member's PCP. Includes immunizations, well-child check-ups and well-teen check-ups.
Maternity Care	All prenatal and delivery visits covered in full.
Neurobiologically based mental illness	Covered the same as any other medical condition.
All other behavioral or mental health	45 inpatient days or 90 outpatient treatment days per benefit period. 20 outpatient visits per benefit period.
Alcohol and Substance Abuse	20 outpatient visits per diagnosis per benefit period. No inpatient coverage.
Physical, Occupational and Speech Therapy	30 outpatient visits per diagnosis per benefit period.
Durable Medical Equipment	Maximum of $2,000 per benefit period, excluding eyeglasses, contacts, or hearing aids.

Service (continued)	Available Benefits (continued)
Home Health Care	Covered in full
Outpatient Prescription Drugs	Covered after copay if included on the formulary
Vision Services	Coverage for age-appropriate preventive care and specialty care. $50 benefits for the purchase of lenses, frames, or contacts per benefit period.
Audiological Services	Coverage for age-appropriate preventive care. Hearing aids for congenital conditions and traumatic injuries up to a maximum of $800 per benefit period.
Transplant Services	Coverage for limited transplants with prior authorization by CHP+.
Dental Care	Periodic cleanings, exams, X-rays, fillings, and root canals. A maximum benefit or $500 per person per calendar year.

Annual Enrollment Fee and Co-Payments

Through CHP+, some families have to pay an Annual Enrollment Fee depending on their family's size and income. The cost is $25 to enroll one child for a year and $35 to enroll two or more children for a year. Families may also have to make a co-payment at the time children receive services. Families do not make co-payments for preventive care, including check-ups, shots, teeth cleanings, and dental x-rays. Generally, co-payments will be $1 to $5 per visit for medical care, and $5 per procedure for fillings and extractions. The chart below displays Annual Enrollment Fees and the price of co-payments for families with six or less members.

Family Size						Annual Payment		Co-Payment for each Office Visit
1 Person	2 People	3 People	4 People	5 People	6 People	One Child	2 or More Children	
Up through $8,980	Up through $12,120	Up through $15,260	Up through $18,400	Up through $21,540	Up through $24,680	No Fee	No Fee	No Copay
$8,981 to $13,470	$12,121 to $18,180	$15,261 to $22,890	$18,401 to $27,600	$21,541 to $32,310	$24,681 to $37,020	No Fee	No Fee	$2 per visit
$13,471 to $15,266	$18,181 to $20,604	$22,891 to $25,942	$27,601 to $31,280	$32,311 to $36,618	$37,021 to $41,956	$25 per year	$35 per year	$5 per visit
$15,267 to $16,613	$20,605 to $22,422	$25,943 to $28,231	$31,281 to $34,040	$36,619 to $39,849	$41,957 to $45,658	$25 per year	$35 per year	$5 per visit

The Department of Health Care Policy and Financing administers CHP+ with contracts for provider network administration, enrollment, outreach, and customer service. The program uses Managed Care Organizations (MCO) for health care delivery services. The statewide provider network established by the former Colorado Child Health Plan has been expanded to care for children who are eligible for CHP+ but who have not yet been enrolled in a HMO (HMOs generally initiate coverage on the first of the month only) and those children who live in areas where no service is available. The State contracts directly with the Plan's administrator (ASO) for professional services. All professional services are subject to the same percent of RBRVS fee schedule.

Section III – Background of Colorado Medicaid

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. Medicaid became law in 1965 as a cooperative venture jointly funded by the Federal and State governments to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

Within broad national guidelines established by Federal statutes, regulations, and policies, each state establishes its own eligibility standards, determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar proximity and size. State legislatures may change Medicaid eligibility, services and/or reimbursement during the year.

Medicaid does not provide medical assistance for all poor persons. Under the broadest provisions of the Federal statute, Medicaid does not provide health care services even for very poor persons unless they are in one of the groups designated below. Low income is only one test for Medicaid eligibility for those within these groups, in conjunction with resource standards. The following enumerates the mandatory Medicaid "categorically needy" eligibility groups for which Federal matching funds are provided:

- Individuals are generally eligible for Medicaid if they meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their State on July 16, 1996, or--at State option--more liberal criteria.

- Children under age 6 whose family income is at or below 133 percent of the Federal poverty level (FPL).

- Pregnant women whose family income is below 133 percent of the FPL (services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care).

- Supplemental Security Income (SSI) recipients in most States (some States use more restrictive Medicaid eligibility requirements that pre-date SSI).

- Recipients of adoption or foster care assistance under Title IV of the Social Security Act.

- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time).

- All children born after September 30, 1983 who are under age 19, in families with incomes at or below the FPL.

Scope of Medicaid Services

Title XIX of the Social Security Act allows considerable flexibility within the State's Medicaid plans. However, some Federal requirements are mandatory if Federal matching funds are to be received. A State's Medicaid program *must* offer medical assistance for certain *basic* services to most categorically needy populations. These services generally include the following:

- Inpatient hospital services.
- Outpatient hospital services.
- Prenatal care.
- Vaccines for children.
- Physician services.
- Nursing facility services for persons aged 21 or older.
- Family planning services and supplies.
- Rural health clinic services.
- Home health care for persons eligible for skilled-nursing services.
- Laboratory and x-ray services.
- Pediatric and family nurse practitioner services.
- Nurse-midwife services.
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings.
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

States may also receive Federal-matching funds to provide certain *optional* services. Colorado also provides the following additional benefits:

- Medical and surgical services furnished by a dentist under EPSDT.
- Podiatrists' services and Optometrist's remedial care services under EPSDT.
- Physical therapy, occupational therapy and speech therapy with limitations.
- Private duty nursing services.
- Prosthetic Device for clients of the EPSDT Program.
- Eyeglasses and contact lenses with limitations.

- Rehab Services
- Mental Health and Substance Abuse Services
- Prescription Drugs

Amount and Duration of Medicaid Services

Within broad Federal guidelines and certain limitations, States determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Two restrictions apply: (1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits; and (2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition.

In general, States are required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible persons. There are two important exceptions: (1) Medically necessary health care services that are identified under the EPSDT program for eligible children, and that are within the scope of mandatory or optional services under Federal law, must be covered even if those services are not included as part of the covered services in that State's Plan; and (2) States may request "waivers" to pay for otherwise uncovered home and community-based services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized. As long as the services are cost effective, States have few limitations on the services that may be covered under these waivers (except that, other than as a part of respite care, States may not provide room and board for the beneficiaries). With certain exceptions, a State's Medicaid program must allow beneficiaries to have some informed choices among participating providers of health care and to receive quality care that is appropriate and timely.

As of June 30, 2003, Colorado had the following comprehensive managed care participants in Medicaid:

Plan	Geographic Area Served	Enrollees
Colorado Access	Adams, Alamosa, Arapahoe, Bent, Boulder, Broomfield, Clear Creek, Conejos, Costilla, Crowley, Custer, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Huerfano, Jefferson, Kiowa, Larimer, Lincoln, Logan, Mineral, Morgan, Otero, Park, Phillips, Prowers, Pueblo, Rio Grande, Saguache, Sedgewick, Teller, Washington, Weld, Yuma	70,150
Primary Care Physician Program	Statewide	82,488
Rocky Mountain HMO	Delta, Mesa, Montrose, Ouray, Rio Blanco, San Miguel	11,911

Section IV – Comparison of Current Benefit Differences between Medicaid & Child Health Plan Plus

The Streamlining Initiative engaged JEN Associates, Inc. ("JEN Associates") to perform a demographic analysis of claim data from the Medicaid and CHP+ programs. This data was analyzed and served as a basis for the CCRC Actuaries projections under the Baseline and Streamline Initiative. JEN Associates completed a series of data analyses of Colorado state children less than 20 years of age enrolled in the Medicaid program and the Children's Health Insurance Program ("CHP+"). The purpose of the JEN Associates studies was to assess whether similarities exist between Medicaid and CHP+ enrolled populations to allow for the partial integration of health care systems and administrative functions. To this end, comparative profiles were produced to identify similarities as well as differences in demographics, disease levels, benefit types and utilization rates between the two populations. The study population includes income-eligible Medicaid children covered under fee-for-service financing and Medicaid children with PCC capitated care, and CHP+ enrollees in self-funded managed care health plans and managed care network. The claims and eligibility data used for the analyses included service and enrollment dates between CY2000-CY2002. It should be noted that JEN Associates did not receive claim information for managed care participants under the Medicaid program. However, JEN Associates concluded that the HMO would be no more at risk than the Medicaid FFS population and would be lower cost with higher levels of outpatient care and lower levels of inpatient acute care and that the inclusion of the HMO population in the analysis would most likely have proportionally increased the size of the Medicaid low risk group and made the utilization statistics more comparable between the CHP+ and Medicaid programs.

JEN Associates Report: Payment and Utilization Rates by Provider Type
Total Colorado Children in CHP+ and Medicaid CY2002

Total Colorado Children	Medicaid			CHP+		
Payment Type	Payments	PMPM	Percent	Payments	PMPM	Percent
Acute Care Hospital	$43,450,081	$50	41%	$3,339,373	$12	17%
Physician/Professional	$28,743,019	$34	27%	$7,796,044	$27	39%
Pharmacy	$9,684,098	$11	9%	$3,394,892	$12	17%
Outpatient Hospital/Clinic	$12,652,577	$15	12%	$2,025,708	$7	10%
Other	$12,330,753	$14	12%	$3,038,286	$10	16%
Program Total	$106,860,528	$124	100%	$19,594,302	$68	100%
Utilization Type	Utilization	Rate per 1,000		Utilization	Rate per 1,000	
MCD Acute Care Hospital Days	48,555	674		2,958	123	
Physician Specialist Encounters	42,294	587		12,781	529	
General Practitioner Encounters	131,401	1,824		64,553	2,674	
Pharmacy Rx/Refills	244,885	3,400		85,417	3,538	
Outpatient Emergency Visits	38,103	529		8,776	364	

Payment and Utilization Rates by Provider Type
Less Than 1-Year-Old Colorado Children in CHP+ and Medicaid CY2002

Less Than 1 Population	**Medicaid**			**CHP+**		
Payment Type	Payments	PMPM	Percent	Payments	PMPM	Percent
Acute Care Hospital	$23,990,017	$173	58%	$188,206	$19	21%
Physician/Professional	$8,729,596	$63	22%	$505,446	$52	57%
Pharmacy	$1,480,593	$11	4%	$59,185	$6	7%
Outpatient Hospital/Clinic	$4,787,475	$34	12%	$74,398	$8	8%
Other	$2,186,295	$16	5%	$65,956	$7	7%
Program Total	$41,173,977	$296	100%	$893,191	$91	100%
Utilization Type	Utilization	Rate per 1,000		Utilization	Rate per 1,000	
MCD Acute Care Hospital Days	30,264	2,612		322	392	
Physician Specialist Encounters	5,617	485		256	311	
General Practitioner Encounters	49,264	4,252		4,611	5,610	
Pharmacy Rx/Refills	37,867	3,268		2,083	2,534	
Outpatient Emergency Visits	10,133	875		399	485	

Payment and Utilization Rates by Provider Type
Pregnant Young Women (between 15-19 years of age) in CHP+ and Medicaid CY2002

Pregnant Young Women Population	**Medicaid**			**CHP+**		
Payment Type	Payments	PMPM	Percent	Payments	PMPM	Percent
Acute Care Hospital	$5,915,076	$184	44%	$116,008	$135	51%
Physician/Professional	$3,051,034	$95	23%	$48,778	$57	21%
Pharmacy	$569,452	$18	4%	$10,522	$12	5%
Outpatient Hospital/Clinic	$1,324,624	$41	10%	$10,677	$12	5%
Other	$2,484,574	$77	19%	$41,455	$48	18%
Program Total	$13,344,760	$416	100%	$227,441	$265	100%
Utilization Type	Utilization	Rate per 1,000		Utilization	Rate per 1,000	
MCD Acute Care Hospital Days	5,926	2,215		116	1,620	
Physician Specialist Encounters	5,208	1,946		55	768	
General Practitioner Encounters	2,905	1,086		458	6,398	
Pharmacy Rx/Refills	16,510	6,171		355	4,959	
Outpatient Emergency Visits	2,342	875		43	601	

Payment and Utilization Rates by Provider Type
Special Needs Children in CHP+ and Medicaid CY2002

Special Needs Children Population	Medicaid			CHP+		
Payment Type	Payments	PMPM	Percent	Payments	PMPM	Percent
Acute Care Hospital	$7,477,993	$149	43%	$1,418,953	$48	26%
Physician/Professional	$4,277,323	$85	24%	$1,579,499	$53	28%
Pharmacy	$2,081,349	$42	12%	$1,024,054	$35	19%
Outpatient Hospital/Clinic	$1,147,748	$23	7%	$501,551	$17	9%
Other	$2,589,962	$52	15%	$1,002,304	$34	18%
Program Total	$17,574,375	$351	100%	$5,526,360	$186	100%
Utilization Type	Utilization	Rate per 1,000		Utilization	Rate per 1,000	
MCD Acute Care Hospital Days	7,317	1,753		1,340	542	
Physician Specialist Encounters	8,564	2,052		4,466	1,806	
General Practitioner Encounters	15,533	3,721		11,109	4,493	
Pharmacy Rx/Refills	39,982	9,578		19,180	7,757	
Outpatient Emergency Visits	4,579	1,097		1,766	714	

The primary findings of the JEN Associates analyses are listed below.

- The number of children under one year of age is significantly higher in the Medicaid program;
- The number of young women between 15-19 years of age with a pregnancy diagnosis is significantly higher in the Medicaid program;
- The Medicaid 'low-risk' population is most comparable to CHP+ enrollees;
- Differences in utilization in the two programs are higher outpatient physician utilization in CHP+ and higher inpatient acute care in Medicaid;
- Claim cost PMPM for CHP+ services are lower than Medicaid in the comparable population by close to 17%; and
- The CHP+ benefit limits are not exceeded in the comparable Medicaid population to any significant degree.

JEN Associates' conclusion is that the current CHP+ program as currently configured, in terms of the types of children enrolled, the benefits offered and the costs of care, is compatible, but not equivalent, with the care needs and costs of low-risk children currently covered under the Medicaid program. It should be noted that Medicaid enrollees who were SSI eligible, in Foster Care, in a Home and Community Based Waiver, or otherwise not linked to an income-eligible aid category were excluded from the study population.

Analytic Design

The JEN Associates comparison of the CHP+ and Medicaid program can be measured using a variety of criteria. However, an essential first step is to understand the impact of program design on the demographics and risk characteristics of the enrolled populations. Both programs are structured to provide a specific population's access to state supported care. The result is that the populations are not pure cross-sections of all children, but rather represent specific sub-groups whose selection is determined by program eligibility criteria and level of outreach to eligible populations.

The Medicaid program enrolls low income children based on a combination of applicant income status and medical care needs. For large portions of the Medicaid population, program benefits are contingent on low income. For these children the medical benefit may be used for preventive care or to treat pre-existing conditions. A second significant population is children who are eligible for Social Security benefits due to disability. For these beneficiaries, the Medicaid benefit represents essential support for high cost and persistent medical and rehabilitation care. A third major non-adult population in Medicaid is pregnant young women and subsequently their babies, requiring coverage for the costs of pre-natal, delivery and newborn care.

CHP+ beneficiary population is composed of a cross-section of low-income children whose families sought enrollment for the coverage of preventive care costs or to address identified health problems. Parent sensitivity to the value of preventive care and/or the recognition of a current health care need of varying severity is critical to CHP+ enrollment. The self-selection aspect of CHP+ enrollment contrasts with Medicaid in which eligibility may be coupled to a state or federal cash benefit (historically), a determination of a major disability or pregnancy. Further complicating any comparison are the CHP+ program benefit design features that limits reimbursement for specific services. These types of restrictions of benefits are not in place with the regular Medicaid program.

CHP+ and Medicaid Demographics

JEN Associates determined that the differences between the CHP+ and Medicaid program eligibility criteria are immediately evident from comparisons of age and gender between the two populations. The Medicaid population profile is representative of children/teens whose Medicaid eligibility falls under the low-income aid categories. The level of medical need is primarily related to well care and episodic illness and /or prenatal and postpartum maternity and newborn care. The CHP+ distribution represents a more normal demographic pattern except with diminished coverage for the oldest teens and children less than one year of age.

Disability and Illness in the Programs

JEN Associates reported that the Medicaid population contains many disabled children who are eligible for SSI benefits. The SSI Eligibles have not been included in the Medicaid population analysis since they represent a clearly identified special needs group that has no direct analog among CHP+ enrollees and do not represent a clear segment to be integrated between the two programs.

JEN Associates reported that the main observed difference in disability rates between the two populations is in the category of Mental Retardation/Developmental Disability with a relative rate in Medicaid that is twice as high as observed in the CHP+ population. However, the main conclusion is that the non-SSI Medicaid and CHP+ children do exhibit significant rates of conditions that are disability related and that the rates are sufficiently similar to suggest cross-program comparability in the care management challenge. The following chart summarizes the JEN Associates conclusions with respect to disability:

Selected Condition Rates in CY 2002 Medicaid and CHP+ Children

Condition	Medicaid	CHP+
Chronic Heart Disease	4%	3%
Injuries	47%	69%
Cancer	2%	3%
Pneumonia	33%	25%
Urinary Tract Infection	26%	28%
Asthma/COPD	61%	55%
Diabetes	3%	4%

Population Types and Payments

JEN Associates has broken the payment profiles out by those significant subpopulations identified in the demographic and disease profiles to ensure comparability of children between CHP+ and Medicaid. A natural demographic classification for the presentation of payment profiles was developed as follows: 1) children with a disability related diagnosis; 2) less than one year of age; 3) young women with a pregnancy diagnosis; 4) the low risk population (all others). The categorization allows for the direct comparison of like populations within each program and adjusting for eligibility and program design based variations.

Payment and Enrollment by Population Type
Colorado Children in CHP+ and Medicaid CY2002

CY 2002 Medicaid Population Type	Enrollee Months	Population Percent	Payments	Payment Percent	Per Enrollee Per Month
Special Needs	50,090	6%	$ 17,574,375	16%	$ 351
Pregnancy	32,107	4%	$ 13,344,760	12%	$ 416
Less Than 1	139,042	16%	$ 41,173,977	39%	$ 296
Low Risk Population	642,882	74%	$ 34,738,482	33%	$ 54
Total	864,121	100%	$ 106,831,594	100%	$ 124

CY 2002 CHP+ Population Type	Enrollee Months	Population Percent	Payments	Payment Percent	Per Enrollee Per Month
Special Needs	29,670	9%	$ 5,526,360	28%	$ 186
Pregnancy	857	0%	$ 227,407	1%	$ 265
Less Than 1	9,863	3%	$ 893,191	5%	$ 91
Low Risk Population	289,667	88%	$ 12,947,345	66%	$ 45
Total	330,057	100%	$ 19,594,302	100%	$ 59

Descriptive Comparison of Medicaid and CHP+ Low Risk Children

Based on JEN Associates' report the comparability within the low risk population can be further established by reviewing the types of conditions that drive Medicaid and CHP+ program costs and the relative costs per case. The results show interesting similarities and differences between the programs. The only conditions that have slighter higher rates of prevalence in the CHP+ population compared to Medicaid are for acute pharyngitis and strep sore throat. For Medicaid children conditions with higher prevalence include acute URI (upper respiratory infection), otitis media, fever, dental care, non-infectious gastroenteritis and hypermetropia. The higher prevalence of hypermetropia is most likely due to benefit differences in vision coverage. The costs per case do vary for some conditions and may relate to differences in the setting of care (inpatient versus outpatient) between the two programs. Medicaid low risk children have higher rates of outpatient emergency room utilization and inpatient acute care days in comparison to their CHP+ program counterparts. These utilization rates explain the differences in per member per month payments, where CHP+ low risk children have higher rate of encounters for general practitioners compared to Medicaid low risk children with higher utilization rates of inpatient and outpatient hospital care.

Compatibility of CHP+ Benefit Structure

The analysis of Medicaid payments performed by JEN Associates includes services that have annual caps in the CHP+ program. To the extent that the Medicaid low risk populations uses these services beyond the capped amount, the analysis may include skewed comparisons between the programs. Additionally, if the Medicaid population includes large numbers of children with care needs far in excess of the services normally provided by CHP+, there will be implications in terms of the understanding of CHP+ administrative and network capacity to support the low-risk Medicaid children.

The affected benefits include the following list of per annum caps on coverage:

1) Durable Medical Equipment is capped at $2,000;
2) Mental health related inpatient covered stay days are limited to 45 days;
3) Rehabilitation therapist covered encounters are limited to 30 encounters;
4) Mental health outpatient covered services is limited to 20 encounters; and
5) Substance abuse outpatient covered services is limited to 20 encounters.

According to the JEN Associates' analysis, the data demonstrates that the number of Medicaid children with high care needs that exceed the current CHP+ benefit structure is relatively low. Based on this analysis, CCRC Actuaries has assumed that the Streamlining Initiative will incorporate expenses in excess of these limitations from the CHP+ benefit package in a "Core Plus" wrap-around resulting in a small increase in CHP+ per capita costs.

Section V – Benefit Design of the Streamlining Initiative

Streamlining Design Considerations

In order to accomplish their goal, the HCPF commissioned MDF Associates, a consulting firm located in Medford, Massachusetts, specializing in the development of health care programs for publicly funded beneficiaries for the public and private sector, to make recommendations around benefit design and delivery systems.

The design of any health care system, including this streamlined program, is multi-faceted and complex, given the interdependencies within the system. The design ultimately chosen will be directly responsible for expected financial results and any variations in the ultimate delivery system will result in changes not reflected in this report. In the case of a streamlined program, key interdependencies include benefits, delivery system configuration and management, risk management, and network management.

In any streamlining initiative, there are potential savings in improved economies of scale for prescription drugs and administrative expenses. We have not attempted to define the potential savings of these two line items in this report.

We have assumed potential savings in the CHP+ program for hospital claims by converting from a percentage of charges to DRGs. We have assumed the streamlining initiative will realize a 5% savings in hospital reimbursements with a corresponding 2% increase in hospital visits. This assumption is based on industry and state experience that when a discounted fee-for-service reimbursement hospital methodology is replaced by a per visit reimbursement methodology such as DRG reimbursement, an increase in utilization is observed.

One area that should be looked at is the value of the stop-loss program for CHP+. Currently, the insurance costs $2.39 PMPM for projected stop-loss claims of $0.202. We have not attempted to define the potential savings of modifying this stop-loss coverage.

MDF Associates, in their February 25, 2004 report, made the following detailed program design recommendations:

- Provide a common "Core" benefit package, with comprehensive, quality, cost-effective services that fully meet the needs of a majority of children. The "Core" benefits will consist of the current CHP+ benefit package.

- Provide "Core Plus" wrap-around benefits to all children in the streamlined program who appropriately require such services. The "Core Plus" benefit package will consist of full Medicaid benefits less full CHP+ benefits.

- Establish a clear delineation between Core and Core Plus benefits for the purpose of enhancing seamlessness, continuity and administrative simplicity.

- Ensure the adequacy, appropriateness, and cost-effectiveness of the Core Benefit Package over time for the majority of children enrolled. Develop and implement a methodology to periodically assess the adequacy and appropriateness of the Core benefit package; develop and implement a methodology to cover additional benefits on an exception case-by-case basis; augment the existing CHP+ benefit package with certain appropriate, cost-effective benefits that will have the effect of reducing long-term health care expenditures for children who require them, when necessary.

- Apply a single definition of Medical Necessity to all children in the streamlined program, including Children with Special Health Care Needs. Implementation of the definition should be managed through the provision of Core and Core Plus benefits.

- Promote seamlessness and continuity of care by utilizing the same provider network(s) for Core and Core Plus benefits, where feasible.

- Develop a series of value-based purchasing strategies to ensure and strengthen the delivery system for the streamlined program. Recommended best practices for value-based purchasing strategies include:

  A. Limited partnerships with vendors that are willing to provide (and will receive) outstanding service in exchange for volume;

     Purchase health care from a limited number of plans, requiring outstanding service in exchange for volume. Offer a market potential of 30,000 to 35,000 wherever possible, while balancing access and choice. Provide an excellent level of service to contracted plans by Department staff.

  B. An enrollment design that supports volume with limited partnerships;

     Structure enrollment in a manner that maximizes market potential for vendors while maintaining strong access. Require enrollees to select plans or providers within their geographic area, regardless of utilization or special needs. Allow variability in the number of vendors based on market conditions by geographic region.

  C. Use of reasonable, measurable performance-based structure, process and outcome measures; and,

     Develop and monitor reasonable, clearly defined structure, process and outcome standards that promote compliance and improvement, based on state of the art practices in the industry. Reinforce performance-based purchasing through incentives and disincentives, such as:

     1. Bonuses for exceeding quality standards;

     2. Enrollment volume (e.g. through an assignment process); and,

     3. Increased or decreased flexibility in plan management/benefit administration.

D. Inclusion of a self-insured product as an enrollment option for consumers;

Maximize competition and leverage by maintaining a self-insured option as a choice for consumers to select among other health plans.

