REPORT OF

THE

STATE AUDITOR

Children's Basic Health Plan
Department of Health Care Policy and Financing

Performance Audit
May 2008

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This report contains the results of a performance audit of the Children's Basic Health Plan (CBHP) administered by the Department of Health Care Policy and Financing. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. This report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy and Financing.

Sally Symanski

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SALLY SYMANSKI, CPA
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Children's Basic Health Plan
Department of Health Care Policy and Financing
Performance Audit
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Authority, Purpose, and Scope

This performance audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct performance audits of all departments, institutions, and agencies of state government. The audit work, performed from February 2007 to May 2008, was conducted in accordance with generally accepted government auditing standards. Our audit focused on how the Department of Health Care Policy and Financing (Department) administers the Children's Basic Health Plan (CBHP), which serves low-income children and pregnant women in Colorado. We evaluated the overall structure and operations of the CBHP program, including the effectiveness and efficiency of the program in meeting its stated goals as required by Section 2-3-113(2), C.R.S., compliance with state and federal laws and regulations, and the Department's overall management and oversight of the program. This audit did not include a review of coordination between CBHP and the Colorado Indigent Care Program or of medical services claims or payments made by the Department for the CBHP program. A second audit of CBHP will focus on: (1) claims processing for clients served by the State Managed Care Network (Network), which serves more than 40 percent of CBHP enrollees as discussed below; (2) utilization management; (3) case management; and (4) the Department's oversight of the Network. We acknowledge the assistance and cooperation provided by the Department of Health Care Policy and Financing and the county departments of human/social services.

Overview

The Children's Basic Health Plan Act (Section 25.5-8-101, C.R.S.) established CBHP as a private-public partnership to provide subsidized health insurance for low-income children and pregnant women. CBHP implements the provisions of federal Title XXI which created the State Children's Health Insurance Program (SCHIP). The Department is designated as the state agency authorized to receive federal SCHIP funds. CBHP is funded by approximately 35 percent state funds (including tobacco settlement, Amendment 35, and general fund monies) and 65 percent federal funds.

To be eligible for CBHP, an individual must be either a child under 19 years of age or a pregnant woman, have family income of less than 205 percent of the federal poverty level, and meet residency and citizenship requirements. Individuals are not eligible for CBHP if they are eligible for Medicaid or have other health insurance. CBHP offers a variety of medical services, including inpatient, outpatient, and emergency care; laboratory services; physician services; prescription drugs; and limited vision, hearing, mental health, and dental services. The Department also operates a "CHP+ at Work" program, which subsidizes an employee's portion of employer-provided health insurance. The Department provides medical services to CBHP enrollees through five health plans—four

contracted HMOs and the State Managed Care Network. The Network consists of more than 4,800 individual providers that are managed by Anthem Blue Cross and Blue Shield. In Fiscal Year 2007 about 58 percent of all enrollees were in HMOs while the remaining 42 percent were in the Network.

Between Fiscal Years 2003 and 2007 the average monthly number of children enrolled in CBHP grew 6 percent from about 49,220 to about 52,200 and the average monthly number of pregnant women enrolled grew 235 percent, from about 400 to about 1,340. In Fiscal Year 2007, medical services costs averaged about $121 per month per enrolled child and about $1,046 per month per enrolled pregnant woman.

Key Findings

Program Performance

While CBHP was designed as a private-public partnership under state statute, the Department is ultimately accountable for managing CBHP operations and funding, ensuring the program performs effectively, and meeting federal and state requirements. We found the Department does not have an adequate system to evaluate the performance of the CBHP program and cannot ensure that expenditures, which have averaged over $76 million annually for the last five years, are justified, as discussed below:

- **Measuring access to high quality care.** We found that CBHP was performing below the national Medicaid median on 5 health status measures for Calendar Year 2006 (the most recent period for which the measures were available at the time of our audit). This suggests that children under the age of six are not receiving the care they need. The 5 measures are part of a set of 13 measures from the Health Employer Data Information Set (HEDIS), a quality assurance tool recommended by the General Assembly and the federal government and used by the Department to evaluate the delivery of services and health status of CBHP enrollees. Although these results should prompt analysis, the Department has not investigated the HEDIS data to identify needed program improvements.