- Offer a tiered case management benefit, provided to children that require services in excess of the Core benefit package. Employ appropriate levels of case management for all enrollees, based on individual need.
- Develop an enhanced screening system featuring child development services to CHP+ and Medicaid enrollees. The offering of child development services relates to how Colorado manages the actual delivery of care, as well as the benefits provided. NOTE: The actual "benefits" provided as part of this service, as well as what Medicaid would or would not cover, are unclear. This requires further investigation. Also, how this service delivery structure would differ from current developmental services provided in Medicaid and CHP+ requires further investigation.
- Review prior authorization and referral requirements to ensure cost-effective, quality driven processes to manage service delivery.
- Employ full-risk capitation to compensate providers for services within the Core benefit package, to the extent feasible, given market conditions, in order to minimize risk and achieve predictability of health care expenditures. Maximizing full-risk capitation depends on the Department's ability to:

  A. Adopt commercial business practices, to the extent practical;

  B. Develop business-oriented relationships driven by value purchasing;

  C. Minimize incentives to cost-shift;

  D. Maximized incentives to provide an appropriate level of care; and,

  E. Pay adequate rates that clearly delineate responsibility for Core and Core Plus benefits.

- Core Plus benefits in a manner that minimizes cost shifting and maximizes coordination and continuity of care. Additional research and analysis currently underway by MDF Associates needs to be completed before a definitive recommendation can be made with respect to how Core Plus services should be reimbursed. This recommendation will drive the selection of the method to minimize the State's exposure and ensure quality.
- Contract for an integrated Administrative Services Only (ASO) product for the self-insured network to administer the self-insured program as any other contracted managed care plan. Network management, risk-based reimbursement, management and limited quality bonuses should all be included in management efforts.

Section VI – Analysis of Historical Claim and Capitation Data

Historical claims for CHP+ and Medicaid were analyzed for fiscal years 2000 through 2003. For Medicaid HMO claims, only the wrap-around services are available. The following two charts show the major provider categories for each fiscal year.

The claims data was provided by JEN Associates and contained the detail of claims paid and member months by calendar year. This file initially was defined on a calendar year basis while our analysis was to be based on a fiscal year basis. An additional file, which identified both the calendar year as well as the fiscal year, provided us with the full 2003 fiscal year data, allowing us to use FY 2003 as our base year. This data included mental health services for both CHP+ and Medicaid.

CHP+

		FY 2000	FY 2001	FY 2002	FY 2003
Hospital Inpatient	Acute Care Hospital	$1,784,799	$2,698,851	$3,631,713	$4,123,556
Hospital Outpatient	Outpatient Hospital/Clinic	525,555	1,169,768	1,945,290	2,482,016
Drugs	Pharmacy	851,468	1,855,606	3,363,382	4,539,165
Physician Services and Other	Cross-Over	0	0	0	0
	Day Care/Foster Care	0	0	0	70
	Diagnostic Testing	522,851	1,223,043	1,946,503	2,294,069
	Home Care/Health	43,697	27,463	51,969	127,216
	Hospice	0	0	194	0
	Intermediate Care Facility	0	0	0	0
	Mental Health Clinic	57,023	90,927	143,611	230,664
	Non-Physician Practitioner	112,051	186,653	318,584	326,343
	Nursing Home	0	0	0	0
	Other	1,386	45,777	16,846	30,015
	Physician	1,422,440	3,041,960	4,507,324	5,352,528
	Premium Buy-in	0	0	0	0
	Rehab./Psych. Hospital	0	0	0	590
	Skilled Nursing Facility	0	0	0	0
	Supplies/DME	188,169	436,591	635,153	834,328
	Transport	59,034	120,408	202,209	230,126
	Waiver Services	0	0	0	0
Total		**$5,568,473**	**$10,897,048**	**$16,762,779**	**$20,570,687**

Medicaid Summary

		FY 2000	FY 2001	FY 2002	FY 2003
Hospital Inpatient	Acute Care Hospital	$43,681,383	$40,846,005	$46,429,645	$50,684,261
Hospital Outpatient	Outpatient Hospital/Clinic	10,378,951	9,662,409	11,196,994	18,456,739
Drugs	Pharmacy	5,384,484	6,821,135	8,907,440	13,743,803
Physician Services and Other	Cross-Over	0	0	0	0
	Day Care/Foster Care	2,618	0	0	0
	Diagnostic Testing	5,134,845	6,767,661	7,608,949	10,639,382
	Home Care/Health	724,329	766,372	926,107	1,073,355
	Hospice	14,431	20,758	6,081	29,617
	Intermediate Care Facility	0	0	0	36,829
	Mental Health Clinic	90,053	4,777	2,582	2,208
	Non-Physician Practitioner	5,440,734	5,803,257	7,235,797	11,240,097
	Nursing Home	35	0	42	0
	Other	0	848	0	0
	Physician	16,423,192	16,830,121	19,864,094	26,429,120
	Premium Buy-in	0	0	0	0
	Rehab./Psych. Hospital	75,237	19,990	46,252	47,253
	Skilled Nursing Facility	0	0	0	0
	Supplies/DME	1,851,715	2,088,600	2,259,423	3,119,404
	Transport	450,138	526,085	940,888	884,586
	Waiver Services	50,167	54,183	80,886	95,299
Total		**$89,702,311**	**$90,212,200**	**$105,505,180**	**$136,481,951**

Section VII – Projection of Baseline Medicaid and CHP+ Program Costs

The original files from JEN Associates contained the detail of claims paid and member months by calendar year broken into categories based on age, sex, FPL, HMO or FFS Plan, etc. We identified specific categories in this database to determine the four major categories of Inpatient, Outpatient, Drugs, and Physician Services and Other. The claims in the database were specified as Acute Care Hospital (Inpatient), Outpatient Hospital/Clinic (Outpatient), Pharmacy (Drugs), and approximately 17 other categories (Physician Services and Other). In addition the Capitation Payments, Patient Copay/Deductible, Third Party Payment were identified by the demographic categories described above. This database provided the base year enrollment, and the cost per service by the categories identified above.

This file initially was defined on a calendar year basis while our analysis was to be based on a fiscal year basis. An additional file, which identified both the calendar year as well as the fiscal year, provided us with the full 2003 fiscal year data, allowing us to use FY 2003 as our base year.

These files did not contain utilization and cost per service information in the detail that we would have liked. This caused us to use the Leif report as a base for the utilization and initial allowable cost. The allowable cost was adjusted by factors applied to each of the four main claim categories to reach the average claim costs from JEN Associates' data.

After reviewing the database sent to us by JEN Associates, the following requested data was received for both the Medicaid and CHP+ Programs unless noted otherwise:

- CHP+ and Medicaid Comparitability Analysis from the Department of Health Care Policy and Financing
- Medicaid budget approvals for FY 2000 to FY 2002, drug rebates and reconciliation
- Medicaid inpatient hospital rates from FY 2000 to FY 2004
- Historical and projected CHP+ monthly enrollment totals
- Historical and projected CPI in the Denver area
- Medicaid rate history from FY 1984 to FY 2001
- A summary of the caseload history for Medicaid from FY 1987 to FY 2004, with estimates for FY 2002 and projections for FY 2003 and FY 2004
- Medicaid fee schedules for FY 2003 and FY 2004
- The Design of A Streamlined Program for CHP+ and Medicaid commissioned by the State of Colorado Department of Health Care Policy and Financing
- The conversion factors by RBRVS codes for the CHP+ SFMC plan
- A summary of CHP+ enrollment by HMO and network
- Report by JEN Associates, Inc. assessing whether the similarities between Medicaid and CHP+ enrolled populations allow for a partial integration of administrative functions
- FY 2004-2005 figure setting and FY 2003-2004 HCPF Premiums/Medicaid Adjustments
- Database containing a list of claims by DRG profiles for Colorado Medicaid and CHP+
- Encounter claims from HMOs fro CHP fiscal years 1999-2001

Data received from JEN Associates was utilized to develop raw PMPM claim cost by category for CHP+ SFMC and CHP+ HMO. Program costs for the varying FPL utilized the raw PMPM claim costs adjusted for the co-pay differentials. Program costs were developed based on the CHP+ SFMC projected PMPM claim costs with an administrative load, and projected CHP+ HMO capitation rates.

Fiscal Year 2003 data was available as the base year data. However, The Leif Associates Colorado CHP+ FY 2004-2005 Rate Development Report provided incurred 2002, paid through 3/31/03 utilization PMPY and allowable cost per unit data. Data for the Self-funded Managed Care Network Claim and Admin Costs (Excluding Prenatal Program) was provided for all ages and income categories combined, as well as for ages 0-1, ages 2-6, and ages 7-18, while the CHP+ HMO Costs (Excluding Prenatal Program) was provided only in total for all ages and income categories combined. In addition, the SFMC data was presented with copay adjustments for the FPL categories <101% FPL, 101% to 150% FPL and >150% FPL.

JEN Associates' data was presented with the following breakdown of ages and FPLs:

- Ages: <1, 1-4, 5-9, 10-14, and 15-19.
- FPLs: 100% FPL, 133% FPL, 185% FPL, and 36% FPL.

The data from Leif associates was converted to the Age and FPL breakdown utilized by JEN Associates. We analyzed the varying data from the two sources, and balanced the historical claim costs to the amount paid.

Assumptions included a uniform distribution across each age band since we had no other data to support a different distribution. Using a different distribution would not have a significant impact on the financial projections.

From the stratified historical data, projected per member per month claims costs were developed base on the Core Benefits and the assumed trend factors. The administrative costs were added to the claim costs, and adjustments were made to reflect the impact of plan co-pays on the varying FPLs to the overall gross projected costs.

A. Claim Assumptions

Historical claim cost PMPM from FY 2003 was developed from the data described above. This data was trended forward by claim category (as detailed on page 37) to project the claim cost PMPM in the charts below.

The CHP+ data was then compared to the historical Medicaid data received from JEN Associates. This data was utilized to develop raw PMPM claim cost by category for Medicaid FFS and the Medicaid HMO wrap-around services. Medicaid wrap-around services include, but are not limited to:

- Prenatal care and deliveries
- Physical therapy, occupational therapy and speech therapy with limitations
- Eyeglasses and contact lenses with limitations
- Rehab services
- Mental health and substance abuse services
- Federally qualified health centers
- Indian Health Services

Program costs were developed based on the Medicaid FFS projected PMPM claim costs, and projected Medicaid HMO capitation rates added to projected Medicaid HMO wrap-around services.

We have not included administrative expenses in our projection.

Null Hypothesis Assumptions:

To project claim costs PMPM (which equals the utilization PMPM times the allowable cost per unit), trend assumptions were developed concerning service utilization and cost. Additionally, enrollment projection assumptions included overall enrollment growth, migration from the HMO program to the SFMC program and migration from the SFMC program to the HMO program were formed.

The null hypothesis or baseline scenario assumes an overall enrollment growth of 2% and 0% migration. The purpose of this report is to analyze the impact of the Streamlining Initiative. While budgeted enrollment for fiscal years 2006 and 2007 may vary from this report, changes to the enrollment will not have a significant impact on cost savings associated with the Streamlining Initiative.

The chart below shows the assumed claim trend assumptions for each claim category type. These assumptions are based on industry experience by claim category type. The industry experience analyzed included national data, Colorado data, as well as other state data. The trend assumptions are consistent with those utilized by similar programs. Ultimately, trend will be affected by changes in the reimbursement schedule, changes in medical technology and other factors.

Provider Reimbursement	**FY 2005 - FY 2007**	
Trend Assumptions	**Ages 0-18**	
Medicaid & CHP+	**Utilization PMPM**	**Allowable Cost Per Unit**
Type of Service		
Inpatient Hospital (days)	5%	2%
Outpatient Hospital (visits)	7%	2%
Lab and Radiology	5%	2%
Physician (Non-capitated)	5%	5%
Mental Health/Substance Abuse	8%	2%
Ambulance	8%	0%
Durable Medical Equipment	5%	2%
Home Health	5%	2%
Drugs/Injections	5%	8%
Supplies - Medical and Surgical	5%	4%
Therapies/Treatments	5%	5%
Vision Services	5%	5%
Other	5%	5%
Unknown	5%	5%

B. Enrollment Assumptions

The next seven pages present a summary of the enrollment by CHP+ and Medicaid for SFMC and HMO. The data received from JEN Associates contained FPL categories marked as "None" that represented only 0.1% of the CHP fee-for-service enrollment and 13.2% of the total HMO enrollment. These numbers were allocated over the four FPL categories based on the distribution of members in each age strata and FPL status. As such, the None category was removed from the charts below.

CHP+ SFMC Enrollment				
Age Strata	**FPL Status**	**FY 2005**	**FY 2006**	**FY 2007**
<1	036% FPL	130	141	144
	100% FPL	101	110	112
	133% FPL	250	271	277
	185% FPL	66	72	73
<1 Total		**548**	**594**	**606**
01-04	036% FPL	935	1,014	1,034
	100% FPL	762	826	842
	133% FPL	1,707	1,851	1,888
	185% FPL	463	502	512
01-04 Total		**3,867**	**4,192**	**4,276**
05-09	036% FPL	1,065	1,155	1,178
	100% FPL	1,028	1,114	1,136
	133% FPL	2,041	2,212	2,256
	185% FPL	460	499	509
05-09 Total		**4,594**	**4,980**	**5,079**
10-14	036% FPL	1,040	1,128	1,150
	100% FPL	985	1,068	1,089
	133% FPL	1,781	1,930	1,969
	185% FPL	368	399	407
10-14 Total		**4,173**	**4,524**	**4,615**
15-19	036% FPL	642	696	710
	100% FPL	564	611	623
	133% FPL	930	1,008	1,029
	185% FPL	201	218	223
15-19 Total		**2,337**	**2,534**	**2,584**
Overall Total		**15,520**	**16,824**	**17,160**

CHP+ HMO Enrollment				
Age Strata	FPL Status	FY 2005	FY 2006	FY 2007
<1	036% FPL	190	206	210
	100% FPL	166	179	183
	133% FPL	428	463	473
	185% FPL	115	125	128
<1 Total		**899**	**974**	**994**
01-04	036% FPL	1,706	1,850	1,887
	100% FPL	1,584	1,717	1,751
	133% FPL	3,534	3,831	3,908
	185% FPL	909	985	1,005
01-04 Total		**7,733**	**8,383**	**8,550**
05-09	036% FPL	2,111	2,288	2,334
	100% FPL	2,208	2,394	2,442
	133% FPL	4,676	5,069	5,170
	185% FPL	918	996	1,016
05-09 Total		**9,914**	**10,747**	**10,962**
10-14	036% FPL	1,949	2,113	2,156
	100% FPL	2,136	2,315	2,361
	133% FPL	3,875	4,201	4,285
	185% FPL	722	783	798
10-14 Total		**8,682**	**9,412**	**9,600**
15-19	036% FPL	1,158	1,256	1,281
	100% FPL	1,192	1,292	1,318
	133% FPL	2,098	2,274	2,320
	185% FPL	401	435	444
15-19 Total		**4,849**	**5,256**	**5,361**
Overall Total		**32,076**	**34,772**	**35,467**

Total CHP+ Enrollment				
Age Strata	**FPL Status**	**FY 2005**	**FY 2006**	**FY 2007**
<1	036% FPL	320	347	354
	100% FPL	267	289	295
	133% FPL	678	735	749
	185% FPL	182	197	201
<1 Total		**1,447**	**1,568**	**1,599**
01-04	036% FPL	2,641	2,863	2,921
	100% FPL	2,345	2,542	2,593
	133% FPL	5,241	5,682	5,796
	185% FPL	1,372	1,488	1,517
01-04 Total		**11,600**	**12,575**	**12,826**
05-09	036% FPL	3,177	3,443	3,512
	100% FPL	3,236	3,508	3,578
	133% FPL	6,717	7,281	7,427
	185% FPL	1,378	1,494	1,524
05-09 Total		**14,507**	**15,727**	**16,041**
10-14	036% FPL	2,990	3,241	3,306
	100% FPL	3,120	3,383	3,450
	133% FPL	5,656	6,131	6,254
	185% FPL	1,090	1,181	1,205
10-14 Total		**12,856**	**13,936**	**14,215**
15-19	036% FPL	1,800	1,951	1,990
	100% FPL	1,755	1,903	1,941
	133% FPL	3,028	3,283	3,348
	185% FPL	603	653	666
15-19 Total		**7,186**	**7,790**	**7,946**
Overall Total		**47,596**	**51,596**	**52,628**

Medicaid SFMC Enrollment				
Age Strata	**FPL Status**	**FY 2005**	**FY 2006**	**FY 2007**
<1	036% FPL	4,534	4,625	4,717
	100% FPL	1,412	1,440	1,469
	133% FPL	23,821	24,297	24,783
	185% FPL	327	334	341
<1 Total		**30,094**	**30,696**	**31,310**
01-04	036% FPL	13,560	13,832	14,108
	100% FPL	13,295	13,561	13,832
	133% FPL	9,655	9,848	10,045
	185% FPL	701	715	730
01-04 Total		**37,212**	**37,956**	**38,715**
05-09	036% FPL	10,417	10,625	10,838
	100% FPL	12,839	13,096	13,358
	133% FPL	1,943	1,982	2,022
	185% FPL	619	631	644
05-09 Total		**25,818**	**26,334**	**26,861**
10-14	036% FPL	7,697	7,851	8,008
	100% FPL	10,049	10,250	10,455
	133% FPL	194	198	202
	185% FPL	491	501	511
10-14 Total		**18,431**	**18,800**	**19,176**
15-19	036% FPL	6,644	6,777	6,912
	100% FPL	5,757	5,873	5,990
	133% FPL	2,461	2,510	2,560
	185% FPL	244	249	254
15-19 Total		**15,106**	**15,408**	**15,717**
Overall Total		**126,662**	**129,195**	**131,779**

Medicaid HMO Enrollment				
Age Strata	**FPL Status**	**FY 2005**	**FY 2006**	**FY 2007**
<1	036% FPL	1,072	1,094	1,116
	100% FPL	318	324	331
	133% FPL	6,486	6,615	6,748
	185% FPL	443	452	461
<1 Total		**8,319**	**8,486**	**8,655**
01-04	036% FPL	8,161	8,324	8,491
	100% FPL	8,267	8,432	8,600
	133% FPL	7,003	7,143	7,286
	185% FPL	1,823	1,859	1,897
01-04 Total		**25,253**	**25,759**	**26,274**
05-09	036% FPL	6,967	7,107	7,249
	100% FPL	9,472	9,661	9,855
	133% FPL	1,936	1,975	2,014
	185% FPL	1,477	1,507	1,537
05-09 Total		**19,853**	**20,250**	**20,655**
10-14	036% FPL	5,391	5,499	5,609
	100% FPL	7,871	8,028	8,189
	133% FPL	230	234	239
	185% FPL	1,114	1,136	1,159
10-14 Total		**14,606**	**14,898**	**15,196**
15-19	036% FPL	3,564	3,635	3,708
	100% FPL	4,049	4,130	4,213
	133% FPL	496	506	516
	185% FPL	417	425	434
15-19 Total		**8,526**	**8,697**	**8,871**
Overall Total		**76,557**	**78,088**	**79,650**

Total Medicaid Enrollment				
Age Strata	FPL Status	FY 2005	FY 2006	FY 2007
<1	036% FPL	5,606	5,718	5,833
	100% FPL	1,730	1,765	1,800
	133% FPL	30,307	30,913	31,531
	185% FPL	771	786	802
<1 Total		**38,413**	**39,182**	**39,965**
01-04	036% FPL	21,721	22,156	22,599
	100% FPL	21,561	21,992	22,432
	133% FPL	16,658	16,991	17,331
	185% FPL	2,524	2,575	2,626
01-04 Total		**62,465**	**63,715**	**64,989**
05-09	036% FPL	17,384	17,732	18,086
	100% FPL	22,311	22,757	23,212
	133% FPL	3,879	3,957	4,036
	185% FPL	2,096	2,138	2,181
05-09 Total		**45,670**	**46,584**	**47,515**
10-14	036% FPL	13,088	13,350	13,617
	100% FPL	17,920	18,278	18,644
	133% FPL	424	433	441
	185% FPL	1,605	1,637	1,670
10-14 Total		**33,037**	**33,698**	**34,372**
15-19	036% FPL	10,208	10,412	10,620
	100% FPL	9,807	10,003	10,203
	133% FPL	2,957	3,016	3,076
	185% FPL	661	674	687
15-19 Total		**23,632**	**24,105**	**24,587**
Overall Total		**203,219**	**207,283**	**211,429**

Total Enrollment				
Age Strata	FPL Status	FY 2005	FY 2006	FY 2007
<1	036% FPL	5,926	6,066	6,187
	100% FPL	1,997	2,054	2,095
	133% FPL	30,984	31,647	32,280
	185% FPL	952	983	1,003
<1 Total		**39,860**	**40,750**	**41,565**
01-04	036% FPL	24,363	25,019	25,519
	100% FPL	23,906	24,535	25,025
	133% FPL	21,900	22,673	23,127
	185% FPL	3,897	4,062	4,144
01-04 Total		**74,066**	**76,290**	**77,815**
05-09	036% FPL	20,561	21,175	21,599
	100% FPL	25,547	26,265	26,790
	133% FPL	10,596	11,238	11,463
	185% FPL	3,474	3,632	3,705
05-09 Total		**60,178**	**62,310**	**63,557**
10-14	036% FPL	16,078	16,591	16,922
	100% FPL	21,040	21,661	22,094
	133% FPL	6,080	6,564	6,695
	185% FPL	2,695	2,818	2,875
10-14 Total		**45,893**	**47,634**	**48,587**
15-19	036% FPL	12,008	12,363	12,611
	100% FPL	11,562	11,906	12,144
	133% FPL	5,985	6,299	6,425
	185% FPL	1,263	1,327	1,354
15-19 Total		**30,819**	**31,895**	**32,533**
Overall Total		**250,815**	**258,879**	**264,056**

C. PMPM Assumptions

CHP+ SFMC Claim Cost PMPM				
Age Strata	**FPL Status**	**FY 2005**	**FY 2006**	**FY 2007**
<1	036% FPL	$89.40	$95.99	$103.21
	100% FPL	89.40	95.99	103.21
	133% FPL	89.18	95.77	102.99
	185% FPL	87.65	94.24	101.46
<1 Total		**$89.09**	**$95.68**	**$102.90**
01-04	036% FPL	$70.62	$75.93	$81.76
	100% FPL	70.62	75.93	81.76
	133% FPL	70.40	75.71	81.54
	185% FPL	69.14	74.45	80.28
01-04 Total		**$70.35**	**$75.65**	**$81.48**
05-09	036% FPL	$47.25	$51.69	$56.59
	100% FPL	47.25	51.69	56.59
	133% FPL	46.90	51.33	56.24
	185% FPL	45.52	49.96	54.86
05-09 Total		**$46.92**	**$51.36**	**$56.26**
10-14	036% FPL	$76.47	$83.37	$91.01
	100% FPL	76.47	83.37	91.01
	133% FPL	76.12	83.02	90.65
	185% FPL	74.74	81.64	89.28
10-14 Total		**$76.17**	**$83.07**	**$90.70**
15-19	036% FPL	$124.08	$135.56	$148.24
	100% FPL	124.08	135.56	148.24
	133% FPL	123.73	135.20	147.88
	185% FPL	122.35	133.82	146.50
15-19 Total		**$123.79**	**$135.26**	**$147.95**
Overall Total		**$73.69**	**$80.14**	**$87.26**

CHP+ HMO Claim Cost PMPM				
Age Strata	**FPL Status**	**FY 2005**	**FY 2006**	**FY 2007**
<1	036% FPL	$169.35	$183.93	$200.01
	100% FPL	169.35	183.93	200.01
	133% FPL	169.11	183.72	199.80
	185% FPL	167.68	182.26	198.34
<1 Total		**$169.02**	**$183.62**	**$199.70**
01-04	036% FPL	$72.35	$77.59	$83.35
	100% FPL	72.35	77.59	83.35
	133% FPL	72.09	77.33	83.09
	185% FPL	70.93	76.17	81.94
01-04 Total		**$72.06**	**$77.30**	**$83.07**
05-09	036% FPL	$68.42	$73.59	$79.31
	100% FPL	68.42	73.59	79.31
	133% FPL	68.01	73.18	78.90
	185% FPL	66.77	71.93	77.66
05-09 Total		**$68.08**	**$73.24**	**$78.97**
10-14	036% FPL	$77.39	$83.56	$90.41
	100% FPL	77.39	83.56	90.41
	133% FPL	76.98	83.15	90.00
	185% FPL	75.74	81.91	88.76
10-14 Total		**$77.07**	**$83.24**	**$90.09**
15-19	036% FPL	$110.90	$120.17	$130.41
	100% FPL	110.90	120.17	130.41
	133% FPL	110.49	119.76	130.01
	185% FPL	109.25	118.52	128.76
15-19 Total		**$110.59**	**$119.86**	**$130.10**
Overall Total		**$80.73**	**$87.07**	**$94.08**

Medicaid SFMC Claim Cost PMPM			
Age Strata	**FY 2005**	**FY 2006**	**FY 2007**
<1 Total	$232.96	$253.27	$275.37
01-04 Total	54.10	59.20	64.86
05-09 Total	39.30	44.24	49.74
10-14 Total	51.39	57.09	63.45
15-19 Total	226.43	247.37	270.34
Overall Total	$113.74	$124.39	$136.09

D. Financial Projection

CHP+ SFMC Benefits				
Age Strata	**FPL Status**	**FY 2005**	**FY 2006**	**FY 2007**
<1	036% FPL	$139,412	$162,264	$177,961
	100% FPL	$108,611	$126,414	$138,642
	133% FPL	$267,823	$311,778	$341,993
	185% FPL	$69,875	$81,440	$89,434
<1 Total		**$585,721**	**$681,897**	**$748,030**
01-04	036% FPL	$792,456	$923,581	$1,014,381
	100% FPL	$645,394	$752,186	$826,135
	133% FPL	$1,442,474	$1,681,528	$1,847,232
	185% FPL	$384,483	$448,772	$493,590
01-04 Total		**$3,264,807**	**$3,806,067**	**$4,181,338**
05-09	036% FPL	$604,116	$716,341	$799,993
	100% FPL	$582,777	$691,038	$771,734
	133% FPL	$1,148,427	$1,362,648	$1,522,681
	185% FPL	$251,276	$298,926	$334,836
05-09 Total		**$2,586,596**	**$3,068,953**	**$3,429,244**
10-14	036% FPL	$954,520	$1,128,107	$1,256,053
	100% FPL	$903,728	$1,068,078	$1,189,215
	133% FPL	$1,626,621	$1,923,173	$2,142,058
	185% FPL	$329,761	$390,477	$435,537
10-14 Total		**$3,814,629**	**$4,509,835**	**$5,022,863**
15-19	036% FPL	$955,540	$1,131,636	$1,262,249
	100% FPL	$839,319	$993,996	$1,108,723
	133% FPL	$1,381,243	$1,636,186	$1,825,444
	185% FPL	$295,834	$350,772	$391,691
15-19 Total		**$3,471,935**	**$4,112,590**	**$4,588,107**
Overall Total		**$13,723,688**	**$16,179,342**	**$17,969,582**

CHP+ HMO Benefits				
Age Strata	**FPL Status**	**FY 2005**	**FY 2006**	**FY 2007**
<1	036% FPL	$386,512	$455,057	$504,736
	100% FPL	$336,409	$396,068	$439,308
	133% FPL	$867,551	$1,021,720	$1,133,369
	185% FPL	$232,238	$273,639	$303,737
<1 Total		**$1,822,710**	**$2,146,484**	**$2,381,150**
01-04	036% FPL	$1,481,301	$1,722,115	$1,887,050
	100% FPL	$1,374,795	$1,598,295	$1,751,371
	133% FPL	$3,057,099	$3,554,948	$3,896,320
	185% FPL	$773,614	$900,588	$988,109
01-04 Total		**$6,686,808**	**$7,775,946**	**$8,522,850**
05-09	036% FPL	$1,733,340	$2,020,791	$2,221,656
	100% FPL	$1,813,034	$2,113,701	$2,323,801
	133% FPL	$3,816,328	$4,451,088	$4,895,498
	185% FPL	$735,898	$859,425	$946,421
05-09 Total		**$8,098,601**	**$9,445,006**	**$10,387,376**
10-14	036% FPL	$1,810,479	$2,118,950	$2,338,551
	100% FPL	$1,983,378	$2,321,307	$2,561,880
	133% FPL	$3,579,937	$4,191,528	$4,627,652
	185% FPL	$656,357	$769,422	$850,463
10-14 Total		**$8,030,150**	**$9,401,206**	**$10,378,547**
15-19	036% FPL	$1,541,295	$1,810,542	$2,004,142
	100% FPL	$1,585,786	$1,862,805	$2,061,994
	133% FPL	$2,781,527	$3,268,360	$3,618,814
	185% FPL	$525,940	$618,536	$685,427
15-19 Total		**$6,434,548**	**$7,560,244**	**$8,370,376**
Overall Total		**$31,072,817**	**$36,328,887**	**$40,040,299**

Medicaid SFMC Benefits			
Age Strata	**FY 2005**	**FY 2006**	**FY 2007**
<1 Total	$84,130,676	93,292,497	$103,463,509
01-04 Total	24,157,914	26,961,918	30,131,015
05-09 Total	12,175,070	13,979,273	16,032,582
10-14 Total	11,365,849	12,880,309	14,599,541
15-19 Total	41,046,273	45,739,522	50,986,098
Overall Total	**$172,875,781**	**$192,853,519**	**$215,212,745**

Benefits Summary

	FY 2005	FY 2006	FY 2007
CHP+ - HMO			
Claim Cost PMPM	$80.73	$87.07	$94.08
Enrollment	32,076	34,772	35,467
Benefits	$31,072,817	$36,328,887	$40,040,299
CHP+ - SFMC			
Claim Cost PMPM	$73.69	$80.14	$87.26
Enrollment	15,520	16,824	7,160
Benefits	$13,723,688	$16,179,342	$17,969,582
CHP+ - TOTAL			
Claim Cost PMPM	$78.43	$84.81	$91.86
Enrollment	47,596	51,596	52,628
Benefits	$44,796,506	$52,508,228	$58,009,880

	FY 2005	FY 2006	FY 2007
Medicaid – HMO			
Wrap-around Claim Cost PMPM	$32.15	$35.97	$40.23
Capitation	73.82	80.73	88.32
Total Claim Benefits PMPM	$105.97	$116.70	$128.55
Enrollment	76,557	78,088	79,650
Benefits	$97,349,299	$109,356,740	$122,870,627
Medicaid – SFMC			
Claim Cost PMPM	$113.74	$124.39	$136.09
Enrollment	126,662	129,195	131,779
Benefits	$172,875,781	$192,853,519	$215,212,745
Medicaid – TOTAL			
Claim Cost PMPM	$110.81	$121.50	$133.25
Enrollment	203,219	207,283	211,429
Benefits	$270,225,080	$302,210,259	$338,083,372
Total Program Cost	**$315,021,586**	**$354,718,488**	**$396,093,253**
Total State Cost	**$150,791,317**	**$169,483,010**	**$189,345,144**

Section VIII – Mandatory Enrollment, Unlimited HMO Capacity

Key assumptions in the streamlining initiative include:

- HMOs have **unlimited capacity** for expansion of membership
- Medicaid kids must **mandatory** enroll into HMO program.
- Medicaid HMO enrollment of 70% or 140,000 kids in FY 2005.
- Medicaid Self-funded enrollment of 30% or 60,000 kids in FY 2005.
- Medicaid Self-funded utilization effectively managed down by 3% by service.
- Medicaid HMO pricing efficiency is improved through combination with CHP+.
- Increased HMO utilization lowers capitations by 3%.
- CHP+ enrollment remains stable at 70% HMO and 30% Self-Funded.

The projection for the streamlining initiative has been provided analyzing the effect of mandatory enrollment of Medicaid children into the Core Benefits. The baseline scenario assumed current Medicaid HMO pricing.

The Streamlining Initiative assumes behavioral and mental health is provided as a separate capitation at the current Medicaid rates for both the SFMC and HMO populations. In a study completed in October 2003 by MDF Associates titled "Purchasing Strategies", it states that "one study, performed by the Mathematica Policy Research, concluded that carve outs for behavioral health could yield benefits that come with specialization, but can also result in fragmented and uncoordinated care. To address this potential, states should ensure that incentives are aligned across systems to encourage coordination, and shared protocols and strong communication." The use of the Medicaid rates is for the purpose of budgeting alone and not for negotiating. Any savings provided in behavioral and mental health could be utilized for expansion.

For the Streamlining Initiative, the current CHP+ efficiencies in claims utilization management and HMO pricing are applied to the Medicaid population. Unified rates for the Streamlining Initiative were developed from weighted average rates for Medicaid and CHP+.

Colorado will realize increased programmatic savings associated with utilization management and cost controls in combining Medicaid and CHP+. Colorado should realize additional cost savings in hospital claims by converting from a percent of charges system to paying claims based on DRGs. Typically, as a medical plan attempts to control utilization or cost per service, other factors may impact the realized savings. For this reason, we have not projected the full realization of cost savings from implementing Medicaid Self-funded utilization review similar to CHP+, but limited the cost savings to 3%.

The projected claim costs segregated by age and FPL for the self-funded managed care network and HMO's for FY 2005 are shown in the table on the following page.

Projected Fiscal Year 2004-2005 Costs for the HMO's (PMPM)

Age	< 100% FPL	100% to 133% FPL	> 133% FPL	Combined
< 1	$ 127.53	$ 127.35	$ 126.33	$ 127.07
1 thru 4	$ 94.84	$ 94.53	$ 93.10	$ 94.38
5 thru 9	$ 86.40	$ 85.93	$ 84.40	$ 85.86
10 thru 14	$ 95.38	$ 94.94	$ 93.43	$ 94.90
> 14	$ 134.13	$ 133.72	$ 132.17	$ 133.64
Combined	$ 102.94	$ 102.57	$ 101.14	$ 102.45

Projected Fiscal Year 2004-2005 Costs for the Self-Funded Managed Care Network (PMPM)

Age	< 100% FPL	100% to 133% FPL	> 133% FPL	Combined
<1	$ 109.21	$ 108.91	$ 106.80	$ 108.79
1 thru 4	$ 83.15	$ 82.85	$ 81.13	$ 82.79
5 thru 9	$ 75.82	$ 75.46	$ 73.68	$ 75.28
10 thru 14	$ 87.90	$ 87.48	$ 85.64	$ 87.52
> 14	$ 150.26	$ 149.84	$ 148.00	$ 149.89
Combined	$ 94.64	$ 94.30	$ 92.48	$ 94.23

The table below shows the adjusted PMPM claims for the streamlining initiative as well as the total cost and state share of the streamlining initiative:

	FY 2005	**FY 2006**	**FY 2007**
SI - HMO			
Claim Cost PMPM	102.45	110.79	120.19
Enrollment	174,329	179,870	183,467
Benefits	214,320,526	239,131,272	264,618,450
SI - SFMC			
Claim Cost PMPM	94.23	102.75	112.32
Enrollment	76,485	79,009	80,589
Benefits	86,486,664	97,418,231	108,620,594
SI - TOTAL			
Claim Cost PMPM	99.94	108.34	117.79
Enrollment	250,815	258,879	264,056
Benefits	300,807,190	336,549,503	373,239,044
Total Program Cost	300,807,190	336,549,503	373,239,044
Total State Cost	141,856,026	158,228,949	175,476,845
Total Program Savings	14,214,396	18,168,985	22,854,209
Total State Savings	8,935,291	11,254,061	13,868,300

The savings identified primarily are developed from the assumed utilization management and cost controls associated with combining Medicaid and CHP+. Colorado should realize additional cost savings in hospital claims by converting from a percent of charges system to paying claims based on Diagnosis-Related Groups (DRGs). The PCP capitation for the Self-Funded Managed Care network may need to be increased to continue to get physicians to participate. A 10% increase in the PCP capitation would result in an additional $1,000,000 in claim costs for fiscal year 2005. The assumptions critical to this conclusion include HMO capacity in Colorado, the ability to adjust Medicaid HMO capitations and the ability to improve Medicaid Self-Funded Managed Care utilization.

The following ten charts breakdown the claim costs PMPM by age and FPL for the Streamlining Initiative. A chart for the overall claim cost PMPM has not been provided since any change in the underlying demographics of the population would change the overall assumed PMPM.

2005 Rates

	Age <1		<100% FPL			100% - 133% FPL			> 133% FPL			Combined
Type of Service	**Utilization PMPY**	**Allowable Cost Per Unit**	**Copay**	**Impact**	**Claim Cost PMPM**	**Copay**	**Impact**	**Claim Cost PMPM**	**Copay**	**Impact**	**Claim Cost PMPM**	**Claim Cost PMPM**
Inpatient Hospital (days)												
Medical/Surgical	0.107	$ 2,152.14			$ 19.25			$ 19.25			$ 19.25	$ 19.22
OB/Newborn	0.114	$ 919.56			$ 8.77			$ 8.77			$ 8.77	$ 8.76
Psychiatric												
Substance Abuse												
Skilled Nursing					$ 0.06			$ 0.06			$ 0.06	$ 0.06
Outpatient Hospital (visits)												
Emergency	0.355	$ 298.67	$3.00	($0.10)	$ 8.74	$3.00	($0.10)	$ 8.74	$15.00	($1.58)	$ 7.26	$ 8.69
Other	0.479	$ 283.51			$ 11.32			$ 11.32			$ 11.32	$ 11.30
Lab and Radiology												
Lab	0.375	$ 20.56			$ 0.64			$ 0.64			$ 0.64	$ 0.64
Radiology	0.284	$ 20.29			$ 0.48			$ 0.48			$ 0.48	$ 0.48
Physician (Non-capitated)												
Allergy and Clinical Immunology	0.005	$ 48.55			$ 0.02	$2.00	($0.00)	$ 0.02	$5.00	($0.00)	$ 0.02	$ 0.02
Anesthesia	0.070	$ 185.71			$ 1.09			$ 1.09			$ 1.09	$ 1.09
Cardiovascular	0.058	$ 34.26			$ 0.17			$ 0.17			$ 0.17	$ 0.17
Central Nervous System												
Chemotherapy Administration												
Consultations	0.072	$ 106.18			$ 0.64	$2.00	($0.01)	$ 0.62	$5.00	($0.04)	$ 0.60	$ 0.62
Critical Care Services	0.006	$ 166.81			$ 0.08			$ 0.08			$ 0.08	$ 0.08
Emergency Department Services	0.432	$ 65.07			$ 2.34			$ 2.34			$ 2.34	$ 2.34
Gastroenterology	0.002	$ 65.71			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Home Services	0.006	$ 95.89			$ 0.05			$ 0.05			$ 0.05	$ 0.05
Hospital Inpatient Services	0.214	$ 68.78			$ 1.23			$ 1.23			$ 1.23	$ 1.23
Maternity and Delivery												
Neurology and Neuromuscular	0.004	$ 50.78			$ 0.02	$2.00	($0.00)	$ 0.02	$5.00	($0.00)	$ 0.02	$ 0.02
Newborn and Neonatal Services	0.083	$ 128.13			$ 0.89			$ 0.89			$ 0.89	$ 0.88
Nursing Facility Services												
Office or Other OPt Services	0.315	$ 43.61			$ 1.14	$2.00	($0.08)	$ 1.07	$5.00	($0.16)	$ 0.99	$ 1.08
Opthalmology	0.005	$ 41.97			$ 0.02			$ 0.02			$ 0.02	$ 0.02
Otorhinolaryngologic Services	0.141	$ 240.38			$ 2.82			$ 2.82			$ 2.82	$ 2.82
Prolonged Services	0.001	$ 49.04			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Pulmonary	0.019	$ 40.53			$ 0.06			$ 0.06			$ 0.06	$ 0.06
Routine Eye Exam	0.005	$ 82.69			$ 0.04			$ 0.04			$ 0.04	$ 0.04
Routine Physical Exam	0.002	$ 14.52			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Surgery	0.226	$ 204.49			$ 3.86			$ 3.86			$ 3.86	$ 3.85
Vascular Diagnostic	0.001	$ 78.92			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Well Baby/Well Child	0.079	$ 70.20			$ 0.46			$ 0.46			$ 0.46	$ 0.46
PCP Capitation					$ 19.79			$ 19.79			$ 19.79	$ 19.76
Mental Health/Substance Abuse					$ 11.74			$ 11.74			$ 11.74	$ 11.74
Psychotherapy												
Alcohol/Substance Abuse												
Ambulance	0.026	$ 203.67			$ 0.44			$ 0.44			$ 0.44	$ 0.44
Durable Medical Equipment												
Hearing Aids												
Orthotics												
Other DME	0.028	$ 120.66			$ 0.29			$ 0.29			$ 0.29	$ 0.29
Oxygen	0.038	$ 72.84			$ 0.23			$ 0.23			$ 0.23	$ 0.23
Prosthetic Devices												
Home Health	0.001	$ 595.31			$ 0.04			$ 0.04			$ 0.04	$ 0.04
Drugs/Injections												
Chemotherapy Drugs												
Injectibles	0.045	$ 27.30			$ 0.10			$ 0.10			$ 0.10	$ 0.10
Prescriptions	1.790	$ 26.46			$ 3.95	$1.00	($0.21)	$ 3.74	$4.00	($0.73)	$ 3.22	$ 3.77
Therapeutic or Diag Injections	0.040	$ 44.57			$ 0.15			$ 0.15			$ 0.15	$ 0.15
Vaccines/Toxoids	3.086	$ 31.49			$ 8.10			$ 8.10			$ 8.10	$ 8.09
Supplies - Medical and Surgical	0.011	$ 8.72			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Therapies/Treatments												
Manipulative Treatment												
Physical Med and Rehab	0.008	$ 61.25			$ 0.04	$2.00	$0.00	$ 0.04	$5.00	($0.00)	$ 0.03	$ 0.04
Enteral/Parenteral Therapy	0.004	$ 27.15			$ 0.01	$2.00	($0.00)	$ 0.01	$5.00	($0.00)	$ 0.01	$ 0.01
Dialysis												
Vision Services						$2.00	$0.00		$5.00	$0.00		
Other	0.021	$ 82.79			$ 0.14			$ 0.14			$ 0.14	$ 0.14
Unknown												
Total Claim Cost					**$ 109.21**			**$ 108.91**			**$ 106.80**	**$ 108.79**

2005 Rates												
	Age 1-4		<100% FPL			100% - 133% FPL			> 133% FPL			Combined
	Utilization	Allowable Cost			Claim Cost			Claim Cost			Claim Cost	Claim Cost
Type of Service	**PMPY**	**Per Unit**	**Copay**	**Impact**	**PMPM**	**Copay**	**Impact**	**PMPM**	**Copay**	**Impact**	**PMPM**	**PMPM**
Inpatient Hospital (days)												
Medical/Surgical	0.054	$ 2,698.08			$ 12.11			$ 12.11			$ 12.11	$ 12.08
OB/Newborn	0.031	$ 928.20			$ 2.39			$ 2.39			$ 2.39	$ 2.39
Psychiatric												
Substance Abuse												
Skilled Nursing												
Outpatient Hospital (visits)												
Emergency	0.298	$ 330.37	$3.00	($0.08)	$ 8.12	$3.00	($0.08)	$ 8.12	$15.00	($1.27)	$ 6.93	$ 8.04
Other	0.383	$ 313.61			$ 10.01			$ 10.01			$ 10.01	$ 9.98
Lab and Radiology												
Lab	0.475	$ 21.53			$ 0.85			$ 0.85			$ 0.85	$ 0.85
Radiology	0.225	$ 22.08			$ 0.41			$ 0.41			$ 0.41	$ 0.41
Physician (Non-capitated)												
Allergy and Clinical Immunology	0.008	$ 54.06			$ 0.03	$2.00	($0.00)	$ 0.03	$5.00	($0.00)	$ 0.03	$ 0.03
Anesthesia	0.059	$ 206.71			$ 1.02			$ 1.02			$ 1.02	$ 1.02
Cardiovascular	0.045	$ 43.30			$ 0.16			$ 0.16			$ 0.16	$ 0.16
Central Nervous System	0.001	$ 537.90			$ 0.02			$ 0.02			$ 0.02	$ 0.02
Chemotherapy Administration	0.000	$ 219.62			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Consultations	0.063	$ 104.33			$ 0.54	$2.00	($0.01)	$ 0.53	$5.00	($0.03)	$ 0.52	$ 0.54
Critical Care Services	0.006	$ 146.13			$ 0.07			$ 0.07			$ 0.07	$ 0.07
Emergency Department Services	0.353	$ 63.98			$ 1.88			$ 1.88			$ 1.88	$ 1.88
Gastroenterology	0.000	$ 66.33			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Home Services	0.002	$ 96.80			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Hospital Inpatient Services	0.091	$ 73.31			$ 0.56			$ 0.56			$ 0.56	$ 0.56
Maternity and Delivery												
Neurology and Neuromuscular	0.004	$ 54.96			$ 0.02	$2.00	($0.00)	$ 0.02	$5.00	($0.00)	$ 0.02	$ 0.02
Newborn and Neonatal Services	0.022	$ 129.33			$ 0.24			$ 0.24			$ 0.24	$ 0.24
Nursing Facility Services												
Office or Other OPt Services	0.321	$ 43.48			$ 1.16	$2.00	($0.07)	$ 1.09	$5.00	($0.14)	$ 1.03	$ 1.13
Opthalmology	0.014	$ 34.69			$ 0.04			$ 0.04			$ 0.04	$ 0.04
Otorhinolaryngologic Services	0.163	$ 232.47			$ 3.15			$ 3.15			$ 3.15	$ 3.15
Prolonged Services	0.003	$ 84.00			$ 0.02			$ 0.02			$ 0.02	$ 0.02
Pulmonary	0.021	$ 59.23			$ 0.10			$ 0.10			$ 0.10	$ 0.10
Routine Eye Exam	0.040	$ 77.70			$ 0.26			$ 0.26			$ 0.26	$ 0.26
Routine Physical Exam	0.001	$ 15.40			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Surgery	0.200	$ 200.56			$ 3.34			$ 3.34			$ 3.34	$ 3.33
Vascular Diagnostic	0.000	$ 63.88			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Well Baby/Well Child	0.045	$ 70.95			$ 0.26			$ 0.26			$ 0.26	$ 0.26
PCP Capitation					$ 14.89			$ 14.89			$ 14.89	$ 14.85
Mental Health/Substance Abuse					$ 11.74			$ 11.74			$ 11.74	$ 11.74
Psychotherapy												
Alcohol/Substance Abuse												
Ambulance	0.021	$ 242.70			$ 0.43			$ 0.43			$ 0.43	$ 0.43
Durable Medical Equipment												
Hearing Aids												
Orthotics	0.002	$ 296.50			$ 0.05			$ 0.05			$ 0.05	$ 0.05
Other DME	0.020	$ 110.55			$ 0.19			$ 0.19			$ 0.19	$ 0.19
Oxygen	0.015	$ 91.24			$ 0.11			$ 0.11			$ 0.11	$ 0.11
Prosthetic Devices	0.000	$ 61.95			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Home Health	0.001	$ 409.16			$ 0.02			$ 0.02			$ 0.02	$ 0.02
Drugs/Injections												
Chemotherapy Drugs												
Injectibles	0.021	$ 23.59			$ 0.04			$ 0.04			$ 0.04	$ 0.04
Prescriptions	1.921	$ 33.12			$ 5.30	$1.00	($0.21)	$ 5.09	$4.00	($0.66)	$ 4.64	$ 5.19
Therapeutic or Diag Injections	0.023	$ 287.81			$ 0.56			$ 0.56			$ 0.56	$ 0.56
Vaccines/Toxoids	1.238	$ 26.76			$ 2.76			$ 2.76			$ 2.76	$ 2.75
Supplies - Medical and Surgical	0.010	$ 16.55			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Therapies/Treatments												
Manipulative Treatment	0.001	$ 35.45			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Physical Med and Rehab	0.004	$ 55.79			$ 0.02	$2.00	($0.00)	$ 0.02	$5.00	($0.00)	$ 0.02	$ 0.02
Enteral/Parenteral Therapy	0.002	$ 111.33			$ 0.01	$2.00	($0.00)	$ 0.01	$5.00	($0.00)	$ 0.01	$ 0.01
Dialysis												
Vision Services	0.013	$ 41.27			$ 0.05	$2.00	($0.00)	$ 0.05	$5.00	$0.00	$ 0.05	$ 0.05
Other	0.010	$ 173.21			$ 0.14			$ 0.14			$ 0.14	$ 0.14
Unknown												
Total Claim Cost					**$ 83.15**			**$ 82.85**			**$ 81.13**	**$ 82.79**