- **Network Adequacy.** We found the Department does not monitor the adequacy of the CBHP provider networks to ensure enrollees have access to a sufficient number of providers. We conducted a preliminary analysis of Department data and found that the ratio of providers to enrollees and the proportion of CBHP providers that are accepting new patients vary widely among the health plans. The analysis indicates the need for the Department to track and monitor the adequacy of its CBHP provider networks to ensure that current and potential enrollees have access to health care services.

- **Program Penetration.** We evaluated the Department's progress in decreasing the proportion of children in Colorado who are uninsured and in serving the CBHP-eligible population and found that the Department does not use a valid and reliable methodology to estimate the number of children eligible for CBHP. As a result, the Department lacks a

reasonable basis for its reported penetration rate for CBHP, which has decreased from about 58 percent in Fiscal Year 2003 to about 51 percent in Fiscal Year 2007.

- **Marketing and Outreach.** The Department is not ensuring that the investment in marketing and outreach services for CBHP is cost-effective, as required by statute. The Department does not evaluate whether its marketing and outreach contractor is meeting its contractual requirement to increase the number of eligible individuals enrolled in CBHP or provide the contractor with information, such as the number of new enrollees by location, to evaluate and target marketing and outreach.

Eligibility and Enrollment

The Department partners with counties and two medical assistance sites to provide eligibility and enrollment services for CBHP. We found the Department lacks a comprehensive monitoring process for these services. As a result, we identified significant problems in these areas, as discussed below:

- **Eligibility Determination and Documentation Errors.** We reviewed applications for 203 applicants who had been enrolled in CBHP at some point between July 1, 2006 and March 31, 2007 and found eligibility determination errors or insufficient documentation to support the eligibility decision for 21 of the applicants (10 percent). Overall, we identified questioned costs of about $48,300 related to eligibility determination errors. The exceptions we identified primarily resulted from staff errors at the eligibility sites and include 16 ineligible applicants who were enrolled in CBHP; 1 applicant who was denied enrollment but was eligible for the CHP+ at Work program; and 4 applicants whose files did not contain documentation to support the eligibility determination.

- **Failure to Process Applications Timely.** We reviewed the applications of 86 individuals enrolled in CBHP between July 1, 2006 and March 31, 2007 and found 8 applications (9 percent) were processed up to 91 days late. We also reviewed 13 weekly reports for July through September 2007 listing every CBHP application that was entered into CBMS but was pending (i.e., eligibility was not determined) for more than 45 days. The average number of pending applications on these reports was about 1,900 or about 2 percent of the approximately 92,200 CBHP applications processed annually. Delays in processing applications could prevent eligible applicants from receiving needed medical services.

- **Problems with Program Retention.** We found that about 16 percent (about 5,300 children) of approximately 32,000 children who were due to reapply for CBHP between April 1, 2006 and March 31, 2007 did not reapply and therefore were not retained in the program. Another 8 percent (about 2,600 children) were reenrolled in CBHP but had a lapse in coverage of up to six months.

- **Inadequate Disenrollment Procedures.** From January 1, 2006 through October 31, 2007, we identified 831 pregnant women who remained enrolled in CBHP past their 60-day post-

partum eligibility period. In addition, from January 1 through July 31, 2007, we identified 54 children who remained enrolled after their eligibility terminated at age 19. We identified questioned costs totaling about $109,400 for these ineligible enrollees.

- **Insufficient Oversight of Enrollment Fees.** The Department does not have adequate controls to ensure that all enrollment fees are collected, deposited into the bank, and properly recorded in CBMS. As a result, the Department cannot ensure fees are assessed in accordance with requirements or that all individuals who have paid the fee are enrolled in CBHP and able to receive program services. Under CBHP rules, families whose incomes exceed 150 percent of the federal poverty level pay annual enrollment fees for their children.