2005 Rates												
	Age 5-9		<100% FPL			100% - 133% FPL			> 133% FPL			Combined
	Utilization	Allowable Cost			Claim Cost			Claim Cost			Claim Cost	Claim Cost
Type of Service	**PMPY**	**Per Unit**	**Copay**	**Impact**	**PMPM**	**Copay**	**Impact**	**PMPM**	**Copay**	**Impact**	**PMPM**	**PMPM**
Inpatient Hospital (days)												
Medical/Surgical	0.016	$ 3,170.27			$ 4.10			$ 4.10			$ 4.10	$ 4.08
OB/Newborn	0.001	$ 1,989.46			$ 0.13			$ 0.13			$ 0.13	$ 0.13
Psychiatric												
Substance Abuse												
Skilled Nursing												
Outpatient Hospital (visits)												
Emergency	0.103	$ 368.64	$3.00	($0.06)	$ 3.09	$3.00	($0.06)	$ 3.09	$15.00	($1.18)	$ 1.98	$ 3.01
Other	0.170	$ 343.55			$ 4.86			$ 4.86			$ 4.86	$ 4.84
Lab and Radiology												
Lab	0.231	$ 21.97			$ 0.42			$ 0.42			$ 0.42	$ 0.42
Radiology	0.131	$ 24.23			$ 0.26			$ 0.26			$ 0.26	$ 0.26
Physician (Non-capitated)												
Allergy and Clinical Immunology	0.029	$ 50.59			$ 0.12	$2.00	($0.01)	$ 0.11	$5.00	($0.02)	$ 0.10	$ 0.12
Anesthesia	0.023	$ 219.45			$ 0.41			$ 0.41			$ 0.41	$ 0.41
Cardiovascular	0.017	$ 52.15			$ 0.07			$ 0.07			$ 0.07	$ 0.07
Central Nervous System	0.000	$ 351.95			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Chemotherapy Administration	0.004	$ 144.64			$ 0.04			$ 0.04			$ 0.04	$ 0.04
Consultations	0.026	$ 96.06			$ 0.21	$2.00	($0.01)	$ 0.19	$5.00	($0.03)	$ 0.18	$ 0.20
Critical Care Services	0.002	$ 134.89			$ 0.02			$ 0.02			$ 0.02	$ 0.02
Emergency Department Services	0.121	$ 59.73			$ 0.60			$ 0.60			$ 0.60	$ 0.60
Gastroenterology	0.000	$ 58.22			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Home Services	0.000	$ 86.73			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Hospital Inpatient Services	0.082	$ 69.94			$ 0.48			$ 0.48			$ 0.48	$ 0.47
Maternity and Delivery	0.004	$ 615.41			$ 0.23			$ 0.23			$ 0.23	$ 0.23
Neurology and Neuromuscular	0.012	$ 63.25			$ 0.06	$2.00	($0.00)	$ 0.06	$5.00	($0.00)	$ 0.06	$ 0.06
Newborn and Neonatal Services												
Nursing Facility Services												
Office or Other OPt Services	0.689	$ 41.03			$ 2.36	$2.00	($0.07)	$ 2.28	$5.00	($0.15)	$ 2.20	$ 2.32
Opthalmology	0.077	$ 25.95			$ 0.17			$ 0.17			$ 0.17	$ 0.16
Otorhinolaryngologic Services	0.287	$ 231.48			$ 5.53			$ 5.53			$ 5.53	$ 5.50
Prolonged Services	0.007	$ 97.48			$ 0.05			$ 0.05			$ 0.05	$ 0.05
Pulmonary	0.052	$ 60.39			$ 0.26			$ 0.26			$ 0.26	$ 0.26
Routine Eye Exam	0.209	$ 67.67			$ 1.18			$ 1.18			$ 1.18	$ 1.17
Routine Physical Exam	0.015	$ 37.63			$ 0.05			$ 0.05			$ 0.05	$ 0.05
Surgery	0.470	$ 168.47			$ 6.59			$ 6.59			$ 6.59	$ 6.56
Vascular Diagnostic	0.001	$ 43.52			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Well Baby/Well Child	0.034	$ 66.84			$ 0.19			$ 0.19			$ 0.19	$ 0.19
PCP Capitation					$ 10.06			$ 10.06			$ 10.06	$ 10.01
Mental Health/Substance Abuse					$ 11.74			$ 11.74			$ 11.74	$ 11.74
Psychotherapy												
Alcohol/Substance Abuse												
Ambulance	0.047	$ 260.79			$ 1.01			$ 1.01			$ 1.01	$ 1.01
Durable Medical Equipment												
Hearing Aids	0.002	$ 299.19			$ 0.04			$ 0.04			$ 0.04	$ 0.04
Orthotics	0.020	$ 206.90			$ 0.34			$ 0.34			$ 0.34	$ 0.34
Other DME	0.023	$ 97.19			$ 0.19			$ 0.19			$ 0.19	$ 0.19
Oxygen	0.006	$ 102.12			$ 0.05			$ 0.05			$ 0.05	$ 0.05
Prosthetic Devices	0.001	$ 93.87			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Home Health	0.003	$ 257.83			$ 0.07			$ 0.07			$ 0.07	$ 0.07
Drugs/Injections												
Chemotherapy Drugs	0.008	$ 236.85			$ 0.17			$ 0.17			$ 0.17	$ 0.17
Injectibles	0.057	$ 50.10			$ 0.24			$ 0.24			$ 0.24	$ 0.24
Prescriptions	4.444	$ 44.84			$ 16.60	$1.00	($0.24)	$ 16.36	$4.00	($0.78)	$ 15.83	$ 16.43
Therapeutic or Diag Injections	0.049	$ 358.88			$ 1.46			$ 1.46			$ 1.46	$ 1.45
Vaccines/Toxoids	0.644	$ 19.59			$ 1.05			$ 1.05			$ 1.05	$ 1.05
Supplies - Medical and Surgical	0.048	$ 20.62			$ 0.08			$ 0.08			$ 0.08	$ 0.08
Therapies/Treatments												
Manipulative Treatment	0.006	$ 32.44			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Physical Med and Rehab	0.131	$ 37.89			$ 0.41	$2.00	($0.01)	$ 0.40	$5.00	($0.02)	$ 0.39	$ 0.41
Enteral/Parenteral Therapy	0.007	$ 161.77			$ 0.10	$2.00	($0.00)	$ 0.10	$5.00	($0.00)	$ 0.10	$ 0.10
Dialysis												
Vision Services	0.102	$ 37.14			$ 0.32	$2.00	($0.01)	$ 0.31	$5.00	($0.01)	$ 0.30	$ 0.31
Other	0.028	$ 149.15			$ 0.34			$ 0.34			$ 0.34	$ 0.34
Unknown												
Total Claim Cost					**$ 75.82**			**$ 75.46**			**$ 73.68**	**$ 75.28**

2005 Rates

Type of Service	Age 10-14 Utilization PMPY	Allowable Cost Per Unit	<100% FPL Copay	Impact	Claim Cost PMPM	100% - 133% FPL Copay	Impact	Claim Cost PMPM	> 133% FPL Copay	Impact	Claim Cost PMPM	Combined Claim Cost PMPM
Inpatient Hospital (days)												
Medical/Surgical	0.038	$ 3,784.07			$ 11.96			$ 11.96			$ 11.96	$ 11.94
OB/Newborn	0.003	$ 2,123.28			$ 0.55			$ 0.55			$ 0.55	$ 0.55
Psychiatric												
Substance Abuse												
Skilled Nursing												
Outpatient Hospital (visits)												
Emergency	0.212	$ 456.35	$3.00	($0.05)	$ 8.00	$3.00	($0.05)	$ 8.00	$15.00	($1.10)	$ 6.95	$ 7.92
Other	0.435	$ 415.47			$ 15.05			$ 15.05			$ 15.05	$ 15.01
Lab and Radiology												
Lab	0.563	$ 25.52			$ 1.20			$ 1.20			$ 1.20	$ 1.19
Radiology	0.384	$ 29.82			$ 0.96			$ 0.96			$ 0.96	$ 0.95
Physician (Non-capitated)												
Allergy and Clinical Immunology	0.112	$ 47.24			$ 0.44	$2.00	($0.03)	$ 0.42	$5.00	($0.05)	$ 0.39	$ 0.44
Anesthesia	0.051	$ 252.90			$ 1.07			$ 1.07			$ 1.07	$ 1.06
Cardiovascular	0.038	$ 63.89			$ 0.20			$ 0.20			$ 0.20	$ 0.20
Central Nervous System	0.001	$116.80			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Chemotherapy Administration	0.014	$50.32			$ 0.06			$ 0.06			$ 0.06	$ 0.06
Consultations	0.061	$ 103.58			$ 0.52	$2.00	($0.01)	$ 0.51	$5.00	($0.03)	$ 0.50	$ 0.52
Critical Care Services	0.004	$ 170.35			$ 0.05			$ 0.05			$ 0.05	$ 0.05
Emergency Department Services	0.253	$ 65.75			$ 1.39			$ 1.39			$ 1.39	$ 1.38
Gastroenterology	0.000	$ 62.13			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Home Services	0.000	$ 92.56			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Hospital Inpatient Services	0.039	$ 71.72			$ 0.23			$ 0.23			$ 0.23	$ 0.23
Maternity and Delivery	0.004	$656.81			$ 0.22			$ 0.22			$ 0.22	$ 0.22
Neurology and Neuromuscular	0.007	$ 82.75			$ 0.05	$2.00	($0.00)	$ 0.05	$5.00	($0.00)	$ 0.05	$ 0.05
Newborn and Neonatal Services												
Nursing Facility Services												
Office or Other OPt Services	0.373	$ 45.07			$ 1.40	$2.00	($0.08)	$ 1.33	$5.00	($0.16)	$ 1.24	$ 1.38
Opthalmology	0.055	$ 26.78			$ 0.12			$ 0.12			$ 0.12	$ 0.12
Otorhinolaryngologic Services	0.128	$ 284.28			$ 3.03			$ 3.03			$ 3.03	$ 3.02
Prolonged Services	0.003	$ 90.28			$ 0.02			$ 0.02			$ 0.02	$ 0.02
Pulmonary	0.030	$ 48.50			$ 0.12			$ 0.12			$ 0.12	$ 0.12
Routine Eye Exam	0.147	$ 71.27			$ 0.87			$ 0.87			$ 0.87	$ 0.87
Routine Physical Exam	0.014	$ 78.81			$ 0.09			$ 0.09			$ 0.09	$ 0.09
Surgery	0.278	$ 154.68			$ 3.58			$ 3.58			$ 3.58	$ 3.57
Vascular Diagnostic												
Well Baby/Well Child	0.007	$ 71.95			$ 0.04			$ 0.04			$ 0.04	$ 0.04
PCP Capitation					$ 8.88			$ 8.88			$ 8.88	$ 8.86
Mental Health/Substance Abuse					$ 11.74			$ 11.74			$ 11.74	$ 11.74
Psychotherapy												
Alcohol/Substance Abuse												
Ambulance	0.027	$ 286.29			$ 0.64			$ 0.64			$ 0.64	$ 0.64
Durable Medical Equipment												
Hearing Aids	0.002	$319.31			$ 0.04			$ 0.04			$ 0.04	$ 0.04
Orthotics	0.016	$100.19			$ 0.13			$ 0.13			$ 0.13	$ 0.13
Other DME	0.008	$ 107.96			$ 0.07			$ 0.07			$ 0.07	$ 0.07
Oxygen	0.001	$ 113.92			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Prosthetic Devices	0.001	$161.44			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Home Health	0.002	$ 316.84			$ 0.06			$ 0.06			$ 0.06	$ 0.06
Drugs/Injections												
Chemotherapy Drugs	0.008	$252.78			$ 0.16			$ 0.16			$ 0.16	$ 0.16
Injectibles	0.042	$ 106.61			$ 0.37			$ 0.37			$ 0.37	$ 0.37
Prescriptions	2.496	$ 62.95			$ 13.09	$1.00	($0.26)	$ 12.83	$4.00	($0.88)	$ 12.22	$ 12.98
Therapeutic or Diag Injections	0.031	$ 212.33			$ 0.54			$ 0.54			$ 0.54	$ 0.54
Vaccines/Toxoids	0.158	$ 18.27			$ 0.24			$ 0.24			$ 0.24	$ 0.24
Supplies - Medical and Surgical	0.035	$ 20.42			$ 0.06			$ 0.06			$ 0.06	$ 0.06
Therapies/Treatments												
Manipulative Treatment	0.004	$33.35			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Physical Med and Rehab	0.116	$ 23.98			$ 0.23	$2.00	($0.03)	$ 0.21	$5.00	($0.05)	$ 0.18	$ 0.22
Enteral/Parenteral Therapy	0.006	$ 159.14			$ 0.08	$2.00	($0.00)	$ 0.08	$5.00	($0.00)	$ 0.08	$ 0.08
Dialysis												
Vision Services	0.078	$37.10			$ 0.24	$2.00	($0.01)	$ 0.23	$5.00	($0.03)	$ 0.21	$ 0.24
Other	0.021	$ 17.60			$ 0.03			$ 0.03			$ 0.03	$ 0.03
Unknown												
Total Claim Cost					**$ 87.90**			**$ 87.48**			**$ 85.64**	**$ 87.52**

2005 Rates

	Age >14		<100% FPL			100% - 133% FPL			> 133% FPL			Combined
Type of Service	**Utilization PMPY**	**Allowable Cost Per Unit**	**Copay**	**Impact**	**Claim Cost PMPM**	**Copay**	**Impact**	**Claim Cost PMPM**	**Copay**	**Impact**	**Claim Cost PMPM**	**Claim Cost PMPM**
Inpatient Hospital (days)												
Medical/Surgical	0.067	$ 4,110.57			$ 23.05			$ 23.05			$ 23.05	$ 23.01
OB/Newborn	0.006	$ 2,306.49			$ 1.07			$ 1.07			$ 1.07	$ 1.06
Psychiatric												
Substance Abuse												
Skilled Nursing												
Outpatient Hospital (visits)												
Emergency	0.376	$ 495.72	$3.00	($0.05)	$ 15.46	$3.00	($0.05)	$ 15.46	$15.00	($1.10)	$ 14.41	$ 15.40
Other	0.771	$ 451.31			$ 28.99			$ 28.99			$ 28.99	$ 28.95
Lab and Radiology												
Lab	0.997	$ 27.73			$ 2.30			$ 2.30			$ 2.30	$ 2.30
Radiology	0.682	$ 32.39			$ 1.84			$ 1.84			$ 1.84	$ 1.84
Physician (Non-capitated)												
Allergy and Clinical Immunology	0.199	$ 51.31			$ 0.85	$2.00	($0.03)	$ 0.83	$5.00	($0.05)	$ 0.80	$ 0.84
Anesthesia	0.090	$ 274.72			$ 2.05			$ 2.05			$ 2.05	$ 2.05
Cardiovascular	0.067	$ 69.41			$ 0.39			$ 0.39			$ 0.39	$ 0.39
Central Nervous System	0.002	$126.88			$ 0.02			$ 0.02			$ 0.02	$ 0.02
Chemotherapy Administration	0.026	$54.66			$ 0.12			$ 0.12			$ 0.12	$ 0.12
Consultations	0.107	$ 112.51			$ 1.01	$2.00	($0.01)	$ 0.99	$5.00	($0.03)	$ 0.98	$ 1.00
Critical Care Services	0.006	$ 185.05			$ 0.10			$ 0.10			$ 0.10	$ 0.10
Emergency Department Services	0.449	$ 71.42			$ 2.67			$ 2.67			$ 2.67	$ 2.67
Gastroenterology	0.000	$ 67.49			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Home Services	0.000	$ 100.55			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Hospital Inpatient Services	0.069	$ 77.91			$ 0.45			$ 0.45			$ 0.45	$ 0.44
Maternity and Delivery	0.007	$713.48			$ 0.43			$ 0.43			$ 0.43	$ 0.43
Neurology and Neuromuscular	0.013	$ 89.90			$ 0.10	$2.00	($0.00)	$ 0.10	$5.00	($0.00)	$ 0.09	$ 0.10
Newborn and Neonatal Services												
Nursing Facility Services												
Office or Other OPt Services	0.662	$ 48.96			$ 2.70	$2.00	($0.08)	$ 2.62	$5.00	($0.16)	$ 2.54	$ 2.67
Opthalmology	0.098	$ 29.10			$ 0.24			$ 0.24			$ 0.24	$ 0.24
Otorhinolaryngologic Services	0.227	$ 308.81			$ 5.83			$ 5.83			$ 5.83	$ 5.82
Prolonged Services	0.005	$ 98.07			$ 0.04			$ 0.04			$ 0.04	$ 0.04
Pulmonary	0.053	$ 52.68			$ 0.23			$ 0.23			$ 0.23	$ 0.23
Routine Eye Exam	0.261	$ 77.42			$ 1.68			$ 1.68			$ 1.68	$ 1.68
Routine Physical Exam	0.024	$ 85.61			$ 0.17			$ 0.17			$ 0.17	$ 0.17
Surgery	0.492	$ 168.03			$ 6.89			$ 6.89			$ 6.89	$ 6.88
Vascular Diagnostic	0.002	$ 43.12			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Well Baby/Well Child	0.012	$ 78.16			$ 0.08			$ 0.08			$ 0.08	$ 0.08
PCP Capitation					$ 8.88			$ 8.88			$ 8.88	$ 8.87
Mental Health/Substance Abuse					$ 11.74			$ 11.74			$ 11.74	$ 11.74
Psychotherapy												
Alcohol/Substance Abuse												
Ambulance	0.048	$ 310.99			$ 1.24			$ 1.24			$ 1.24	$ 1.24
Durable Medical Equipment												
Hearing Aids	0.003	$346.86			$ 0.08			$ 0.08			$ 0.08	$ 0.08
Orthotics	0.028	$108.84			$ 0.25			$ 0.25			$ 0.25	$ 0.25
Other DME	0.014	$ 117.27			$ 0.14			$ 0.14			$ 0.14	$ 0.14
Oxygen	0.002	$ 123.75			$ 0.02			$ 0.02			$ 0.02	$ 0.02
Prosthetic Devices	0.001	$175.37			$ 0.02			$ 0.02			$ 0.02	$ 0.02
Home Health	0.004	$ 344.18			$ 0.12			$ 0.12			$ 0.12	$ 0.12
Drugs/Injections												
Chemotherapy Drugs	0.014	$274.59			$ 0.31			$ 0.31			$ 0.31	$ 0.31
Injectibles	0.074	$ 115.81			$ 0.72			$ 0.72			$ 0.72	$ 0.72
Prescriptions	4.426	$ 68.39			$ 25.22	$1.00	($0.27)	$ 24.95	$4.00	($0.88)	$ 24.35	$ 25.10
Therapeutic or Diag Injections	0.054	$ 230.65			$ 1.05			$ 1.05			$ 1.05	$ 1.04
Vaccines/Toxoids	0.281	$ 19.85			$ 0.46			$ 0.46			$ 0.46	$ 0.46
Supplies - Medical and Surgical	0.063	$ 22.18			$ 0.12			$ 0.12			$ 0.12	$ 0.12
Therapies/Treatments												
Manipulative Treatment	0.006	$36.23			$ 0.02			$ 0.02			$ 0.02	$ 0.02
Physical Med and Rehab	0.205	$ 26.05			$ 0.45	$2.00	($0.03)	$ 0.42	$5.00	($0.05)	$ 0.39	$ 0.44
Enteral/Parenteral Therapy	0.011	$ 172.87			$ 0.15	$2.00	($0.00)	$ 0.15	$5.00	($0.00)	$ 0.15	$ 0.15
Dialysis												
Vision Services	0.138	$40.30			$ 0.46	$2.00	($0.01)	$ 0.45	$5.00	($0.03)	$ 0.43	$ 0.46
Other	0.036	$ 19.12			$ 0.06			$ 0.06			$ 0.06	$ 0.06
Unknown												
Total Claim Cost					**$ 150.26**			**$ 149.84**			**$ 148.00**	**$ 149.89**

2005 Rates

Type of Service	Age <1 Utilization PMPY	Age <1 Allowable Cost Per Unit	<100% FPL Copay	<100% FPL Impact	<100% FPL Claim Cost PMPM	100% - 133% FPL Copay	100% - 133% FPL Impact	100% - 133% FPL Claim Cost PMPM	> 133% FPL Copay	> 133% FPL Impact	> 133% FPL Claim Cost PMPM	Combined Claim Cost PMPM
Inpatient Hospital (days)												
Medical/Surgical	0.198	$ 1,391.36			$ 22.91			$ 22.91			$ 22.91	$ 22.85
OB/Newborn	0.057	$ 1,047.24			$ 4.97			$ 4.97			$ 4.97	$ 4.96
Psychiatric												
Substance Abuse												
Skilled Nursing												
Outpatient Hospital (visits)												
Emergency	1.091	$ 96.61	$3.00	($0.10)	$ 8.69	$3.00	($0.10)	$ 8.69	$15.00	($0.82)	$ 7.97	$ 8.65
Other	0.978	$ 170.70			$ 13.91			$ 13.91			$ 13.91	$ 13.87
Lab and Radiology												
Lab	1.508	$ 14.39			$ 1.81			$ 1.81			$ 1.81	$ 1.80
Radiology	0.528	$ 24.94			$ 1.10			$ 1.10			$ 1.10	$ 1.09
Physician (Non-capitated)												
Allergy and Clinical Immunology	0.006	$ 50.76			$ 0.02	$2.00	($0.00)	$ 0.02	$5.00	($0.00)	$ 0.02	$ 0.02
Anesthesia	0.079	$ 145.64			$ 0.96			$ 0.96			$ 0.96	$ 0.96
Cardiovascular	0.092	$ 40.23			$ 0.31			$ 0.31			$ 0.31	$ 0.31
Central Nervous System												
Chemotherapy Administration												
Consultations	0.152	$ 104.23			$ 1.32	$2.00	($0.01)	$ 1.31	$5.00	($0.02)	$ 1.30	$ 1.31
Critical Care Services	0.100	$ 24.61			$ 0.20			$ 0.20			$ 0.20	$ 0.20
Emergency Department Services	0.608	$ 56.78			$ 2.88			$ 2.88			$ 2.88	$ 2.87
Gastroenterology	0.005	$ 96.89			$ 0.04			$ 0.04			$ 0.04	$ 0.04
Home Services	0.009	$ 74.29			$ 0.06			$ 0.06			$ 0.06	$ 0.06
Hospital Inpatient Services	0.271	$ 70.82			$ 1.60			$ 1.60			$ 1.60	$ 1.60
Maternity and Delivery												
Neurology and Neuromuscular	0.005	$ 47.33			$ 0.02	$2.00	($0.00)	$ 0.02	$5.00	($0.00)	$ 0.02	$ 0.02
Newborn and Neonatal Services	0.023	$ 84.70			$ 0.16			$ 0.16			$ 0.16	$ 0.16
Nursing Facility Services												
Office or Other OPt Services	2.951	$ 40.36			$ 9.93	$2.00	($0.05)	$ 9.88	$5.00	($0.08)	$ 9.84	$ 9.86
Opthalmology	0.017	$ 37.20			$ 0.05			$ 0.05			$ 0.05	$ 0.05
Otorhinolaryngologic Services	0.113	$ 20.04			$ 0.19			$ 0.19			$ 0.19	$ 0.19
Prolonged Services	0.002	$ 37.36			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Pulmonary	0.131	$ 21.41			$ 0.23			$ 0.23			$ 0.23	$ 0.23
Routine Eye Exam	0.010	$ 39.92			$ 0.03			$ 0.03			$ 0.03	$ 0.03
Routine Physical Exam	0.040	$ 11.28			$ 0.04			$ 0.04			$ 0.04	$ 0.04
Surgery	0.449	$ 116.88			$ 4.38			$ 4.38			$ 4.38	$ 4.36
Vascular Diagnostic	0.004	$ 67.15			$ 0.02			$ 0.02			$ 0.02	$ 0.02
Well Baby/Well Child	2.044	$ 59.16			$ 10.08			$ 10.08			$ 10.08	$ 10.05
Capitation					$ 7.47			$ 7.47			$ 7.47	$ 7.45
Mental Health/Substance Abuse					$ 11.74			$ 11.74			$ 11.74	$ 11.74
Psychotherapy												
Alcohol/Substance Abuse												
Ambulance	0.057	$ 61.01			$ 0.29			$ 0.29			$ 0.29	$ 0.29
Durable Medical Equipment												
Hearing Aids												
Orthotics												
Other DME	0.088	$ 99.47			$ 0.73			$ 0.73			$ 0.73	$ 0.73
Oxygen	0.112	$ 60.62			$ 0.57			$ 0.57			$ 0.57	$ 0.56
Prosthetic Devices												
Home Health												
Drugs/Injections												
Chemotherapy Drugs												
Injectibles	0.085	$ 33.99			$ 0.24			$ 0.24			$ 0.24	$ 0.24
Prescriptions					$ 6.54	$1.00	($0.12)	$ 6.42	$4.00	($0.38)	$ 6.17	$ 6.42
Therapeutic or Diag Injections	0.059	$ 63.28			$ 0.31			$ 0.31			$ 0.31	$ 0.31
Vaccines/Toxoids	5.950	$ 25.30			$ 12.54			$ 12.54			$ 12.54	$ 12.51
Supplies - Medical and Surgical	0.034	$ 21.54			$ 0.06			$ 0.06			$ 0.06	$ 0.06
Therapies/Treatments												
Manipulative Treatment												
Physical Med and Rehab	0.006	$ 74.56			$ 0.04	$2.00	$0.00	$ 0.04	$5.00	($0.00)	$ 0.04	$ 0.04
Enteral/Parenteral Therapy	0.012	$ 37.19			$ 0.04	$2.00	($0.00)	$ 0.04	$5.00	($0.00)	$ 0.04	$ 0.04
Dialysis												
Vision Services						$2.00	$0.00		$5.00	$0.00		
Other	0.300	$ 42.42			$ 1.06			$ 1.06			$ 1.06	$ 1.06
Unknown												
Total Claim Cost					**$ 127.53**			**$ 127.35**			**$ 126.33**	**$ 127.07**

2005 Rates

Type of Service	Age 1-4 Utilization PMPY	Age 1-4 Allowable Cost Per Unit	<100% FPL Copay	<100% FPL Impact	<100% FPL Claim Cost PMPM	100% - 133% FPL Copay	100% - 133% FPL Impact	100% - 133% FPL Claim Cost PMPM	> 133% FPL Copay	> 133% FPL Impact	> 133% FPL Claim Cost PMPM	Combined Claim Cost PMPM
Inpatient Hospital (days)												
Medical/Surgical	0.093	$ 1,735.76			$ 13.48			$ 13.48			$ 13.48	$ 13.44
OB/Newborn	0.014	$ 1,051.90			$ 1.27			$ 1.27			$ 1.27	$ 1.27
Psychiatric												
Substance Abuse												
Skilled Nursing												
Outpatient Hospital (visits)												
Emergency	0.861	$ 106.34	$3.00	($0.08)	$ 7.54	$3.00	($0.08)	$ 7.54	$15.00	($1.10)	$ 6.53	$ 7.47
Other	0.735	$ 187.90			$ 11.50			$ 11.50			$ 11.50	$ 11.46
Lab and Radiology												
Lab	1.796	$ 14.99			$ 2.24			$ 2.24			$ 2.24	$ 2.24
Radiology	0.394	$ 27.00			$ 0.89			$ 0.89			$ 0.89	$ 0.88
Physician (Non-capitated)												
Allergy and Clinical Immunology	0.009	$ 56.24			$ 0.04	$2.00	($0.00)	$ 0.04	$5.00	($0.00)	$ 0.04	$ 0.04
Anesthesia	0.063	$ 161.32			$ 0.85			$ 0.85			$ 0.85	$ 0.84
Cardiovascular	0.066	$ 50.59			$ 0.28			$ 0.28			$ 0.28	$ 0.28
Central Nervous System	0.003	$ 137.88			$ 0.03			$ 0.03			$ 0.03	$ 0.03
Chemotherapy Administration	0.000	$ 94.76			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Consultations	0.124	$ 101.91			$ 1.05	$2.00	($0.01)	$ 1.04	$5.00	($0.02)	$ 1.03	$ 1.04
Critical Care Services	0.093	$ 21.45			$ 0.17			$ 0.17			$ 0.17	$ 0.17
Emergency Department Services	0.466	$ 55.56			$ 2.16			$ 2.16			$ 2.16	$ 2.15
Gastroenterology	0.001	$ 97.32			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Home Services	0.002	$ 74.62			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Hospital Inpatient Services	0.109	$ 75.12			$ 0.68			$ 0.68			$ 0.68	$ 0.68
Maternity and Delivery												
Neurology and Neuromuscular	0.005	$ 50.97			$ 0.02	$2.00	($0.00)	$ 0.02	$5.00	($0.00)	$ 0.02	$ 0.02
Newborn and Neonatal Services	0.006	$ 85.08			$ 0.04			$ 0.04			$ 0.04	$ 0.04
Nursing Facility Services												
Office or Other OPt Services	2.833	$ 40.05			$ 9.45	$2.00	($0.07)	$ 9.38	$5.00	($0.12)	$ 9.33	$ 9.39
Opthalmology	0.043	$ 30.60			$ 0.11			$ 0.11			$ 0.11	$ 0.11
Otorhinolaryngologic Services	0.123	$ 19.28			$ 0.20			$ 0.20			$ 0.20	$ 0.20
Prolonged Services	0.007	$ 63.68			$ 0.04			$ 0.04			$ 0.04	$ 0.04
Pulmonary	0.136	$ 31.14			$ 0.35			$ 0.35			$ 0.35	$ 0.35
Routine Eye Exam	0.068	$ 37.33			$ 0.21			$ 0.21			$ 0.21	$ 0.21
Routine Physical Exam	0.011	$ 11.91			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Surgery	0.373	$ 114.08			$ 3.54			$ 3.54			$ 3.54	$ 3.53
Vascular Diagnostic	0.001	$ 54.09			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Well Baby/Well Child	1.085	$ 59.50			$ 5.38			$ 5.38			$ 5.38	$ 5.36
Capitation					$ 5.62			$ 5.62			$ 5.62	$ 5.60
Mental Health/Substance Abuse					$ 11.74			$ 11.74			$ 11.74	$ 11.74
Psychotherapy												
Alcohol/Substance Abuse												
Ambulance	0.044	$ 72.34			$ 0.26			$ 0.26			$ 0.26	$ 0.26
Durable Medical Equipment												
Hearing Aids												
Orthotics	0.003	$ 333.33			$ 0.07			$ 0.07			$ 0.07	$ 0.07
Other DME	0.060	$ 90.69			$ 0.45			$ 0.45			$ 0.45	$ 0.45
Oxygen	0.040	$ 75.57			$ 0.25			$ 0.25			$ 0.25	$ 0.25
Prosthetic Devices	0.000	$ 187.09			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Home Health												
Drugs/Injections												
Chemotherapy Drugs												
Injectibles	0.038	$ 29.22			$ 0.09			$ 0.09			$ 0.09	$ 0.09
Prescriptions					$ 8.22	$1.00	($0.22)	$ 8.01	$4.00	($0.57)	$ 7.65	$ 8.10
Therapeutic or Diag Injections	0.033	$ 406.67			$ 1.11			$ 1.11			$ 1.11	$ 1.11
Vaccines/Toxoids	2.244	$ 21.39			$ 4.00			$ 4.00			$ 4.00	$ 3.99
Supplies - Medical and Surgical	0.028	$ 40.69			$ 0.10			$ 0.10			$ 0.10	$ 0.10
Therapies/Treatments												
Manipulative Treatment	0.001	$ 38.22			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Physical Med and Rehab	0.003	$ 67.59			$ 0.02	$2.00	($0.00)	$ 0.02	$5.00	($0.00)	$ 0.01	$ 0.02
Enteral/Parenteral Therapy	0.004	$ 151.77			$ 0.05	$2.00	($0.00)	$ 0.05	$5.00	($0.00)	$ 0.05	$ 0.05
Dialysis												
Vision Services	0.076	$47.24			$ 0.30	$2.00	($0.00)	$ 0.30	$5.00	$0.00	$ 0.30	$ 0.30
Other	0.132	$ 88.32			$ 0.97			$ 0.97			$ 0.97	$ 0.97
Unknown												
Total Claim Cost					**$ 94.84**			**$ 94.53**			**$ 93.10**	**$ 94.38**

2005 Rates												
	Age 5-9		<100% FPL			100% - 133% FPL			> 133% FPL			Combined
Type of Service	Utilization PMPY	Allowable Cost Per Unit	Copay	Impact	Claim Cost PMPM	Copay	Impact	Claim Cost PMPM	Copay	Impact	Claim Cost PMPM	Claim Cost PMPM
Inpatient Hospital (days)												
Medical/Surgical	0.022	$ 1,926.81			$ 3.61			$ 3.61			$ 3.61	$ 3.61
OB/Newborn	0.000	$ 2,129.98			$ 0.05			$ 0.05			$ 0.05	$ 0.05
Psychiatric												
Substance Abuse												
Skilled Nursing												
Outpatient Hospital (visits)												
Emergency	0.248	$ 112.10	$3.00	($0.06)	$ 2.26	$3.00	($0.06)	$ 2.26	$15.00	($1.10)	$ 1.22	$ 2.20
Other	0.273	$ 194.46			$ 4.42			$ 4.42			$ 4.42	$ 4.42
Lab and Radiology												
Lab	0.732	$ 14.46			$ 0.88			$ 0.88			$ 0.88	$ 0.88
Radiology	0.192	$ 28.00			$ 0.45			$ 0.45			$ 0.45	$ 0.45
Physician (Non-capitated)												
Allergy and Clinical Immunology	0.029	$ 49.72			$ 0.12	$2.00	($0.01)	$ 0.11	$5.00	($0.02)	$ 0.10	$ 0.12
Anesthesia	0.020	$ 161.80			$ 0.27			$ 0.27			$ 0.27	$ 0.27
Cardiovascular	0.020	$ 57.57			$ 0.10			$ 0.10			$ 0.10	$ 0.10
Central Nervous System	0.002	$ 85.23			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Chemotherapy Administration	0.001	$ 58.96			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Consultations	0.043	$ 88.64			$ 0.31	$2.00	($0.02)	$ 0.30	$5.00	($0.03)	$ 0.29	$ 0.31
Critical Care Services	0.026	$ 18.71			$ 0.04			$ 0.04			$ 0.04	$ 0.04
Emergency Department Services	0.134	$ 49.01			$ 0.55			$ 0.55			$ 0.55	$ 0.55
Gastroenterology	0.000	$ 80.70			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Home Services	0.000	$ 63.16			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Hospital Inpatient Services	0.082	$ 67.71			$ 0.46			$ 0.46			$ 0.46	$ 0.46
Maternity and Delivery	0.010	$ 496.65			$ 0.40			$ 0.40			$ 0.40	
Neurology and Neuromuscular	0.011	$ 55.42			$ 0.05	$2.00	($0.00)	$ 0.05	$5.00	($0.00)	$ 0.05	$ 0.05
Newborn and Neonatal Services												
Nursing Facility Services												
Office or Other OPt Services	5.087	$ 35.70			$ 15.14	$2.00	($0.09)	$ 15.04	$5.00	($0.14)	$ 14.99	$ 15.12
Opthalmology	0.190	$ 21.62			$ 0.34			$ 0.34			$ 0.34	$ 0.34
Otorhinolaryngologic Services	0.181	$ 18.14			$ 0.27			$ 0.27			$ 0.27	$ 0.27
Prolonged Services	0.012	$ 69.81			$ 0.07			$ 0.07			$ 0.07	$ 0.07
Pulmonary	0.280	$ 29.99			$ 0.70			$ 0.70			$ 0.70	$ 0.70
Routine Eye Exam	0.294	$ 30.71			$ 0.75			$ 0.75			$ 0.75	$ 0.75
Routine Physical Exam	0.253	$ 27.49			$ 0.58			$ 0.58			$ 0.58	$ 0.58
Surgery	0.734	$ 90.53			$ 5.54			$ 5.54			$ 5.54	$ 5.54
Vascular Diagnostic	0.003	$ 34.82			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Well Baby/Well Child	0.702	$ 52.96			$ 3.10			$ 3.10			$ 3.10	$ 3.10
Capitation					$ 3.80			$ 3.80			$ 3.80	$ 3.80
Mental Health/Substance Abuse					$ 11.74			$ 11.74			$ 11.74	$ 11.74
Psychotherapy												
Alcohol/Substance Abuse												
Ambulance	0.080	$ 73.44			$ 0.49			$ 0.49			$ 0.49	$ 0.49
Durable Medical Equipment												
Hearing Aids	0.001	$ 269.57			$ 0.03			$ 0.03			$ 0.03	$ 0.03
Orthotics	0.023	$ 219.75			$ 0.43			$ 0.43			$ 0.43	$ 0.43
Other DME	0.057	$ 75.32			$ 0.36			$ 0.36			$ 0.36	$ 0.36
Oxygen	0.014	$ 79.91			$ 0.10			$ 0.10			$ 0.10	$ 0.10
Prosthetic Devices	0.001	$ 267.80			$ 0.03			$ 0.03			$ 0.03	$ 0.03
Home Health												
Drugs/Injections												
Chemotherapy Drugs	0.006	$ 205.63			$ 0.11			$ 0.11			$ 0.11	$ 0.11
Injectibles	0.086	$ 58.63			$ 0.42			$ 0.42			$ 0.42	$ 0.42
Prescriptions					$ 20.37	$1.00	($0.32)	$ 20.05	$4.00	($0.73)	$ 19.64	$ 20.28
Therapeutic or Diag Injections	0.057	$ 479.05			$ 2.28			$ 2.28			$ 2.28	$ 2.28
Vaccines/Toxoids	0.978	$ 14.79			$ 1.21			$ 1.21			$ 1.21	$ 1.21
Supplies - Medical and Surgical	0.110	$ 47.87			$ 0.44			$ 0.44			$ 0.44	$ 0.44
Therapies/Treatments												
Manipulative Treatment	0.004	$ 33.04			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Physical Med and Rehab	0.083	$ 43.36			$ 0.30	$2.00	($0.01)	$ 0.29	$5.00	($0.02)	$ 0.28	$ 0.30
Enteral/Parenteral Therapy	0.017	$ 208.34			$ 0.29	$2.00	($0.00)	$ 0.29	$5.00	($0.00)	$ 0.29	$ 0.29
Dialysis												
Vision Services	0.488	$ 40.17			$ 1.63	$2.00	($0.01)	$ 1.63	$5.00	($0.01)	$ 1.62	$ 1.63
Other	0.316	$ 71.85			$ 1.89			$ 1.89			$ 1.89	$ 1.90
Unknown												
Total Claim Cost					**$ 86.40**			**$ 85.93**			**$ 84.40**	**$ 85.86**

2005 Rates												
	Age 10-14		<100% FPL			100% - 133% FPL			> 133% FPL			Combined
	Utilization	Allowable Cost			Claim Cost			Claim Cost			Claim Cost	Claim Cost
Type of Service	PMPY	Per Unit	Copay	Impact	PMPM	Copay	Impact	PMPM	Copay	Impact	PMPM	PMPM
Inpatient Hospital (days)												
Medical/Surgical	0.057	$ 2,377.30			$ 11.35			$ 11.35			$ 11.35	$ 11.31
OB/Newborn	0.001	$ 2,349.80			$ 0.25			$ 0.25			$ 0.25	$ 0.25
Psychiatric												
Substance Abuse												
Skilled Nursing												
Outpatient Hospital (visits)												
Emergency	0.534	$ 143.44	$3.00	($0.05)	$ 6.34	$3.00	($0.05)	$ 6.34	$15.00	($0.96)	$ 5.43	$ 6.26
Other	0.728	$ 243.08			$ 14.75			$ 14.75			$ 14.75	$ 14.69
Lab and Radiology												
Lab	1.855	$ 17.36			$ 2.68			$ 2.68			$ 2.68	$ 2.67
Radiology	0.587	$ 35.61			$ 1.74			$ 1.74			$ 1.74	$ 1.74
Physician (Non-capitated)												
Allergy and Clinical Immunology	0.117	$ 47.99			$ 0.47	$2.00	($0.03)	$ 0.44	$5.00	($0.04)	$ 0.43	$ 0.46
Anesthesia	0.047	$ 192.74			$ 0.75			$ 0.75			$ 0.75	$ 0.75
Cardiovascular	0.049	$ 72.91			$ 0.30			$ 0.30			$ 0.30	$ 0.30
Central Nervous System	0.005	$ 29.24			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Chemotherapy Administration	0.006	$ 21.20			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Consultations	0.105	$ 98.80			$ 0.86	$2.00	($0.01)	$ 0.85	$5.00	($0.02)	$ 0.84	$ 0.86
Critical Care Services	0.048	$ 24.42			$ 0.10			$ 0.10			$ 0.10	$ 0.10
Emergency Department Services	0.292	$ 55.75			$ 1.36			$ 1.36			$ 1.36	$ 1.35
Gastroenterology	0.000	$ 89.03			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Home Services	0.000	$ 69.68			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Hospital Inpatient Services	0.040	$ 71.76			$ 0.24			$ 0.24			$ 0.24	$ 0.24
Maternity and Delivery	0.009	$ 547.90			$ 0.41			$ 0.41			$ 0.41	$ 0.41
Neurology and Neuromuscular	0.007	$ 74.95			$ 0.04	$2.00	($0.00)	$ 0.04	$5.00	($0.00)	$ 0.04	$ 0.04
Newborn and Neonatal Services												
Nursing Facility Services												
Office or Other OPt Services	2.871	$ 40.54			$ 9.70	$2.00	($0.08)	$ 9.62	$5.00	($0.14)	$ 9.56	$ 9.64
Opthalmology	0.143	$ 23.07			$ 0.28			$ 0.28			$ 0.28	$ 0.27
Otorhinolaryngologic Services	0.084	$ 23.03			$ 0.16			$ 0.16			$ 0.16	$ 0.16
Prolonged Services	0.005	$ 66.83			$ 0.03			$ 0.03			$ 0.03	$ 0.03
Pulmonary	0.168	$ 24.90			$ 0.35			$ 0.35			$ 0.35	$ 0.35
Routine Eye Exam	0.216	$ 33.44			$ 0.60			$ 0.60			$ 0.60	$ 0.60
Routine Physical Exam	0.236	$ 59.51			$ 1.17			$ 1.17			$ 1.17	$ 1.17
Surgery	0.452	$ 85.92			$ 3.24			$ 3.24			$ 3.24	$ 3.23
Vascular Diagnostic												
Well Baby/Well Child	0.143	$ 58.92			$ 0.70			$ 0.70			$ 0.70	$ 0.70
Capitation					$ 3.35			$ 3.35			$ 3.35	$ 3.34
Mental Health/Substance Abuse					$ 11.74			$ 11.74			$ 11.74	$ 11.74
Psychotherapy												
Alcohol/Substance Abuse												
Ambulance	0.048	$ 83.34			$ 0.33			$ 0.33			$ 0.33	$ 0.33
Durable Medical Equipment												
Hearing Aids	0.001	$ 297.39			$ 0.03			$ 0.03			$ 0.03	$ 0.03
Orthotics	0.019	$ 110.00			$ 0.18			$ 0.18			$ 0.18	$ 0.18
Other DME	0.020	$ 86.49			$ 0.14			$ 0.14			$ 0.14	$ 0.14
Oxygen	0.003	$ 92.14			$ 0.02			$ 0.02			$ 0.02	$ 0.02
Prosthetic Devices	0.001	$ 476.09			$ 0.05			$ 0.05			$ 0.05	$ 0.05
Home Health												
Drugs/Injections												
Chemotherapy Drugs	0.006	$ 226.85			$ 0.11			$ 0.11			$ 0.11	$ 0.11
Injectibles	0.066	$ 128.97			$ 0.71			$ 0.71			$ 0.71	$ 0.70
Prescriptions					$ 17.31	$1.00	($0.28)	$ 17.02	$4.00	($0.76)	$ 16.54	$ 17.16
Therapeutic or Diag Injections	0.037	$ 292.97			$ 0.91			$ 0.91			$ 0.91	$ 0.91
Vaccines/Toxoids	0.251	$ 14.26			$ 0.30			$ 0.30			$ 0.30	$ 0.30
Supplies - Medical and Surgical	0.085	$ 49.02			$ 0.35			$ 0.35			$ 0.35	$ 0.35
Therapies/Treatments												
Manipulative Treatment	0.003	$ 35.11			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Physical Med and Rehab	0.077	$ 28.37			$ 0.18	$2.00	($0.03)	$ 0.15	$5.00	($0.05)	$ 0.14	$ 0.17
Enteral/Parenteral Therapy	0.014	$ 211.85			$ 0.25	$2.00	($0.00)	$ 0.25	$5.00	($0.00)	$ 0.25	$ 0.25
Dialysis												
Vision Services	0.388	$ 41.47			$ 1.34	$2.00	($0.01)	$ 1.33	$5.00	($0.03)	$ 1.31	$ 1.33
Other	0.246	$ 8.76			$ 0.18			$ 0.18			$ 0.18	$ 0.18
Unknown												
Total Claim Cost					**$ 95.38**			**$ 94.94**			**$ 93.43**	**$ 94.90**

2005 Rates												
	Age >14		<100% FPL			100% - 133% FPL			> 133% FPL			Combined
	Utilization	Allowable Cost			Claim Cost			Claim Cost			Claim Cost	Claim Cost
Type of Service	PMPY	Per Unit	Copay	Impact	PMPM	Copay	Impact	PMPM	Copay	Impact	PMPM	PMPM
Inpatient Hospital (days)												
Medical/Surgical	0.080	$ 2,527.71			$ 16.83			$ 16.83			$ 16.83	$ 16.78
OB/Newborn	0.002	$ 2,498.47			$ 0.37			$ 0.37			$ 0.37	$ 0.37
Psychiatric												
Substance Abuse												
Skilled Nursing												
Outpatient Hospital (visits)												
Emergency	0.745	$ 152.52	$3.00	($0.05)	$ 9.41	$3.00	($0.05)	$ 9.41	$15.00	($0.96)	$ 8.51	$ 9.35
Other	1.015	$ 258.46			$ 21.85			$ 21.85			$ 21.85	$ 21.80
Lab and Radiology												
Lab	2.586	$ 18.46			$ 3.98			$ 3.98			$ 3.98	$ 3.97
Radiology	0.819	$ 37.86			$ 2.58			$ 2.58			$ 2.58	$ 2.58
Physician (Non-capitated)												
Allergy and Clinical Immunology	0.163	$ 51.03			$ 0.69	$2.00	($0.02)	$ 0.67	$5.00	($0.04)	$ 0.65	$ 0.69
Anesthesia	0.065	$ 204.93			$ 1.12			$ 1.12			$ 1.12	$ 1.11
Cardiovascular	0.068	$ 77.52			$ 0.44			$ 0.44			$ 0.44	$ 0.44
Central Nervous System	0.006	$ 31.09			$ 0.02			$ 0.02			$ 0.02	$ 0.02
Chemotherapy Administration	0.008	$ 22.54			$ 0.02			$ 0.02			$ 0.02	$ 0.02
Consultations	0.146	$ 105.05			$ 1.28	$2.00	($0.01)	$ 1.27	$5.00	($0.02)	$ 1.25	$ 1.27
Critical Care Services	0.068	$ 25.96			$ 0.15			$ 0.15			$ 0.15	$ 0.15
Emergency Department Services	0.407	$ 59.28			$ 2.01			$ 2.01			$ 2.01	$ 2.01
Gastroenterology	0.001	$ 94.66			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Home Services	0.000	$ 74.09			$ 0.00			$ 0.00			$ 0.00	$ 0.00
Hospital Inpatient Services	0.056	$ 76.30			$ 0.36			$ 0.36			$ 0.36	$ 0.36
Maternity and Delivery	0.013	$ 582.57			$ 0.61			$ 0.61			$ 0.61	$ 0.61
Neurology and Neuromuscular	0.010	$ 79.69			$ 0.06	$2.00	($0.00)	$ 0.06	$5.00	($0.00)	$ 0.06	$ 0.06
Newborn and Neonatal Services												
Nursing Facility Services												
Office or Other OPt Services	4.002	$ 43.11			$ 14.37	$2.00	($0.07)	$ 14.30	$5.00	($0.14)	$ 14.23	$ 14.32
Opthalmology	0.200	$ 24.53			$ 0.41			$ 0.41			$ 0.41	$ 0.41
Otorhinolaryngologic Services	0.117	$ 24.48			$ 0.24			$ 0.24			$ 0.24	$ 0.24
Prolonged Services	0.007	$ 71.06			$ 0.04			$ 0.04			$ 0.04	$ 0.04
Pulmonary	0.234	$ 26.47			$ 0.52			$ 0.52			$ 0.52	$ 0.52
Routine Eye Exam	0.301	$ 35.55			$ 0.89			$ 0.89			$ 0.89	$ 0.89
Routine Physical Exam	0.329	$ 63.27			$ 1.74			$ 1.74			$ 1.74	$ 1.73
Surgery	0.631	$ 91.35			$ 4.80			$ 4.80			$ 4.80	$ 4.79
Vascular Diagnostic	0.004	$ 34.89			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Well Baby/Well Child	0.199	$ 62.65			$ 1.04			$ 1.04			$ 1.04	$ 1.04
Capitation					$ 3.35			$ 3.35			$ 3.35	$ 3.34
Mental Health/Substance Abuse					$ 11.74			$ 11.74			$ 11.74	$ 11.74
Psychotherapy												
Alcohol/Substance Abuse												
Ambulance	0.067	$ 88.61			$ 0.49			$ 0.49			$ 0.49	$ 0.49
Durable Medical Equipment												
Hearing Aids	0.002	$ 316.21			$ 0.04			$ 0.04			$ 0.04	$ 0.04
Orthotics	0.027	$ 116.96			$ 0.26			$ 0.26			$ 0.26	$ 0.26
Other DME	0.028	$ 91.96			$ 0.21			$ 0.21			$ 0.21	$ 0.21
Oxygen	0.004	$ 97.97			$ 0.03			$ 0.03			$ 0.03	$ 0.03
Prosthetic Devices	0.002	$ 506.21			$ 0.08			$ 0.08			$ 0.08	$ 0.08
Home Health												
Drugs/Injections												
Chemotherapy Drugs	0.008	$ 241.21			$ 0.16			$ 0.16			$ 0.16	$ 0.16
Injectibles	0.092	$ 137.12			$ 1.05			$ 1.05			$ 1.05	$ 1.05
Prescriptions					$ 25.65	$1.00	($0.26)	$ 25.39	$4.00	($0.76)	$ 24.89	$ 25.50
Therapeutic or Diag Injections	0.052	$ 311.51			$ 1.35			$ 1.35			$ 1.35	$ 1.35
Vaccines/Toxoids	0.350	$ 15.16			$ 0.44			$ 0.44			$ 0.44	$ 0.44
Supplies - Medical and Surgical	0.119	$ 52.12			$ 0.52			$ 0.52			$ 0.52	$ 0.52
Therapies/Treatments												
Manipulative Treatment	0.004	$ 37.33			$ 0.01			$ 0.01			$ 0.01	$ 0.01
Physical Med and Rehab	0.107	$ 30.17			$ 0.27	$2.00	($0.02)	$ 0.24	$5.00	($0.05)	$ 0.22	$ 0.26
Enteral/Parenteral Therapy	0.020	$ 225.26			$ 0.37	$2.00	($0.00)	$ 0.37	$5.00	($0.00)	$ 0.37	$ 0.37
Dialysis												
Vision Services	0.541	$ 44.10			$ 1.99	$2.00	($0.01)	$ 1.98	$5.00	($0.03)	$ 1.96	$ 1.98
Other	0.343	$ 9.32			$ 0.27			$ 0.27			$ 0.27	$ 0.27
Unknown												
Total Claim Cost					**$ 134.13**			**$ 133.72**			**$ 132.17**	**$ 133.64**

Section IX – Alternative Benefit Structures

“Core” and “Core Plus” Benefit Packages

The HCPF management team asked CCRC Actuaries to evaluate proposed changes to the “Core” benefit package. The potential impact to both the SFMC and HMO PMPM were projected based on the suggested changes.