Program Management and Oversight

Throughout the audit we found an overall lack of effective management and oversight by the Department of the public and private partners in the CBHP program. In addition to concerns discussed above, we found weaknesses in the Department's management of contracts and its oversight of suspected fraud and abuse and complaints related to CBHP, as follows:

- **Contract management.** We found incomplete provisions and inadequate oversight for several Fiscal Year 2006 and 2007 CBHP contracts. For example, the Department's contract with its eligibility and enrollment vendor, which requires the contractor to process applications, enroll and disenroll clients as appropriate, and manage enrollment fees, lacks requirements and performance measures for timely and accurate disenrollments and proper handling of enrollment fees. The Department's contract monitoring practices do not include thorough reviews of contractor reports, independent verification of contractor performance, or documentation of monitoring activities.

- **Fraud, Abuse, and Complaints.** The Department has not clearly informed its contractors of their duties to conduct activities related to detecting fraud and abuse and does not have procedures to verify that suspected fraud and abuse are properly investigated and referred to law enforcement as needed. In Federal Fiscal Years 2006 and 2007 the Department reported a combined total of 15 cases of suspected fraud or abuse in CBHP to the federal government but had no detailed information about these cases, including how or if they were resolved. The Department also lacks a central tracking and resolution process for CBHP complaints.

Our recommendations and responses from the Department of Health Care Policy and Financing can be found in the Recommendation Locator and in the body of the report.

RECOMMENDATION LOCATOR

Agency Addressed: Department of Health Care Policy and Financing

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
1	28	Ensure access to quality and appropriate care for CBHP enrollees by: (a) assessing the costs and benefits of requiring the Network to undergo NCQA audits of its HEDIS data; (b) continuing to require all health plans to use the same method to calculate all HEDIS measures if different methods make the results unusable; (c) regularly analyzing the HEDIS results to assess program performance and identify needed improvements; and (d) using the analyses to formulate and implement improvements.	Agree	July 2009
2	32	Improve monitoring of network adequacy for CBHP by: (a) evaluating the provider network for CBHP before contracting with an HMO, (b) regularly obtaining data about the provider networks of the CBHP health plans, and (c) analyzing the data obtained on an ongoing basis, along with enrollment information, to assess network adequacy and correct weaknesses.	Agree	October 2008
3	37	Discontinue use of the current methodology to estimate the number of children eligible for CBHP and implement a system to obtain valid estimates that includes: (a) use of a reliable, accurate, and verifiable estimation method; (b) documentation of all source data, calculations, methodology, and the rationale for each element of the methodology; (c) rigorous oversight of the methodology and results by a knowledgeable staff member prior to reporting results; and (d) regular analysis of penetration rates to assess program performance, identify needed improvements, and inform decisions about marketing and outreach.	Agree	April 2009
4	40	Improve the accuracy and consistency of data reported about CBHP by: (a) either using consistent definitions for reporting program data such as enrollment, eligibles, and penetration rates, or explaining in reports the basis for any differences in the data and (b) improving supervisory reviews of reported data before reports are used by the Department or issued.	Agree	April 2009

RECOMMENDATION LOCATOR

Agency Addressed: Department of Health Care Policy and Financing

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
5	45	Ensure the effectiveness of marketing and outreach activities by: (a) working with the marketing and outreach contractor to identify key outreach-related data, (b) extracting key data from CBMS on a quarterly or semi-annual basis, (c) developing additional methods to collect and record data on how applicants learned of CBHP, and (d) providing these data, as well as penetration rate data, to the contractor for evaluating marketing activities and modifying strategies, as necessary.	Agree	October 2009
6	48	Strengthen objectives, measures, and reporting for CBHP by: (a) ensuring objectives are targeted, measurable, clearly tied to key health care services, and include services specifically referenced in federal regulations; (b) establishing measures that reflect the program's progress in accomplishing each objective; and (c) routinely analyzing the measures to identify and address program weaknesses.	Agree	April 2009/Ongoing
7	54	Reduce eligibility-determination errors for CBHP by: (a) expanding efforts to establish a comprehensive program for monitoring eligibility determination, (b) expanding CBHP training to target key issues identified through the monitoring program and include information on CBMS income calculations, (c) requiring eligibility sites to improve their quality/supervisory review processes, and (d) investigating the causes of CBMS errors identified in the audit and correcting the errors.	Agree	January 2009
8	59	Improve monitoring of timely application processing for CBHP by: (a) developing reports in CBMS and compiling statistics on timely application processing, (b) working with eligibility sites to investigate causes of processing delays, (c) targeting training to address the causes of late processing, and (d) considering the costs and benefits of expanding the eligibility and enrollment contract on either a permanent or temporary basis to reduce processing backlogs.	Agree	July 2009

RECOMMENDATION LOCATOR

Agency Addressed: Department of Health Care Policy and Financing

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
9	63	Improve the redetermination process and improve retention for CBHP by: (a) routinely calculating program retention rates and analyzing data on program retention, (b) clarifying the redetermination application, (c) sending reminders to families to submit their redetermination applications, and (d) considering methods to identify barriers to reapplication.	Agree	October 2009
10	67	Ensure ineligible women and children are timely disenrolled from CBHP by: (a) reviewing the 885 individuals identified during the audit who were not disenrolled on time, disenrolling ineligible individuals, and recovering payments for ineligible individuals; (b) strengthening efforts to ensure that participants are disenrolled when their eligibility ends; and (c) prioritizing changes to MMIS and CBMS to ensure disenrollments occur timely and accurately in the future.	Agree	September 2008
11	72	Strengthen controls over the handling and safeguarding of CBHP enrollment fee collections and recording into CBMS by: (a) amending the contract to require the eligibility and enrollment contractor to establish and follow specified cash control policies and procedures, (b) verifying that the contractor complies with contract requirements and taking corrective action if necessary, and (c) performing monthly bank reconciliations of enrollment fees paid, deposits, and CBMS records.	Agree	September 2008
12	74	Ensure procedures for approving applicants for CBHP are consistent with federal regulations by continuing to work with the Centers for Medicare and Medicaid Services to ensure the corrective action plan for implementing the Deficit Reduction Act as it affects CBHP is acceptable.	Agree	Ongoing

RECOMMENDATION LOCATOR

Agency Addressed: Department of Health Care Policy and Financing

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
13	81	Implement policies and procedures for contract management that require: (a) contracts to include performance standards for all key contracted functions, (b) contract managers to conduct ongoing assessments of contractors against performance standards, (c) documentation to fully demonstrate oversight of contractors, (d) contract managers to have adequate training, and (e) staff to take timely action to address contracts that lack needed provisions and contractor failure to meet contractual requirements.	Agree	January 2009
14	84	Improve the management of CBHP by: (a) systematically identifying the data needed to manage CBHP, the sources of such data, and how the data will be used; (b) establishing data collection processes to meet the identified needs; and (c) analyzing and using the data on an ongoing basis to evaluate CBHP and identify and implement needed improvements.	Agree	June 2009
15	88	Establish a fraud and abuse oversight system for CBHP by: (a) implementing written policies and procedures to prevent, detect, and investigate suspected fraud and abuse; (b) modifying contracts to specify duties for handling suspected fraud and abuse; (c) ensuring that contractors and county departments routinely report fraud and abuse information; and (d) reviewing the reported data to ensure that allegations are properly handled and to identify areas in which program controls need to be strengthened.	Agree	June 2009
16	91	Implement a comprehensive complaints-management system for CBHP by: (a) clearly defining the complaint-handling duties of eligibility sites, contractors, and Department staff; (b) developing guidance on referring complaints among organizations for proper handling; (c) establishing a mechanism to collect, log, track, and ensure the resolution of all CBHP-related complaints; and (d) analyzing complaint data to help improve CBHP operations.	Agree	January 2009

Overview of the Children's Basic Health Plan

The Children's Basic Health Plan Act (Act) created the Children's Basic Health Plan (CBHP) to provide subsidized health insurance for children in low-income families [Section 25.5-8-101, et. seq., C.R.S.]. CBHP began operations in April 1998 when House Bill 98-1325 established the program to align with provisions of federal Title XXI, which was enacted by Congress in August 1997. Title XXI created the State Children's Health Insurance Program (SCHIP) to "initiate and expand the provision of child health assistance to uninsured, low-income children." Accordingly, CBHP serves as Colorado's SCHIP program. In 2002 the Department of Health Care Policy and Financing (Department) began offering a prenatal program through CBHP for low-income pregnant women. Prenatal services are offered to pregnant women over the age of 19 through a federal waiver program. The Department is the state agency designated to receive federal SCHIP funds and is therefore responsible for administering the CBHP program in compliance with all applicable federal laws and regulations.