The benefit for vision coverage in the baseline includes $50 for eyeglasses. The proposed benefit change is to increase coverage to $150. The numbers below represent the increase to the fiscal year 2005 PMPMs for addition for each of the benefits listed by age grouping.

Benefit	Increase to PMPM					
Addition	Overall	<1	1-4	5-9	10-14	>14
Vision	$0.508	$0.054	$0.131	$0.546	$0.593	$0.598

Overall, total annual program costs are projected to increase $1,580,000 for expanded vision services.

The benefit for hearing aids in the baseline is limited to $800. The proposed benefit change is to increase coverage to a level that will provide for most children’s needs. The numbers below represent the fiscal year 2005 PMPMs for each benefits level listed by age grouping.

Max Hearing	Percent of children	Increase to PMPM					
Aid Benefit	with 100% of costs paid	Overall	<1	1-4	5-9	10-14	>14
$800	10%	$0.113	$0.012	$0.029	$0.121	$0.132	$0.133
1,500	43	0.194	0.021	0.050	0.209	0.227	0.229
2,000	58	0.235	0.025	0.061	0.253	0.274	0.277
3,000	83	0.284	0.030	0.073	0.305	0.331	0.334
4,000	95	0.303	0.032	0.078	0.326	0.354	0.357

Overall, total annual program costs are projected to increase $570,000 for the cost of expanding hearing aid coverage to $4,000.

In addition to the “Core” benefit package, wrap-around benefits recommended as the “Core Plus” package as defined on page 17 were priced to be $0.23 PMPM in fiscal year 2005. However, depending on how utilization is managed and the provider reaction to the enhanced benefits, it is conceivable that the increase in the PMPM is up to $2.30 in an unmanaged environment.

Overall, total annual program costs for the “Core Plus” package are projected to be $690,000.

Elimination of PCP Capitation

The HCPF management team asked CCRC Actuaries to evaluate the potential savings of eliminating the PCP capitation. We evaluated the alternative benefit structure that would result from the elimination of the PCP capitation under the SFMC program. Capitation works best with volume. Single physicians with a small Medicaid and CHP patient-load run the risk of sustaining a loss even though we show that the current PCP Capitation is in excess of the projected claim cost.

By eliminating this service, the following savings would be available by age group on a PMPM basis:

Savings to SFMC PMPM				
<1	1-4	5-9	10-14	>14
$0.384	$0.587	$1.650	$1.009	$1.010

This results in a total annual savings to the program of $860,000 in fiscal year 2005.

Increase in RBRVS Payments

Also under consideration by HCPF management as an alternative benefit structure is increasing RBRVS payments from 80% to 85%. Under this alternative scenario, assumptions incorporate an adjustment to utilization as experienced in the industry. The following table shows the increase in the SFMC PMPM by age group:

	Increase to SFMC PMPM				
RBRVS	<1	1-4	5-9	10-14	>14
Payment of 85%	$ 0.68	$ 0.61	$ 0.86	$ 0.69	$ 1.33

This amounts to an annual additional cost of $720,000 to the program.

Combinations of Alternative Benefits

The HCPF management team asked CCRC Actuaries to assess the effect of the increase of the RBRVS payment on the "Core Plus" benefit package and the elimination of the PCP capitation. Increasing the RBRVS payment will result in the "Core Plus" package costing $0.24 PMPM in fiscal year 2005 and be associated with the same risk.

Overall, total annual program costs for the "Core Plus" package assuming an increase in reimbursement to 85% of RBRVS are projected to be $720,000.

Increasing the RBRVS percentage paid to 85% and eliminating the PCP capitation will bring about both increases and decreases to the savings of the SFMC PMPM associated under just the elimination of the PCP capitation as displayed in the middle chart on the previous page. The savings due to the combination of these alternative benefit structures is summarized below:

Savings to SFMC PMPM				
<1	1-4	5-9	10-14	>14
($0.416)	($0.003)	$1.303	$0.685	$0.686

This results in a reduction in total annual savings to the program for eliminating the PCP capitation from $860,000 to $420,000 in fiscal year 2005.

Incorporating all of the above changes to the Streamlining Initiative would increase the costs as follows:

	Population Impacted	**PMPM**	**Total Cost**
Vision	All Children	$0.508	$1,580,000
Hearing Aids ($4,000)	All Children	0.190	570,000
Increase reimbursement to 85% of RBRVS	SFMC Children	1.280	720,000
Core Plus w/ increase in RBRVS	All Children	0.240	720,000
Eliminating PCP capitation w/ increase in RBRVS	SFMC Children	-0.456	(420,000)
Total			**$3,170,000**

Section X – Projection of Alternative Expansion Scenario

We spoke with the Rhode Island Department regarding their expansion of the CHP to include parents of CHP+ eligible children not enrolled in a current program. Unfortunately, to date they have not analyzed any claim data separating this population from the general claims data and do not know the impact of this expansion group on their CHP+ program.

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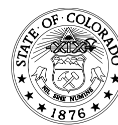

Bill Owens
Governor

Karen Reinertson
Executive Director

Appendix B: Summary of Public Process

July 01, 2005

Summary of Public Process

Beginning in October 2003, the State of Colorado, Department of Health Care Policy and Financing began exploring streamlining the publicly funded health care programs for children and families. In order to design and implement the best possible program for Colorado kids and their families, a public input process was initiated immediately. HCPF wanted to solicit feedback from all segments of the community regarding all facets of the program including the delivery system and benefit package. This summary highlights the activities and strategies implemented to maximize input opportunities.

- **External Advisory Committee**
  Through the support of the Rose Community Foundation, a dozen community and business leaders were assembled to explore the specifics of a streamlined model. This group has met nine times to date. Their recommendations have shaped the direction this effort has taken.

- **Special Forum for Stakeholders and Advocates – October, 28, 2003**
  The first "open" meeting was held at the Colorado History Museum. Over 100 persons attended this meeting. A general overview of the project was presented and then small groups discussed several questions related to current operations and desired changes.

- **Public Input Feedback Sheet, Email and Phone Number**
  To promote continuing feedback, a standardized feedback sheet was created. A dedicated phone number and email address were designated. Business cards presenting this information were printed and circulated. Dozens of written comments have been received. The voice mail line has received some input; however, the majority of calls have requested information. These input opportunities remain active at the present time.

- **Six Community Meetings – December 2, 2003 – December 15, 2003**
  Alamosa, Pueblo, Denver, Grand Junction, Ft. Collins, Colorado Springs
  Approximately 250 people, including community leaders and the general public, participated in these meetings held throughout the state. Once again, a general overview and update was provided. Input was focused on three different areas – program design, delivery system for children with special health care needs and priorities for increased coverage.

- **Public Input Meetings – April 28 & 29, 2004**
  Two additional meetings were held in Denver at Front Range Community College. Over 50 people attended. A PowerPoint presentation provided updated information. Following the prepared remarks, participants presented their thoughts and concerns. This format allowed for dialogue between presenters and participants.

- **Small Group Meetings/Presentations – 2004 and 2005**
  Throughout the process, HCPF staff has met with community members and groups to discuss the HIFA Waiver and streamlining process. These groups have including key business, provider and community groups such as: American Association of Pediatrics (Colorado); Coalition for the Medically Underserved; Colorado Community Health Network; Colorado Consumer Health Initiative; Colorado Funders Association; Colorado Medicaid Community Mental Health Services Program Advisory Committee; Colorado Medical Society.

- **Publicly Funded Health Care Streamlining Input**
  The Department provided a phone number (303-866-5434) and an email address (streamlininginput@hcpf.state.co.us) for comments and suggestions regarding the streamlining initiative.

STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street
Denver, CO 80203-1714
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(303) 866-4411 FAX
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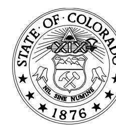

Bill Owens
Governor

Karen Reinertson
Executive Director

Appendix C:
Authorizing Legislation
Senate Bill 05-221

July 01, 2005

NOTE: This bill has been prepared for the signature of the appropriate legislative officers and the Governor. To determine whether the Governor has signed the bill or taken other action on it, please consult the legislative status sheet, the legislative history, or the Session Laws.

An Act

SENATE BILL 05-221

BY SENATOR(S) Hagedorn, Bacon, Johnson, Shaffer, Tochtrop, Tupa, Williams, and Keller;
also REPRESENTATIVE(S) Buescher, Berens, Boyd, Butcher, Carroll M., Coleman, Frangas, and Paccione.

CONCERNING A REQUIREMENT THAT THE STATE SEEK A WAIVER UNDER THE HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION PROGRAM, AND MAKING AN APPROPRIATION THEREFOR.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Part 5 of article 4 of title 26, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

26-4-534. ColoradoCares program - health insurance flexibility and accountability waiver - evaluation. (1) THE STATE DEPARTMENT SHALL PREPARE A WAIVER UNDER THE HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION PROGRAM TO PERMIT THE STATE DEPARTMENT TO CREATE A NEW SERVICE DELIVERY OR PURCHASING SYSTEM IN ORDER TO BETTER SERVE CHILDREN AND ADULTS UNDER THIS ARTICLE OR UNDER ARTICLE 19 OF THIS TITLE, REFERRED TO AS THE COLORADOCARES PROGRAM. THE WAIVER MAY INCLUDE THE POPULATIONS IDENTIFIED IN

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

SECTION 26-4-201 (1) (a), (1) (b), (1) (f), (1) (g), AND (1) (o), 26-4-301 (1) (a), (1) (d), (1) (e), (1) (o), AND (1) (s), 26-4-508, OR 26-19-109 AND ANY ADDITIONAL POPULATIONS THAT THE STATE DEPARTMENT DETERMINES THE FEDERAL GOVERNMENT SHALL REQUIRE TO BE COVERED FOR APPROVAL OF THE WAIVER. THE STATE DEPARTMENT SHALL NOT FINALIZE ANY WAIVER WITH THE FEDERAL GOVERNMENT THAT REDUCES OR DIMINISHES FEDERAL FINANCIAL PARTICIPATION IN THE MEDICAL ASSISTANCE PROGRAM, THE CHILDREN'S BASIC HEALTH PLAN ESTABLISHED PURSUANT TO ARTICLE 19 OF THIS TITLE, THE DISPROPORTIONATE SHARE HOSPITAL FACTOR, OR ANY OTHER CURRENT OR FUTURE FEDERAL PROGRAM TO PROVIDE HEALTH SERVICES TO LOW-INCOME POPULATIONS. THE STATE DEPARTMENT SHALL NOT IMPLEMENT, WITHOUT PRIOR STATUTORY AUTHORIZATION, THE WAIVER IF IT WOULD RESULT IN A REDUCTION OF BENEFITS COVERED TO THE CATEGORICALLY NEEDY AS REQUIRED BY SECTIONS 26-4-202, 26-4-203, AND 26-4-302.

(2) (a) THE STATE DEPARTMENT SHALL SUBMIT THE PROPOSED WAIVER TO THE HEALTH AND HUMAN SERVICES COMMITTEES OF THE SENATE AND HOUSE OF REPRESENTATIVES. IF NOT INCLUDED IN THE WAIVER, THE STATE DEPARTMENT SHALL ALSO SUBMIT TO THE COMMITTEES INFORMATION ON:

(I) ANY ACTUARIAL ANALYSIS OR OTHER FINANCIAL STUDY CONDUCTED, INCLUDING BUT NOT LIMITED TO ANY STUDY REGARDING THE FEASIBILITY OF THE WAIVER AND COST SAVINGS TO BE REALIZED UNDER THE WAIVER;

(II) WHETHER THE WAIVER SEEKS A PROGRAMMATIC CAP ON FEDERAL MONEYS OR A PER CAPITA CAP ON FEDERAL MONEYS AND HOW THE WAIVER WILL ADDRESS INCREASES IN COSTS DUE TO POPULATION GROWTH OR GROWTH IN EXPENDITURES;

(III) THE SPECIFIC REQUIREMENTS OF FEDERAL OR STATE LAW, INCLUDING BUT NOT LIMITED TO ANY RULE OR REGULATION, PROPOSED TO BE WAIVED;

(IV) HOW BENEFITS PROVIDED TO A RECIPIENT WHO IS ELIGIBLE FOR BENEFITS BEFORE THE IMPLEMENTATION OF THE WAIVER WILL BE INCREASED OR DECREASED;

(V) THE ELIGIBILITY OF RECIPIENTS WHO WERE NOT ELIGIBLE BEFORE

THE IMPLEMENTATION OF THE WAIVER AND A COMPARISON OF THE BENEFITS AND COST SHARING REQUIREMENTS OF THE NEWLY ELIGIBLE RECIPIENTS TO RECIPIENTS WHO WERE ELIGIBLE FOR BENEFITS BEFORE THE IMPLEMENTATION OF THE WAIVER;

(VI) WHETHER EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES SHALL BE PART OF THE CORE WAIVER SERVICE PACKAGE AND WHICH OUTREACH EFFORTS SHALL BE INCLUDED;

(VII) HOW THE WAIVER WILL ADDRESS DURABLE MEDICAL EQUIPMENT AND WHETHER THERE WILL BE A MONETARY CAP ON SUCH EQUIPMENT;

(VIII) HOW THE WAIVER WILL DEFINE "MEDICAL NECESSITY" AND WHETHER IT WILL INCLUDE DIFFERENT DEFINITIONS FOR ADULTS AND CHILDREN;

(IX) WHETHER THE WAIVER WILL INCLUDE A RESTRUCTURING OF ANY PROVIDER REIMBURSEMENT RATES AND, IF SO, AN EXPLANATION OF THE PROPOSED CHANGES TO REIMBURSEMENT RATES;

(X) HOW THE SERVICES DESCRIBED IN THE WAIVER SHALL BE DELIVERED INCLUDING AN IDENTIFICATION OF THE TYPES OF ENTITIES OR ORGANIZATIONS THAT WILL DELIVER THE SERVICES AND HOW THE IMPLEMENTATION OF THE WAIVER WILL ENCOURAGE THE PARTICIPATION OF NEW MANAGED CARE ORGANIZATIONS;

(XI) HOW THE WAIVER WILL MINIMIZE BARRIERS TO ACCESS OR DELAYS IN THE AVAILABILITY OF SERVICES TO RECIPIENTS REQUIRING SERVICES, INCLUDING WRAP-AROUND SERVICES; AND

(XII) HOW THE WAIVER WILL IMPROVE ON THE ADEQUACY OF A STATEWIDE NETWORK OF PROVIDERS AVAILABLE TO RECIPIENTS UNDER THE WAIVER, INCLUDING BUT NOT LIMITED TO PROVISIONS FOR ADEQUATE REIMBURSEMENT RATES AND CONSIDERATION OF THE BURDEN OF PROGRAM ADMINISTRATION ON PROVIDERS.

(b) THE HEALTH AND HUMAN SERVICES COMMITTEES SHALL HOLD AT LEAST FOUR JOINT PUBLIC HEARINGS ON THE WAIVER, AT WHICH PUBLIC TESTIMONY SHALL BE ACCEPTED. THE HEARINGS AT WHICH PUBLIC TESTIMONY IS ACCEPTED MAY BE CONDUCTED WITH THE ATTENDANCE OF

FEWER MEMBERS THAN A QUORUM OF EACH OF THE HEALTH AND HUMAN SERVICES COMMITTEES. ONE JOINT HEARING SHALL BE CONDUCTED IN THE DENVER METROPOLITAN AREA, ONE JOINT HEARING SHALL BE HELD WEST OF THE CONTINENTAL DIVIDE, ONE JOINT HEARING SHALL BE HELD IN NORTHERN COLORADO, AND ONE JOINT HEARING SHALL BE HELD IN SOUTHERN COLORADO. FOLLOWING THE JOINT HEARINGS BUT WITHIN SIXTY DAYS AFTER THE SUBMISSION OF THE WAIVER TO THE JOINT COMMITTEES, AT A HEARING AT WHICH A QUORUM OF EACH HEALTH AND HUMAN SERVICES COMMITTEE IS PRESENT, THE JOINT HEALTH AND HUMAN SERVICES COMMITTEE SHALL EITHER APPROVE OR REJECT THE WAIVER AS SUBMITTED BY THE DEPARTMENT. IF A MAJORITY OF THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE AND A MAJORITY OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE APPROVES THE WAIVER, THE JOINT HEALTH AND HUMAN SERVICES COMMITTEE SHALL SUBMIT THE WAIVER TO THE JOINT BUDGET COMMITTEE FOR APPROVAL.

(c) THE JOINT BUDGET COMMITTEE MAY HOLD HEARINGS AND ACCEPT PUBLIC TESTIMONY ON THE WAIVER. WITHIN FIFTEEN DAYS AFTER THE APPROVAL OF THE WAIVER BY THE JOINT COMMITTEES, THE JOINT BUDGET COMMITTEE SHALL EITHER APPROVE OR REJECT THE WAIVER AS SUBMITTED BY THE DEPARTMENT. IF THE JOINT BUDGET COMMITTEE APPROVES THE WAIVER, THE STATE DEPARTMENT SHALL SUBMIT THE WAIVER TO THE FEDERAL GOVERNMENT.

(3) (a) IF THE FEDERAL GOVERNMENT RETURNS THE WAIVER WITH SUGGESTED OR REQUIRED AMENDMENTS, THE STATE DEPARTMENT SHALL SUBMIT AN AMENDED WAIVER TO THE HEALTH AND HUMAN SERVICES COMMITTEES OF THE SENATE AND HOUSE OF REPRESENTATIVES. THE COMMITTEES SHALL HOLD A JOINT HEARING AND MAY TAKE PUBLIC TESTIMONY ON THE AMENDED WAIVER. IF A MAJORITY OF THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE AND A MAJORITY OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE APPROVES THE AMENDED WAIVER, THE JOINT HEALTH AND HUMAN SERVICES COMMITTEE SHALL SUBMIT THE AMENDED WAIVER TO THE JOINT BUDGET COMMITTEE FOR ITS APPROVAL.

(b) THE JOINT BUDGET COMMITTEE MAY HOLD HEARINGS AND ACCEPT PUBLIC TESTIMONY ON THE AMENDED WAIVER. IF THE JOINT BUDGET COMMITTEE APPROVES THE AMENDED WAIVER, THE STATE DEPARTMENT SHALL SUBMIT THE AMENDED WAIVER TO THE FEDERAL GOVERNMENT.

(4) (a) IF A WAIVER SUBMITTED PURSUANT TO THIS SECTION IS IMPLEMENTED, THE STATE AUDITOR'S OFFICE SHALL OVERSEE AN EVALUATION OF THE WAIVER PURSUANT TO THE PROVISIONS OF THIS SUBSECTION (4). OUT OF MONEYS APPROPRIATED BY THE GENERAL ASSEMBLY TO COVER THE COSTS OF THE EVALUATIONS REQUIRED BY THIS SUBSECTION (4), THE STATE AUDITOR'S OFFICE SHALL BE REIMBURSED FOR ITS REASONABLE AND NECESSARY COSTS INCURRED IN CONNECTION WITH ADMINISTERING THE CONTRACT FOR THE EVALUATION.

(b) THE EXECUTIVE DIRECTOR OF THE STATE DEPARTMENT SHALL NOTIFY THE STATE AUDITOR ONCE THE WAIVER IS IMPLEMENTED. NO MORE THAN SIX MONTHS FOLLOWING THE IMPLEMENTATION OF THE WAIVER, THE STATE AUDITOR'S OFFICE SHALL ISSUE A REQUEST FOR PROPOSALS FOR A PUBLIC OR PRIVATE ENTITY TO CONDUCT THE EVALUATIONS REQUIRED BY THIS SUBSECTION (4). NO ENTITY INVOLVED WITH THE DEVELOPMENT OR OVERSIGHT OF THE WAIVER SHALL BE ELIGIBLE TO SUBMIT A RESPONSE TO THE REQUEST FOR PROPOSALS. THE STATE AUDITOR'S OFFICE SHALL SEEK INPUT FROM RECIPIENTS, PROVIDERS, AND ADVOCATES IN DEVELOPING THE REQUEST FOR PROPOSALS REQUIRED BY THIS PARAGRAPH (b).

(c) THE GOALS OF THE EVALUATIONS SHALL BE TO OBTAIN AN OBJECTIVE ANALYSIS OF THE OUTCOMES REALIZED AS A RESULT OF THE IMPLEMENTATION OF THE WAIVER AND WHETHER THERE SHOULD BE ANY CHANGES TO THE WAIVER. SUCH OUTCOMES SHALL INCLUDE BUT ARE NOT LIMITED TO:

(I) THE NUMBER OF NEW RECIPIENTS WHO WOULD NOT HAVE BEEN ELIGIBLE FOR BENEFITS WITHOUT THE WAIVER;

(II) THE LENGTH OF TIME RECIPIENTS UNDER THE WAIVER REMAIN IN THE MEDICAL ASSISTANCE PROGRAM AS COMPARED TO OTHER RECIPIENTS NOT UNDER THE WAIVER;

(III) THE UTILIZATION RATES OF RECIPIENTS UNDER THE WAIVER FOR PRIMARY AND PREVENTATIVE CARE AND EMERGENCY ROOM AND HOSPITAL-BASED CARE AND THE REASONS FOR ANY INCREASE OR DECREASE IN THE RATES;

(IV) THE RATE OF UTILIZATION FOR EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES AND PROCEDURES FOR MAKING RECIPIENTS AWARE OF EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND

TREATMENT SERVICES;

(V) THE RATE OF PROVIDER PARTICIPATION AND THE REASONS FOR ANY INCREASE OR DECREASE IN THE RATE;

(VI) THE ACCESS TO CARE IN ALL GEOGRAPHIC AREAS OF THE STATE;

(VII) THE CONTINUED AVAILABILITY OF THE SAME APPELLATE PROCEDURES AVAILABLE TO RECIPIENTS WHO ARE NOT PART OF THE WAIVER;

(VIII) THE STABILITY OF HEALTH OUTCOMES FOR RECIPIENTS AND THE REASONS FOR ANY CHANGES IN THE STABILITY;

(IX) THE IMPACT OF COST SHARING, IF ANY, ON UTILIZATION OF PRIMARY AND PREVENTATIVE CARE, INCLUDING BUT NOT LIMITED TO WHETHER COST SHARING HAS RESULTED IN COLLECTION ACTIONS BEING INITIATED BY PROVIDERS;

(X) IF THERE IS A PREMIUM ASSISTANCE WAIVER COMPONENT, HOW THIS COMPONENT IMPACTS A RECIPIENT'S ABILITY TO ACCESS SERVICES; AND

(XI) THE IMPACT OF THE WAIVER ON THE STATE DEPARTMENT'S ADMINISTRATIVE COSTS.

(d) THE EVALUATIONS REQUIRED BY THIS SUBSECTION (4) SHALL BE CONDUCTED FOLLOWING THE FIRST, SECOND, AND FOURTH YEAR OF IMPLEMENTATION OF THE WAIVER.

(e) TO THE EXTENT PERMISSIBLE UNDER THE FEDERAL "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996", 42 U.S.C. SEC. 1320d TO 1320d-8, THE STATE AUDITOR'S OFFICE AND THE ENTITY CONDUCTING THE EVALUATIONS SHALL HAVE ACCESS TO ALL RECORDS, DOCUMENTS, AND REPORTS PREPARED BY OR FOR, OR MAINTAINED BY OR FOR, THE STATE DEPARTMENT. THE STATE AUDITOR'S OFFICE AND THE ENTITY CONDUCTING THE EVALUATIONS SHALL COMPLY WITH ALL PROVISIONS OF THE FEDERAL "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996", 42 U.S.C. SEC. 1320d TO 1320d-8.

(f) THE ENTITY THAT CONDUCTS THE EVALUATIONS SHALL REPORT TO THE STATE AUDITOR'S OFFICE ON A QUARTERLY BASIS CONCERNING ITS PROGRESS IN COMPLETING THE EVALUATIONS REQUIRED BY THIS SUBSECTION

(4).

SECTION 2. Article 19 of title 26, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

26-19-112.5. Health insurance flexibility and accountability waiver. IF THE STATE DEPARTMENT IMPLEMENTS A WAIVER SUBMITTED PURSUANT TO SECTION 26-4-534 AFFECTING AN ELIGIBLE PERSON UNDER THIS ARTICLE, THE BENEFITS OF THE ELIGIBLE PERSON SHALL BE DETERMINED BY THE PROVISIONS OF THE WAIVER.

SECTION 3. Appropriation. (1) In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the legislative department, for allocation to the general assembly, for the fiscal year beginning July 1, 2005, the sum of twenty thousand dollars ($20,000), or so much thereof as may be necessary, for the implementation of this act.

(2) It is the intent of the general assembly that the general fund appropriation in subsection (1) of this section shall be derived from savings generated from the implementation of the provisions of House Bill 05-1243, as enacted during the First Regular Session of the Sixty-fifth General Assembly.

SECTION 4. Effective date. This act shall take effect upon passage only if:

(a) House Bill 05-1243 is enacted at the First Regular Session of the Sixty-fifth General Assembly and becomes law; and

(b) The final fiscal estimate for House Bill 05-1243, as determined from the appropriations enacted in said bill, shows a net reduction in the amount of general fund revenues appropriated for the state fiscal year 2005-06, that is equal to or greater than the amount of the general fund appropriation made for the implementation of this act for the state fiscal year 2005-06, as reflected in section 3 of this act; and

(c) The staff director of the joint budget committee files written notice with the revisor of statutes no later than July 15, 2005, that the requirement set forth in paragraph (b) of this subsection (2) has been met.

SECTION 5. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

____________________________ ____________________________

Joan Fitz-Gerald
PRESIDENT OF
THE SENATE

Andrew Romanoff
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

____________________________ ____________________________

Karen Goldman
SECRETARY OF
THE SENATE

Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED____

____

Bill Owens
GOVERNOR OF THE STATE OF COLORADO

STATE OF COLORADO

DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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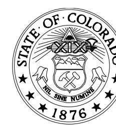

Bill Owens
Governor

Karen Reinertson
Executive Director

Appendix D1:
Physical Health Benefits

July 01, 2005

"The mission of the Department of Health Care Policy & Financing is to purchase cost-effective health care for qualified, low-income Coloradans."
http://www.state.co.us/gov_dir/chcpf/index.html

Appendix D1: Physical Health Benefits

Colorado Health Plan Description Form
Medicaid and CHP+ Streamlined Program
For Children

Basic/Standard HMO Health Benefit Plan

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Health Maintenance Organization (HMO)
2. OUT-OF-NETWORK CARE COVERED?[i]	Only for Emergency and Urgent Care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract; it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities) and are subject to medical necessity. Consult the actual Evidence of Coverage (EOC) to determine the exact terms and conditions of coverage.[ii]

	Medicaid/CHP+ Streamlined Program In-Network Only (Out-of-network is not covered except as noted.)
4. ANNUAL DEDCUTIBLE[iii] a) Individual b) Family	No deductibles.
5. ENROLLEE OUT-OF-POCKET ANNUAL MAXIMUM[iv] a) Individual b) Family	For CHP+ only and if applicable: 5% of family's adjusted gross income, as determined by CHP+.
5A. COINSURANCE (amount paid by carrier) or COPAYMENT[v] a) Individual b) Family	No co-payments for Medicaid mandatory populations; co-payments for CHP+ per current program regulations.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No Lifetime Maximum.
7A. COVERED PROVIDERS	Streamlined Program HMO Network.
7B. WITH RESPECT TO NETWORK PLANS, ARE ALL THE PROVIDERS LISTED IN 7A ACCESSIBLE TO ME THROUGH MY PRIMARY CARE PROVIDER?	Yes.

8. ROUTINE MEDICAL OFFICE VISITS[vi] **a) PCP** **b) Specialist** **c) Family Planning Services**	c) NOTE: Prenatal and gynecological care are not included in definition of family planning services. Refer to Maternity/Obstetrical Services.
9. PREVENTIVE CARE[vii] **Children's services (no deductible)**	• Periodic Examinations[viii] See Appendix E for AAP Recommended Periodicity Schedule. • Inter-periodic Examinations.[ix] • Immunizations[x] See Appendix D for recommended schedule. • Screening Services.
10. MATERNITY **a) Prenatal care** **b) Delivery** **c) Post-partum Care** **d) Inpatient well baby care**	• Includes services of certified nurse midwives. • Includes pre-natal care (pregnancy-related services for other conditions that might complicate pregnancy).
11. PRESCRIPTION DRUGS **Level of coverage and restrictions on prescriptions** **Inpatient care** **Outpatient care** **Prescription Mail Service**	The outpatient pharmacy benefits available are subject to a formulary managed by a pharmacy benefits management company that promotes and enforces the appropriate use of medications by reviewing for proper dosage, potential drug-to-drug interactions or drug-pregnancy interactions. The formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the formulary is not a guarantee of coverage. Covered services will be limited based on medical necessity, quantity limits established by the pharmacy benefits management company or utilization guidelines.
12. INPATIENT HOSPITAL	Covered service.
13. OUTPATIENT/AMBULATORY SURGERY	Covered service.
14. DIAGNOSTICS	• Laboratory and x-ray. • MRI, Nuclear Medicine and Other High Tech Services.
15. EMERGENCY CARE[xi]	Covered service.
16. AMBULANCE	Covered ambulance services to the nearest appropriate medical facility when any other form of transportation is not medically advisable and when the ambulance service is provided in conjunction with emergency medical care. Such covered ambulance services include the following situations: • Air ambulance o Air ambulance services, including rotary- and fixed-wing aircraft, are covered only if the enrollee requires medical attention, the client is transported to the nearest appropriate medical facility, and; o Services shall be provided when the point of pick-up is inaccessible by land emergency transport vehicles, o Great distances or other obstacles are involved in transport to the nearest appropriate facility and prompt

	admission is essential; or ○ The client is suffering from an illness, injury, or psychiatric condition that makes all other forms of transport inadvisable.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE[xii]	Covered as specified in Colorado Division of Insurance regulation 4-2-17(6)(G).
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[xiii]	Coverage is no less extensive than coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE[xiv] **a) Inpatient care** **b) Outpatient care**	a) Inpatient – 45 full or 90 partial days[xv] per benefit year. b) Outpatient – 20 visits per benefit year.
20. ALCOHOL AND SUBSTANCE ABUSE	Limited to 20 outpatient rehabilitation visits
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY	Limited to 30 visits per diagnosis per benefit year. However, up until the member's 5th birthday, this exclusion shall not apply to therapies for the care and treatment of congenital defects or birth abnormalities.
22. DURABLE MEDICAL EQUIPMENT	Coverage limited to $2,000 maximum per benefit year, except for prosthetic devices, oxygen and insulin pumps and supplies, which are not subject to the maximum payment, but which do reduce the maximum payment of $2,000.
23. OXYGEN	Not subject to a maximum payment but does reduce the maximum payment of $2,000 per benefit year for Durable Medical Equipment.
24. ORGAN TRANSPLANTS[xvi]	Limited coverage. Will include those transplants covered by the Small Group Standard Plan (Colorado Division of Insurance regulation 4-6-5), including liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas and bone marrow for Hodgkin's disease, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions listed above for bone marrow transplants. Coverage is no less extensive than the coverage for any other physical illnesses.
25. HOME HEALTH CARE	• Professional, skilled nursing services of a RN, LPN, LVN or CNA on an intermittent basis (acute, not chronic conditions). • Home health aide services for purposes of providing skilled personal care, in conjunction with a nurse or therapist and under the supervision of a nurse or therapist; • Covered supplies customarily furnished by the agency for its patients.
26. HOSPICE CARE	Covered service.
27. SKILLED NURSING FACILITY CARE	Not to exceed 100 days per benefit year.
28. DENTAL CARE	• Not covered except for dental care needed as a result of an accident.[xvii] • Orthodontic and prosthondontic treatment for

	cleft lip or cleft palate is covered. • Dental anesthesia[xviii]
29. VISION CARE	• Vision exams – limited to one routine eye exam per benefit year. Additional visits covered as routine medical office visits. • Vision hardware – limited to $150 per year for the purchase of vision hardware.[xix]
30. CHIROPRACTIC CARE	Not covered under Core
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5) **(1) AUDIOLOGY SERVICES[xx]** **(2) KIDNEY DIALYSIS** **(3) INTRACTABLE PAIN CARE** **(4) AUTISM** **(5) DIETARY COUNSELING/NUTRITIONAL SERVICES** **(6) CASE MANAGEMENT[xxi]**	(1) Audiology Services also includes $4,000 per benefit year for hearing aids for congenital[xxii] and traumatic[xxiii] injuries. (4) Autism is included as a benefit with the medical office visit. (5) Medical Nutrition Coverage is limited coverage. Formula for metabolic disorders, total parenteral nutrition, enterals and nutrition products and formulas for gastrostemy tubes are covered for enrollees with documented medical need, including gastrointestinal disorders, malabsorption syndromes or conditions affecting normal growth patterns or the normal absorption of nutrition. Benefits for enteral therapy and Total Parenteral Nutrition (TPN) include a combination of nursing, durable medical equipment and pharmaceutical services. Durable medical equipment and supplies are subject to the limitations as cited under "Durable Medical Equipment and Disposable Supplies" benefit.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED[xxiv]	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No.
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY? **(1) ABORTION**	(1) Abortion is covered only under the following circumstances: • When a physician has found and certified in writing the life of the mother would be endangered if the fetus were carried to term or when the pregnancy results from acts of rape or incest, when documented in accordance with federal requirements (CFR 50.306). 42 C.F.R. 441.203 • For the purpose of this benefit, treatment for the following conditions is not considered to be an abortion: o Ectopic pregnancies (pregnancy occurring in other than a normal position or place) o Miscarriage (spontaneous abortion)

PART D: USING THE PLAN

	BENEFIT LEVELS
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	Yes.
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No.
39. What is the main customer service number?	TBD.
40. Whom do I write/call if I have a complaint or want to file a grievance?[xxv]	Appropriate Health Plan.
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	State of Colorado, Department of Health Care Policy and Financing.
42. To assist in filling a grievance indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Not Applicable.
43. What is the cost of this plan?	Not Applicable.

[i] Network refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e. go in-network) than if you don't (i.e., go out-of-network).

[ii] Evidence of Coverage. The health plan description plan represents only a general description of services covered. At such time as the "Core" and "Core Plus" benefit packages are implemented, the Evidence of Coverage (EOC) will be prepared describing in greater detail the limits, inclusions and exclusions of the benefit package.

[iii] Deductible refers to the portion of a medical expense a plan member must pay before the plan will begin to cover any medical expenses. Under this plan, there are no deductibles.

[iv] Out-of-pocket maximum refers to the maximum amount you will have to pay for allowable expenses under a health plan, which may or may not include the deductible or co-payments, depending on the contract for that plan. CHP+ refers to this as "out-of-pocket annual limit," which should not exceed 5% of your adjusted annual income as determined by CHP+ for all CHP+ members in your family. For Medicaid-EPSDT services, you will not be required to pay any out-of-pocket amounts.

[v] Co-payment is a small payment due at the time service is received.

[vi] Routine medical office visit includes physician mid-level practitioner and specialist visits, including outpatient psychotherapy visits for biologically based mental illnesses. Includes physician services, Federally qualified health center (FQHC) services, pediatric and family nurse practitioner services, rural health clinic services and other clinic services.

[vii] Preventive Care includes routine exams related to sports, insurance, school, church or camps.

[viii] As defined by CDHCPF EPSDT 8.282.02 PERIODIC EXAMINATIONS.

[ix] As defined by CDHCPF EPSDT 8.282.032 INTER-PERIODIC EXAMINATIONS.

[x] Immunizations covered according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines.

[xi] Emergency Care means services delivered by an emergency care facility, which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life-or-limb threatening emergency existed.

[xii] Urgent/Non-routine care means situations that are non-life threatening, but require prompt medical attention to prevent a serious deterioration in a member's health.

[xiii] Biologically based mental illnesses means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[xiv] All other mental health benefits include coverage for all mental health conditions recognized in the DSM-IV Manual.

[xv] One in-patient day is defined as an admission to a facility for more than 12 hours of treatment. One partial treatment day is defined as no less than three and no more than 12 hours of treatment per day. Every

two partial day treatments count as one full inpatient day and will be applied against the 45-day maximum inpatient benefit. The maximum number of partial hospitalization days available is 90 per benefit year.

[xvi] Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

[xvii] Medical Coverage in connection with treatment of the teeth or periodontium is excluded unless such treatment is performed by a physician or legally licensed dentist and is begun within 72 hours after an accidental injury to sound natural teeth.

[xviii] Dental Anesthesia - Benefits are provided for general anesthesia when provided in a hospital, outpatient surgical facility or other facility, and for associated hospital or facility charges for dental care if the care is provided to a covered dependent child who 1) has a physical, mental or medically compromising condition; 2) has dental needs for which local anesthesia is not effective due to acute infection, anatomic variation or allergy; 3) is extremely uncooperative, unmanageable, uncommunicative, or anxious and whose dental needs are deemed sufficiently important that dental care cannot be deferred; or 4) has sustained extensive or facial and dental trauma.

[xix] Additional vision hardware is covered when medically necessary but is limited to a maximum of $150 per episode.

[xx] Audiology services include testing for hearing disorders through the identification and evaluation of hearing loss.

[xxi] Case Management can be classified as either an administrative activity or a covered medical service, depending on what specific activities it includes.

[xxii] Congenital condition refers to any condition, present from birth, which is significantly different from the common form; for example, a cleft palate or certain heart defects.

[xxiii] Traumatic injury means an injury to live tissue resulting from an external force.

[xxiv] Waiver of pre-existing condition exclusions refers to the fact that State law requires carrier to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. CHP+ and Medicaid-EPSDT members are subject to the waiver of pre-existing condition exclusions.

[xxv] Grievances. Colorado law requires all health plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

STATE OF COLORADO

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Appendix D2:
Oral Health Benefits

July 01, 2005

"The mission of the Department of Health Care Policy & Financing is to purchase cost-effective health care for qualified, low-income Coloradans."

http://www.state.co.us/gov_dir/chcpf/index.html

Appendix D2: Oral Health Benefits

Colorado Health Plan Description Form
Medicaid and CHP+ Streamlined Program for Children

Diagnostic and Preventive Procedures

Code	Procedure
D0120	Periodic oral evaluation
D0140	Limited oral evaluation-problem focused
D0150	Comprehensive oral evaluation
D0160	Detailed and extensive oral evaluation-problem focused
	Any combination of the above procedures are limited to two (2) procedures per 12 months

Code	Procedure
D0210	Full mouth x-rays complete series* (1/ 60 months) *includes bitewings
D0220	Intraoral periapical x-ray 1st film
D0230	Intraoral periapical x-ray each additional film
D0270	Bitewing x-ray – Single film
D0272	Bitewings – Two films
D0274	Bitewings – Four films
D0277	Vertical bitewings – 7 to 8 films
D0330	Panoramic film (1/ 5 years)

Code	Procedure
D1110	Adult prophylaxis (age 14 and above)
D1120	Child prophylaxis (through age 13)
D1203	Topical fluoride treatment* *excluding prophylaxis
D1351	Sealants (through age 14)

Code	Procedure
D1510	Space maintainer - fixed unilateral
D1515	Space maintainer - fixed bilateral
D1520	Space maintainer - removable unilateral
D1525	Space maintainer - removable bilateral
D1550	Recementation of space maintainer
D9110	Palliative treatment (for pain relief)
D9440	Office visit – after regularly scheduled hours

Diagnostic and Preventive Limitations

1. Prophylaxis (cleaning) is a benefit only ONCE in a twelve (12) month period.
2. Oral evaluations (exams) are a benefit twice in a twelve (12) month period.

3. Topical fluoride application is a benefit only through age fifteen (15), and is a benefit only once in a twelve (12) month period.
4. Bitewing x-rays are a benefit only ONCE in a twelve (12) month period and are not a benefit in addition to a complete mouth series. Complete mouth x-rays are a benefit only once in sixty (60) months.
5. Space maintainer is a benefit only for premature loss of deciduous (baby) posterior (back) teeth for children through age thirteen (13).
6. Sealant Benefits include the application of sealants only to permanent molar teeth with the occlusal surfaces intact, no caries (decay), and/or with no restorations.
7. Separate benefit shall not be made for any preparation or conditioning of the tooth or any other procedure associated with sealant application.
8. Sealant Benefits do not include any repair or replacement of a sealant on any tooth within thirty-six (36) months of its application. Such repair or replacement done by the same dentist is considered included in the fee for the initial placement of the sealant.
9. Sealants are a benefit only for eligible children through the age of fourteen (14).

Basic Restorative Procedures

Amalgam (metal) Restorations

Code	**Procedure**
D2140	Amalgam-1 surface primary or permanent
D2150	Amalgam-2 surface primary or permanent
D2160	Amalgam-3 surface primary or permanent
D2161	Amalgam-4 or more surfaces primary or permanent

Resin (white plastic) Restorations – Anterior (front) Teeth ONLY

Code	**Procedure**
D2330	Resin-1 surface anterior
D2331	Resin-2 surfaces anterior
D2332	Resin-3 surfaces anterior
D2335	Resin-4 or more surfaces (anterior) or involving incisal angle

Resin (white plastic) Restorations – Posterior (back) Teeth

Code	**Procedure**
D2391	Resin based composite-1 surface permanent posterior
D2392	Resin based composite-2 surface permanent posterior
D2393	Resin based composite-3 surface permanent posterior
D2394	Resin based composite-4 or more surfaces permanent Posterior

Other Restorative Services

Code	Procedure
D2920	Recement crown $5.00
D2930	Prefabricated stainless steel crown (primary tooth)
D2931	Prefabricated stainless steel crown (permanent tooth)
D2932	Prefabricated resin crown (anterior tooth only)
D2933	Prefabricated stainless steel crown with resin window (anterior tooth only)
D2940	Sedative filling
D2951	Pin retention - per tooth - in addition to restoration

Oral Surgery (extractions include local anesthesia and routine post-operative care)
****Prophylactic removal of third molars is not a covered benefit.****

Code	Procedure
D7111	Coronal remnants-deciduous tooth
D7140	Extraction erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth-soft tissue
D7230	Removal of impacted tooth-partially bony
D7240	Removal of impacted tooth-completely bony
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications

Endodontics

Code	Procedure
D3220	Therapeutic pulpotomy (primary tooth) excluding final restoration
D3310	Root canal therapy-anterior (excluding final restoration)
D3320	Root canal therapy-bicuspid (excluding final restoration)
D3330	Root canal therapy-molar (excluding final restoration)
	Root canal therapy is a benefit for permanent teeth only.

Basic Restorative Limitations

1. Benefits for the same covered Amalgam (metal) or Resin (white plastic) Restoration shall not be provided more than once in any twenty-four (24) month period.

2. Resin or plastic restorations on posterior (back) teeth are not a benefit, unless prior to placement, you are informed and agree to pay the cost difference between the Amalgam (metal) filling fee and Resin (white plastic) filling fee.

3. Pulpotomy/pulpectomy is a benefit only for primary (baby) teeth.

4. If more than one restoration is used to restore a tooth, benefit allowance will be paid for the most inclusive service.

5. Prefabricated crowns per tooth are a benefit only once in twenty-four (24) months.

6. Prophylactic removal of third molars is not a covered benefit. Removal because of malocclusion or orthodontic reasons is not covered. The removal of third molars for active caries that renders the tooth unrestorable and/or involves the pulp may be covered with prior approval. Third molar removal may be covered with prior written approval for active periodontal infections that cannot be treated in another manner. Third molars fully impacted in bone are not covered for removal. Partial bony impactions and soft tissue impactions may be covered with prior approval if the tooth and/or supporting structures are involved with active disease such as an acute periodontal infection. Second opinions may be required as part of the approval process prior to treatment. If emergency removal of a third molar is needed, radiographs and/or documentation of the pathological condition causing the emergent situation may be required prior to payment. Have your dentist complete a pre-treatment estimate form for a third molar extraction to determine if it will be covered.

5. Exclusions

The following charges are not covered under any portion of the CHP+ Dental Program:

1. Procedures (or services) not listed in the Coinsurance and Procedure Code List are not a benefit. If your child's dentist performs a procedure that is not listed, you will be responsible for the full billed charges.

2. Services for injuries or conditions which are compensable under Worker's Compensation or employer's liability laws, or services which are provided to the eligible member by any federal or state government agency or are provided without cost to the eligible member by any municipality, county or other political sub-division, or any services for which the eligible member would have no obligation to pay in absence of this coverage, except as such exclusion may be prohibited by law.

3. Any covered service started during any period when your child was not eligible for such service under the CHP+ Dental Program.

4. Services for treatment of congenital (present at birth) or developmental (following birth) malformations, except intraoral dental services for treatment of a condition which is related to or developed as a result of cleft lip and/or cleft palate, unless otherwise included as a covered procedure of the CHP+ Dental Program.

5. Services for cosmetic reasons.

6. Services for restoring tooth structure lost from wear or for any services related to protecting, altering, correcting, stabilizing, rebuilding or maintaining teeth due to

improper alignment, occlusion or contour or for splinting or stabilization of teeth.

7. Pre-medication, analgesia, hypnosis or any other patient management services.

8. Experimental procedures, or any procedures other than those covered services for which the prognosis is good. Any procedures done in anticipation of future need (except covered preventive services).

9. Hospital costs and any additional fees charged by the dentist or hospital for hospital services, visits, or charges for use of any facility.

10. General anesthesia, intravenous sedation or analgesia.

11. Prescription drugs.

12. Orthodontic services.

13. Services for the treatment of any disturbances of the temporomandibular joint (jaw joint), facial pain, or any related conditions.

14. Services not performed in accordance with the laws of the state of Colorado, services performed by any person other than a person authorized by license to perform such services, or services performed to treat any condition other than an oral or dental disease, malformation, abnormality or condition.

15. Oral hygiene instructions or dietary instructions.

16. Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records.

17. Services for which payment is prohibited by any law of the jurisdiction in which the eligible person resides at the time the expenses are incurred.

18. Services for which charges would not have been made if this coverage had not existed, except for services as provided under Medicaid.

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Appendix E:
Performance Indicator Dashboard

July 01, 2005

"The mission of the Department of Health Care Policy & Financing is to purchase cost-effective health care for qualified, low-income Coloradans."

http://www.state.co.us/gov_dir/chcpf/index.html

Managed care organization Performance Indicator Dashboard Measures

I. Access Measures

Measure	Source of Measure	Basis for Standard	Resp.[1]
A. Getting Needed Care: Children			
% good access to routine care	CAHPS[2] 3.0H Child Questionnaire		
% good access to needed care	CAHPS 3.0H Child Questionnaire		
% good access to urgent care	CAHPS 3.0H Child Questionnaire		
% good access to a needed specialist	CAHPS 3.0H Child Questionnaire		
% no delays for an approval	CAHPS 3.0H Child Questionnaire		
% no exam room wait >15 minutes	CAHPS 3.0H Child Questionnaire		
% wait of more than 1 day for urgent care	CAHPS 3.0H Child Questionnaire		
B. Getting Needed Care: Adults			
% good access to routine care	CAHPS 3.0H Adult Questionnaire		
% good access to needed care	CAHPS 3.0H Adult Questionnaire		
% good access to urgent care	CAHPS 3.0H Adult Questionnaire		
% good access to a needed specialist	CAHPS 3.0H Adult Questionnaire		
% no delays for an approval	CAHPS 3.0H Adult Questionnaire		
% no exam room wait >15 minutes	CAHPS 3.0H Adult Questionnaire		
% wait of more than 1 day for urgent care	CAHPS 3.0H Adult Questionnaire		
C. Network Composition			
% of PCPs with open panels	HMO self-report using GeoAccess or comparable software		
% children with 2 open PCPs within 30 miles	HMO self-report using GeoAccess or comparable software		
% adults with 2 open PCPs within 30 miles	HMO self-report using GeoAccess or comparable software		
% mbrs with 1 open MH outpt provider in 30 miles	HMO self-report using GeoAccess or comparable software		
% women with 1 open OB/GYN within 30 miles	HMO self-report using GeoAccess or comparable software		
% mbrs with 1 open orthopedist within 30 miles	HMO self-report using GeoAccess or comparable software		
% child mbrs with 1 open otolaryngologist in 30 miles	HMO self-report using GeoAccess or comparable software		

[1] Indicates whether the State or the Contractor will be responsible for calculating the measure. Measures calculated by State (or its agent) may often require the provision of Contractor information to the State or its agent following State request.

[2] CAHPS (formerly the Consumer Assessment of Health Plans Survey) was developed between 1995 and 2000 at the behest of the federal Agency for Health Care Policy and Research (now the federal Agency for Health Care Research and Quality). The development team also included Harvard Medical School, the Research Triangle Institute, Westat, RAND, and HCFA (now CMS). CAHPS is now the standard survey instrument for assessing consumer experience in commercial, Medicaid, and Medicare managed care, with several variant surveys available. CAHPS must be administered according to detailed specifications by a National Committee for Quality Assurance (NCQA)-approved survey vendor.