Federal law allows states several options in structuring their SCHIP programs: develop a separate health insurance program; expand the state's existing Medicaid program; or use a combination—creating both a separate SCHIP program and using SCHIP funds to expand Medicaid for children. As of February 2008 Colorado is 1 of 18 states that designed a separate, stand-alone health insurance program; 8 states expanded their Medicaid programs; and 24 states developed a combined program.

The Act states that it is the intent of CBHP to make health insurance affordable, but not to serve as an entitlement for health insurance coverage. CBHP is targeted to individuals in families between 100 and 205 percent of the federal poverty level, rather than to families who meet the more restrictive income requirements of Medicaid. Medicaid primarily serves families with incomes below 100 percent of the federal poverty level. CBHP is marketed under the name "Child Health Plan Plus," or "CHP+." Federal regulations, state statutes, and Department rules all contain information on the eligibility criteria for CBHP. To be eligible for the program, a person must:

- Be a child under 19 years of age or a pregnant woman.
- Have family income of less than 205 percent of the federal poverty level, adjusted for family size. As of April 1, 2008, a family of four is eligible for CBHP if its annual income does not exceed $43,460.
- Not be eligible for Medicaid.

- Be a resident of Colorado and a U.S. citizen or a permanent U.S. resident who has had an Alien Registration number for at least 5 years.

- Not have other insurance (except under the CHP+ at Work federal waiver pilot program which pays a portion of health insurance premiums for enrolled children of one local employer) and not have access to state employee health insurance benefits.

- Not have had other insurance within three months prior to the date of application, with a few exceptions (e.g., loss of health insurance due to a loss of employment).

The following table shows the total number of enrollees in CBHP over the last five years and the average monthly cost for medical services for enrollees.

Department of Health Care Policy and Financing
Children's Basic Health Plan
Average Monthly Enrollment and Medical Services Cost per Enrollee
Fiscal Years 2003 through 2007

Average Monthly Figures	2003	2004[1]	2005	2006	2007	Percent Change 2003 - 2007[2]
Number of Enrolled Children	49,220	46,690	40,010	46,870	52,200	6%
Number of Enrolled Prenatal Women	400	120	560	1,140	1,340	235%
Total Number of Enrollees	**49,620**	**46,810**	**40,570**	**48,010**	**53,540**	**8%**
Medical Cost per Child[3]	N/A[4]	$99	$97	$109	$121	22%[2]
Medical Cost per Prenatal Woman	N/A[4]	$796	$908	$874	$1,046	31%[2]
Total Medical Cost per Enrollee	**$92**	**$101**	**$108**	**$128**	**$144**	**57%**

Source: Information from the Department of Health Care Policy and Financing and COFRS.
Notes:
[1] Due to budget constraints, CBHP enrollment was suspended for children and pregnant women during Fiscal Year 2004.
[2] For Average Monthly Medical Cost per Child and per Prenatal Woman, the percentage change is from 2004 to 2007.
[3] Includes dental costs for children. Prenatal enrollees do not have dental coverage.
[4] Medical cost data were not broken out between children and women in COFRS in Fiscal Year 2003. As a result, we could not determine the average monthly medical costs for each group.

The increases in average cost per enrollee reflect, in part, rising medical costs. According to the Federal Bureau of Labor Statistics, medical costs for people living along the Front Range rose about 21 percent between 2003 and 2007.

CBHP Health Care Benefits

The Children's Basic Health Plan offers the following benefits to enrolled children and pregnant women:

- Inpatient, outpatient, and emergency care.
- Laboratory services.
- Physician and clinical services.

- Prescription drugs.
- Preventive services and screenings.
- Limited vision and hearing services.
- Limited mental health and substance abuse services.
- Limited dental services for children.
- Other approved services (e.g., physical, occupational, and speech therapy; home health care; hospice care; and skilled nursing facility care).

Colorado also operates a "CHP+ at Work" pilot program which subsidizes an employee's portion of employer-provided health insurance up to $100 per month per qualifying child, or the actual cost to the employee, whichever is less. To qualify for CHP+ at Work a family must meet CBHP income requirements. As of December 2007 the program had about 170 participants in 40 families.