% members with 1 acute hospital in 30 miles	HMO self-report using GeoAccess or comparable software		

I. Access Measures (continued)

Measure	Source of Measure	Basis for Standard	Resp.
D. Use of Behavioral Health Services			
% of mbrs receiving ambulatory mental health services	HEDIS[3] 2005		
% of mbrs receiving intermediate care mental health services	HEDIS 2005		
% of mbrs receiving inpatient mental health services	HEDIS 2005		
% of mbrs with AOD[4] abuse/dependence diagnosis & service	HEDIS 2005		

II. Quality of Care Measures

Measure	Source of Measure	Basis for Standard	Resp.
A. Children's Preventive Care			
% children w/childhood immunizations: Combo 2	HEDIS 2005		
% teens w/adolescent immunizations: Combo 2	HEDIS 2005		
% children with 6+ well-child visits: 1st 15 months	HEDIS 2005		
% children with well-child visits: 3rd- 6th yrs of life	HEDIS 2005		
% adolescents with well-care visits	HEDIS 2005		
% children with URI with appropriate treatment	HEDIS 2005		
% children with pharyngitis with appropriate testing	HEDIS 2005		
B. Adult Preventive Care			
% women with timely prenatal care	HEDIS 2005		
% women with appropriate postpartum care	HEDIS 2005		
% women with breast cancer screening	HEDIS 2005		
% women with cervical cancer screening	HEDIS 2005		
% women 16-20 yrs of age with chlamydia screening	HEDIS 2005		
% women 21-25 yrs of age with chlamydia screening	HEDIS 2005		
% smokers advised to quit	CAHPS 3.0H Adult Questionnaire		

[3] HEDIS, or the Health Plan Employer Data and Information Set was developed by a coalition of group and staff model HMOs (The HMO Group) working in concert with a small number of large employers and benefit consultants beginning in 1989, with HEDIS 1.0 released in 1991. HEDIS was intended to provide standard performance measures by which corporate purchasers could hold HMOs accountable. Shortly thereafter NCQA assumed responsibility for maintaining HEDIS and continues to do so to this day. HEDIS is widely accepted as the standard measurement set for managed care plans. Reporting health plans must adhere to detailed specifications and must obtain independent external audit of their results from an NCQA-trained and approved auditor.

[4] Alcohol or other drug

II. Quality of Care Measures (continued)

Measure	Source of Measure	Basis for Standard	Resp.
C. Care for Chronic Illness			
Diabetes			
% persons with HbA1c testing	HEDIS 2005		
% persons poor HbA1c controlled	HEDIS 2005		
% persons diabetic eye exam	HEDIS 2005		
% persons LCL screening	HEDIS 2005		
% persons LDL controlled	HEDIS 2005		
% persons nephropathy monitoring	HEDIS 2005		
Asthma % with appropriate medication			
ages 5-9	HEDIS 2005		
ages 10-17	HEDIS 2005		
ages 18-56	HEDIS 2005		
all ages combined	HEDIS 2005		
Controlling High Blood Pressure			
% persons with high blood pressure controlled	HEDIS 2005		
Follow-Up After Hospitalization for Mental Illnesses			
% MH discharges w/ follow-up visit within 7 days	HEDIS 2005		
Anti-Depressant Medication Management			
% members with appropriate acute phase treatment	HEDIS 2005		
% mbrs w/appropriate continuation phase treatment	HEDIS 2005		
% members with optimal practitioner contacts	HEDIS 2005		

III. Administrative Service Measures

Measure	Source of Measure	Basis for Standard	Resp.
Services to Members			
% able to find or understand plan info for adults	CAHPS 3.0H Adult Questionnaire		
% able to find or understand plan info for children	CAHPS 3.0H Child Questionnaire		
% getting good help from cust. service for adults	CAHPS 3.0H Adult Questionnaire		
% getting good help from cust. service for children	CAHPS 3.0H Child Questionnaire		
% appeals & complaints resolved in 30 days	HMO self-report using HCPF parameters		
% member service calls abandoned	HEDIS 2005		
% member calls answered within 30 seconds	HEDIS 2005		
Services to Providers			
% provider calls abandoned	HMO self-report using HCPF parameters		
% provider answered within 30 seconds	HMO self-report using HCPF parameters		
% clean claims finalized within 14 days	HMO self-report using HCPF parameters		
% claims finalized within 30 days	HEDIS 2005		

IV. Efficiency Measures

Measure	Source of Measure	Basis for Standard	Resp.
administrative cost as a % of premium	HMO self-report using HCPF parameters		
ER visits/1000	HEDIS 2005		

V. Financial Stability Measures

Measure	Source of Measure	Basis for Standard	Resp.
current ratio	HMO self-report using HCPF parameters		
days in unpaid claims	HMO self-report using HCPF parameters		
profit margin	HMO self-report using HCPF parameters		
debt/equity ratio	HMO self-report using HCPF parameters		

Managed care organization Performance Indicator Dashboard Measures

I. Access Measures

Measure	Source of Measure	Basis for Standard	Resp.[1]
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% good access to urgent care	CAHPS 3.0H Child Questionnaire		
% good access to a needed specialist	CAHPS 3.0H Child Questionnaire		
% no delays for an approval	CAHPS 3.0H Child Questionnaire		
% no exam room wait >15 minutes	CAHPS 3.0H Child Questionnaire		
% wait of more than 1 day for urgent care	CAHPS 3.0H Child Questionnaire		
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% women with 1 open OB/GYN within 30 miles	HMO self-report using GeoAccess or comparable software		
% mbrs with 1 open orthopedist within 30 miles	HMO self-report using GeoAccess or comparable software		
% child mbrs with 1 open otolaryngologist in 30 miles	HMO self-report using GeoAccess or comparable software		

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% members with 1 acute hospital in 30 miles	HMO self-report using GeoAccess or comparable software		

I. Access Measures (continued)

Measure	Source of Measure	Basis for Standard	Resp.
D. Use of Behavioral Health Services			
% of mbrs receiving ambulatory mental health services	HEDIS[3] 2005		
% of mbrs receiving intermediate care mental health services	HEDIS 2005		
% of mbrs receiving inpatient mental health services	HEDIS 2005		
% of mbrs with AOD[4] abuse/dependence diagnosis & service	HEDIS 2005		

II. Quality of Care Measures

Measure	Source of Measure	Basis for Standard	Resp.
A. Children's Preventive Care			
% children w/childhood immunizations: Combo 2	HEDIS 2005		
% teens w/adolescent immunizations: Combo 2	HEDIS 2005		
% children with 6+ well-child visits: 1st 15 months	HEDIS 2005		
% children with well-child visits: 3rd- 6th yrs of life	HEDIS 2005		
% adolescents with well-care visits	HEDIS 2005		
% children with URI with appropriate treatment	HEDIS 2005		
% children with pharyngitis with appropriate testing	HEDIS 2005		
B. Adult Preventive Care			
% women with timely prenatal care	HEDIS 2005		
% women with appropriate postpartum care	HEDIS 2005		
% women with breast cancer screening	HEDIS 2005		
% women with cervical cancer screening	HEDIS 2005		
% women 16-20 yrs of age with chlamydia screening	HEDIS 2005		
% women 21-25 yrs of age with chlamydia screening	HEDIS 2005		
% smokers advised to quit	CAHPS 3.0H Adult Questionnaire		

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[3] HEDIS, or the Health Plan Employer Data and Information Set was developed by a coalition of group and staff model HMOs (The HMO Group) working in concert with a small number of large employers and benefit consultants beginning in 1989, with HEDIS 1.0 released in 1991. HEDIS was intended to provide standard performance measures by which corporate purchasers could hold HMOs accountable. Shortly thereafter NCQA assumed responsibility for maintaining HEDIS and continues to do so to this day. HEDIS is widely accepted as the standard measurement set for managed care plans. Reporting health plans must adhere to detailed specifications and must obtain independent external audit of their results from an NCQA-trained and approved auditor.

[4] Alcohol or other drug

II. Quality of Care Measures (continued)

Measure	Source of Measure	Basis for Standard	Resp.
C. Care for Chronic Illness			
Diabetes			
% persons with HbA1c testing	HEDIS 2005		
% persons poor HbA1c controlled	HEDIS 2005		
% persons diabetic eye exam	HEDIS 2005		
% persons LCL screening	HEDIS 2005		
% persons LDL controlled	HEDIS 2005		
% persons nephropathy monitoring	HEDIS 2005		
Asthma % with appropriate medication			
ages 5-9	HEDIS 2005		
ages 10-17	HEDIS 2005		
ages 18-56	HEDIS 2005		
all ages combined	HEDIS 2005		
Controlling High Blood Pressure			
% persons with high blood pressure controlled	HEDIS 2005		
Follow-Up After Hospitalization for Mental Illnesses			
% MH discharges w/ follow-up visit within 7 days	HEDIS 2005		
Anti-Depressant Medication Management			
% members with appropriate acute phase treatment	HEDIS 2005		
% mbrs w/appropriate continuation phase treatment	HEDIS 2005		
% members with optimal practitioner contacts	HEDIS 2005		

III. Administrative Service Measures

Measure	Source of Measure	Basis for Standard	Resp.
Services to Members			
% able to find or understand plan info for adults	CAHPS 3.0H Adult Questionnaire		
% able to find or understand plan info for children	CAHPS 3.0H Child Questionnaire		
% getting good help from cust. service for adults	CAHPS 3.0H Adult Questionnaire		
% getting good help from cust. service for children	CAHPS 3.0H Child Questionnaire		
% appeals & complaints resolved in 30 days	HMO self-report using HCPF parameters		
% member service calls abandoned	HEDIS 2005		
% member calls answered within 30 seconds	HEDIS 2005		
Services to Providers			
% provider calls abandoned	HMO self-report using HCPF parameters		
% provider answered within 30 seconds	HMO self-report using HCPF parameters		
% clean claims finalized within 14 days	HMO self-report using HCPF parameters		
% claims finalized within 30 days	HEDIS 2005		

IV. Efficiency Measures

Measure	Source of Measure	Basis for Standard	Resp.
administrative cost as a % of premium	HMO self-report using HCPF parameters		
ER visits/1000	HEDIS 2005		

V. Financial Stability Measures

Measure	Source of Measure	Basis for Standard	Resp.
current ratio	HMO self-report using HCPF parameters		
days in unpaid claims	HMO self-report using HCPF parameters		
profit margin	HMO self-report using HCPF parameters		
debt/equity ratio	HMO self-report using HCPF parameters		

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Appendix F:
Employer Sponsored Insurance

July 01, 2005

"The mission of the Department of Health Care Policy & Financing is to purchase cost-effective health care for qualified, low-income Coloradans."
http://www.state.co.us/gov_dir/chcpf/index.html

June 1, 2005

Ms. Barbara Ladon
Director, Child Health Plan Plus Division
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

RE: *Employer Sponsored Insurance/HIFA Waiver Program and Implementation Summary*

Dear Ms. Ladon:

I am pleased to submit to you the culmination of discussions and research to provide the Department with a plan to implement an *Employer Sponsored Insurance (ESI)/HIFA Waiver Program* for Colorado residents. PSI facilitated discussions that included participation of a number of health plans that currently serve Colorado Medicaid and CHIP members, and conducted research on best practices and lessons learned from existing ESI programs around the country. I also received input from you and your staff on the Department's vision and specific concerns that need to be addressed in the program design.

Our efforts are shaped by two important goals. First, to keep the administration of the ESI program as simple as possible for employers, health plans, enrollees and the State. Second, not to be constrained by existing ESI models particularly because States have different histories related to Medicaid and CHIP programs and differ in the number of low-income workers that have access to employer-based insurances.

One of the most important elements of our proposal is the involvement of the health plans and employers in the design of the ESI program including the way it's marketed to employees, the accounting process of subsidy payments and defining the questions we answer in the evaluation of the program. We recommend these details be worked out during the time period starting when the Department submits the Waiver Request to CMS through receipt of CMS approval, approximately July 1, 2005 through January 1, 2006.

This ESI program will be one more option the Department will have in place to meet its mission to "purchase cost effective health care for qualified, low-income Coloradoans". We recommend a goal of enrolling approximately 200 children into the ESI program during each of the first few years under the waiver. This is a realistic goals based on 1) actual experience of existing programs we researched, 2) the desire to develop an administrative process that is simple for all parties which is easier to modify with a smaller number of enrollees and 3) the need to make timely changes to the program based on feedback from all involved parties and data analysis.

The *Summary of the ESI Waiver Program* includes the following topics:

- Project Purpose
- Goals
- Challenges
- Health Plan and Employer Partners
- Eligibility
- Marketing
- ESI Premium Payment Assistance (PAP) and Accounting Process
- Miscellaneous Issues
- Program Evaluation
- Implementation

All of the individuals representing the organizations that have been working together on this effort are committed to seeing it through implementation. We believe Colorado's approach is different enough from what other states have tried that we will generate more interest on the part of families, health plans, and employers than has been experienced in the past. We look forward to continuing to work with the Department to make the ESI Waiver Program a success.

Sincerely,

Joan Henneberry
Senior Vice President
Government Health Services

Enclosure

Plan for Colorado Employer Sponsored Insurance (ESI)/ HIFA Waiver Program

Project Purpose

The purpose of the ESI Waiver is to increase the number of children in Colorado from low-income families who are able to acquire health insurance coverage. To achieve this result the Colorado Department of Health Care Policy and Financing (HCPF) wants to implement an innovative, employer-sponsored insurance (ESI) program. The ESI program will be administered through the Colorado Child Health Plan Plus (CHP+) program. This pilot project presents a unique opportunity to coordinate publicly-funded health insurance with insurance benefits offered by employers to the dependent children of employees. Parents of these children will be given the option to purchase employer-based health insurance using state and federal healthcare dollars.

Goals

The ESI Waiver is an opportunity to develop a partnership between health plans, employers and HCPF in support of a common goal, that is, to increase the number of insured, low-income children. Other goals include:

- Enrollment of 200 eligible, low-income children per year (twelve month period)
- Address common administrative challenges for the state, employers, health plans and recipients for ESI enrollment
- Understand the motivations and barriers to ESI participation by employers, health plans and low-income working parents
- Define and measure key success factors for all partners in the ESI partnership

Lack of health insurance is often an obstacle in obtaining necessary preventive care and/or timely treatment of illnesses for children. Working parents may be impacted by their children's health care needs, showing up through increased absenteeism and reduced productivity. Some low-income parents cannot qualify for Medicaid and others have reservations about their children receiving coverage through CHP+, a Medicaid-related public benefits program. Employers in some industries have experienced higher retention among employees who have enrolled in their health insurance plan. This ESI program should be attractive to workers who understand the importance of health insurance coverage and see this as an affordable opportunity to get their children covered.

Challenges

Each partner has goals specific to its role in the ESI partnership:

- **The State wants to enroll children eligible for CHP+ but currently not enrolled at a cost less than or equal to the cost of insuring children through the public program**
- **Health plans want to increase enrollment without additional administrative burdens, and be able to maintain financial viability**
- **Employers want to assist employees and increase the enrollment of dependents in order to stabilize employment and have a competitive advantage, at the same time protecting their current rates and risk pool**

- **Parents of CHP+ -eligible children want more choices for coverage and want all family members covered in a single plan that has reasonable levels of cost sharing and adequate benefits for their children.**

The approach we propose intends to address all of these goals and concerns. The evaluation findings will determine the extent to which we are able to meet the goals.

Today, fourteen states offer a premium assistance program through Medicaid, SCHIP or 1115 Waivers. The programs vary substantially in their program goals, target population, eligibility criteria, level of subsidy and number of enrollees. Despite these differences, Colorado has the opportunity to leverage their experience and "lessons learned" to increase the likelihood of success of our pilot. In our design, we have solutions to address the major challenges facing ESI programs:

- ♦ Recruit health plans (also referred to as "health insurance carriers") and employers interested in participating in the pilot project.
- ♦ Involve health plans and employers early in the planning stages to work with HCPF to design processes to reduce the administrative complexity for all parties involved.
- ♦ Conduct focus groups with potential enrollees from employer groups to better understand their needs, concerns and questions; use the feedback to develop enrollment materials and administrative processes
- ♦ Design an evaluation component that is not too complex or costly, but one that provides all parties – insurance carriers, employers and the State – with useful information about the pilot's successes and areas that need to be modified. We also want to identify those components that did not work.

Health Plan and Employer Partners

Involving health plans and employers in the design of the ESI program will be an important factor to the success of the Colorado ESI Waiver. This approach is different than most of the ESI programs we researched. The plan to recruit these stakeholders is as follows:

- ♦ *Health plans* – identify health plans that already provide coverage to Medicaid and/or CHP+ enrollees. To date, we have identified two health plans—Kaiser Permanente and Rocky Mountain Health Plans—that meet the criteria. Both have expressed initial interest in participating in the pilot, and have been active participants during the early planning stages.
- ♦ *Employers* – identify medium- to large-sized employer groups that have a relatively large number of low-income workers who could qualify for CHP+. We prefer to partner with employer groups that are existing clients of the health plans so that we can more easily develop the enrollment and accounting processes. To date, we have identified three employers that meet the criteria—Denver Public Schools, the Marriott Corporation, and Children's Hospital—and have had preliminary conversations with employee benefit representatives to gauge their interest to participate in the ESI pilot.

In addition to general guidance, we will solicit input from health plans and employers on: the marketing plan, enrollment process, accounting process and evaluation plan.

Eligibility

Eligibility criteria for the ESI Waiver are based on CHP+ eligibility requirements. They include:

- ♦ Children must be uninsured at the time of application and have been without health insurance coverage for six (6) months. This six-month window does not apply to the parents, that is, the children are eligible for ESI even if the parent has been enrolled in the employer's insurance plan during the previous six months.
- ♦ Any child eligible for CHP+ is eligible for ESI. The application requires a form signed by the employer to verify the employee has also submitted an application to enroll in the employer's family coverage.
- ♦ The parent makes the decision to enroll the child in the "regular" CHP+ health plan or in the employer-based coverage.
- ♦ The CHP+ application needs to be submitted far enough in advance of the closing date for the employer's open enrollment period so the State can finalize its eligibility determination and communicate this to the applicant. If the applicant does not qualify for CHP+ we want to make sure the worker does not miss the employer's open enrollment deadline to opt for employee-only coverage.
- ♦ The employer's health plan must meet the minimum requirements of the Colorado Division of Insurance Standard Benefits package for small group coverage. (By design, we will have this information in advance from the health insurance carriers so that the CHP+ enrollment unit does not need to make this determination.)

The enrollment process needs to be seamless to the employer and worker to eliminate barriers to get families to sign up with ESI. The project will need to include training to three groups in advance of the employer's enrollment period to ensure the process runs smoothly:

- ♦ the employer's human resources/management staff
- ♦ health plan account managers/benefits specialists
- ♦ CHP+ enrollment specialists

Timing for enrolling into ESI will need to take place during the employer's annual open enrollment period that typically takes place one or two months in advance for a July 1 or January 1 effective date. Working with the employer we will need to identify the individual(s) at each worksite that is authorized to sign the form to verify the employee has also submitted an application to enroll in the employer's family coverage. This information will be included in the employer-specific enrollment materials.

We may determine that we need one or two people on the staff of the CHP+ enrollment broker who will be trained beyond the introductory training session so they can troubleshoot applications and reduce the number of inquiries that require input from the Department.

Marketing

Working with the health plans and employers we will develop a plan to attract parents of low-income children to sign up with the ESI waiver that we refer to as "marketing" for this discussion. Prior to developing the written and graphic materials, we propose to hold focus groups with workers from each of the employer groups who could be eligible for ESI. This is especially necessary because the experience and success of existing ESI waiver programs is sparse. We need to have a better understanding of the challenges, barriers and opportunities associated with our specific Colorado target group.

Working as a pilot program, we want to take advantage of the flexibility that this allows the project. We anticipate the need to "tweak" the marketing materials based on the level of success achieved at each open enrollment. The use of focus groups and/or follow-up telephone surveys will be very useful in this effort.

Prior to offering the ESI option to low-income parents at a worksite, the health plans will be asked to certify that the employer's health plan meets the minimum requirements for the State of Colorado Standard Benefits Plan.

ESI Premium Payment Assistance (PAP) and Accounting Process

The State, health plans and employers all need to know the status of premium payments for each worker enrolled in the ESI waiver that fits into the normal monthly accounting cycles. Working within the constraints of existing accounting systems and tracking mechanisms, the partners will need to define their needs related to the premium payment assistance (PAP) process, accounting procedures and reporting requirements. The extent to which the parent of the children enrolled needs and/or wants premium payment information can be obtained through the focus groups described under "Marketing". We also want to be mindful of the literature that suggests users of health care are better consumers when they have information about the cost of health care. The design process will result in documentation on the roles and responsibilities of each partner, timeframes associated with the different steps in the process and content of reports.

Miscellaneous Issues

We have not listed all open issues that we will need to resolve, however, we have listed few we believe are going to require attention:

- ♦ Cost-sharing limit: Children enrolled through the ESI Waiver are subject to the same cost-sharing maximums as those enrolled in the "regular CHP+". That is, for children with incomes at or above 150% of the Federal poverty level, the aggregate of premiums, enrollment fees and other cost-sharing cannot exceed 5% of family income. We will need to develop the mechanisms with the health plans and the Department to include the premium subsidy in this calculation.
- ♦ Movement from ESI back to "regular" CHP+: In the design of the ESI program we want to make the reasons for staying with the employer-sponsored insurance as attractive as possible. We have identified a few instances when switching to "regular" CHP+ may be a better financial decision for a family than staying with the ESI waiver. For example, a family enrolled in ESI may switch if a child becomes very ill and the family experiences financial hardships; second, the family can no longer afford the employee portion of the employer's insurance

premium but can afford the cost-sharing of CHP+. In both cases, the family could be blocked from moving to "regular" CHP+ because of the current requirement that the children have to be without insurance for six months. We see this as a deterrent to the family to enroll with ESI when compared to CHP+ and will work with the Department to assure consistent interpretation of any waiting periods.

Program Evaluation

The evaluation plan is an important component of the overall ESI Waiver Pilot program. First, the evaluation will help the Department and the other stakeholders determine if the program should be expanded after the pilot is over. Second, it will add to the knowledge base available to other states and CMS pursuing these initiatives. Ongoing and retrospective evaluation topics may include the following:

- ♦ Identification of variables that contribute to increased enrollment and barriers to enrollment
- ♦ Comparison of ESI Waiver Program costs to "regular" CHP+
- ♦ Assessment of employers' satisfaction with the processes and value of the ESI waiver
- ♦ Assessment of parents' satisfaction with the processes and value of the ESI waiver
- ♦ Defining factors that need to be considered to expand the pilot program to more employer sites

Implementation

We propose to use the time period from July 1, 2005 to January 1, 2006 to work out the details for implementing the ESI Waiver Pilot project. The target is to have all processes and materials in place to conduct the first open enrollment for a July 1, 2006 effective date. During this time period the State will be seeking waiver approval from CMS.

The implementation process will result in a number of deliverables. Below is a list of some, but not all, deliverables:

- ♦ Overall implementation project plan
- ♦ Written commitment from two health plans to participate in the pilot project.
- ♦ Written commitment from at least two employers to participate in the pilot project.
- ♦ List of project goals agreed to by all partners.
- ♦ Workflow documents with timeframes, roles/responsibilities and resource requirements for the major processes to include, but not limited to: marketing, enrollment, premium assistance payment, accounting, operational reporting and evaluation.
- ♦ Outline for focus group sessions including naming facilitator(s), schedule, location, objectives (goals and questions) and process to select attendees.
- ♦ Format for status updates to HCPF and other communication protocols as necessary.

The implementation plan is divided into three phases:

- Phase 1: finalize commitment from health plans and employers to participate in pilot
- Phase 2: discuss and document detailed operational workflows and tasks
- Phase 3: finalize workflows and document other tasks that need to be completed prior to starting enrollment for a July 1, 2006 effective date

Task	Start Date	End Date
Phase 1	**6/1/05**	**8/15/05**
Discuss project with employers		
Convene meetings with health plans and employers to discuss project goals, concerns, operational issues		
Develop estimate of number of potential enrollees based on employers' workforce composition		
Obtain final commitment from employers and health plans to participate in pilot		
Deliverable of Phase 1	*Letter of intent to participate from employers and health plans*	
Phase 2	**8/15/05**	**11/30/05**
Work together with health plans, employers and HCPF to: ♦ Develop a list of all components of operations that need to be defined and documented to meet program requirements and goals ♦ Develop a list of all open issues that need to be closed before design is completed	8/15/05	9/15/05
Meet with health plans, employers and HCPF to define/determine: ♦ Enrollment criteria ♦ operational workflows (e.g., enrollment, subsidy payment, accounting, communication, training, customer service, etc) ♦ roles/responsibilities of HCPF, employers and health plans ♦ eligibility criteria ♦ subsidy amount ♦ reporting requirements ♦ marketing/enrollment materials ♦ evaluation criteria and measurement	8/15/05	10/15/05
Conduct employee focus groups	10/15/05	10/31/05
Summarize employee focus group feedback and incorporate into policies, procedures, marketing materials, etc	11/1/05	12/1/05
Deliverable of Phase 2	*Prepare initial draft of all policies, procedures, marketing materials and workflows for review*	
Phase 3	**12/1/05**	**12/31/05**

Task	Start Date	End Date
HCPF, health plans and employers review draft documents and provide feedback	12/1/05	12/15/05
Prepare final draft of all policies, procedures and workflows – present to HCPF	12/15/05	12/31/05
Deliverable of Phase 3	*Present Final Draft of all documents to HCPF*	