Private-Public Partnership

The Children's Basic Health Plan Act states that the program was designed as a private-public partnership to take advantage of the "efficiency and creativity . . . [of the] private sector . . . while maintaining the highest level of accountability to the General Assembly . . . and the public. . . ." The Act also specifies that the Department may "allocate functions relating to the administration of [CBHP]" among private contractors, county departments of human/social services, and Department staff. Consistent with this statutory design, the Department allocates many of the day-to-day administrative functions of CBHP to private vendors, counties, and community organizations. The Department is responsible for overseeing these delegated functions, recommending CBHP rules to the Medical Services Board, and maintaining quality assurance and performance measurement systems for CBHP. The services provided by private contractors, county departments of human/social services, medical assistance sites (entities designated by the Department to accept medical assistance applications and determine eligibility), and community-based organizations are described below.

Application Processing and Enrollment. County departments of human/social services and medical assistance sites accept joint Medicaid/CBHP applications, which are processed simultaneously for both programs. During the period of our audit, there were two designated medical assistance sites—Denver Health and Affiliated Computer Services—that processed Medicaid/CBHP applications. The counties and medical assistance sites (collectively referred to as eligibility sites) determine eligibility and enroll eligible applicants into the appropriate program using the Colorado Benefits Management System (CBMS). In addition to serving as an eligibility site, Affiliated Computer Services (ACS) contracts with the Department to provide other services, including customer service, disenrollment of CBHP participants who are no longer eligible for the program, and collection of all CBHP enrollment fees (discussed below). In Fiscal Year 2007 the Department paid ACS about $4 million for these services. ACS processed about

14 percent of all CBHP applications in Fiscal Year 2007 while the other eligibility sites processed the remaining 86 percent. In addition, approximately 100 community-based organizations, such as hospitals, medical centers, and schools, provide application assistance to applicants at no charge to the Department.

Marketing and Outreach. The Department contracts with Maximus, Inc., to provide marketing and outreach for CBHP. Maximus manages statewide advertising for CBHP and develops marketing and outreach materials. Maximus employs seven outreach coordinators who work with county agencies and community-based organizations to identify and enroll CBHP-eligible children around the State. In Fiscal Year 2007, the Department paid Maximus $1.5 million for these services.

Health Care Services. The Department provides medical care services to CBHP enrollees through five health plans. Among the health plans are four different HMOs and the State Managed Care Network (Network), which comprises more than 4,800 independent providers that contract directly with the Department. Children may access services through the HMOs and/or the Network, depending on the county in which they reside. Pregnant women may only access services through the Network. Appendix A provides a table showing the breakdown of counties covered by HMOs and the Network. In addition, CBHP provides dental coverage for all children enrolled in the program through Delta Dental.

The Department contracts with Anthem Blue Cross and Blue Shield (Anthem) to: (1) recruit and manage providers in the Network; (2) process claims; (3) handle customer service activities; (4) manage behavioral and pharmacy benefits; and (5) provide utilization review and case management services.

The Department pays the HMOs a monthly capitation payment to cover the medical services provided to CBHP enrollees by each HMO's providers. The HMOs are responsible for paying all provider claims from the amounts they receive from the Department. The Department pays the Network providers, through Anthem, on a fee-for-service basis. The table below shows the number of CBHP enrollees and the total payments made by the Department to the HMOs and the Network (collectively referred to as health plans) in Fiscal Year 2007.

Department of Health Care Policy and Financing
Children's Basic Health Plan
Average Monthly Enrollment and Total Annual Payments by Health Plan
Fiscal Year 2007

	Enrollment		Annual Payments	
Health Plan	**Average Monthly**	**Percent of Total**	**Amount**	**Percent of Total**
Managed Care Network – Women [1]	1,300	3%	$16,767,200	18%
Managed Care Network – Children	21,000	39%	$30,786,000	33%
Colorado Access	21,400	40%	$26,113,600	28%
Denver Health	3,800	7%	$4,613,100	5%
Rocky Mountain HMO	3,100	6%	$3,640,200	4%
Kaiser Permanente	2,900	5%	$3,470,100	4%
Delta Dental	N/A [2]	N/A [2]	$6,888,800	8%
Total	**53,500**	**100%**	**$92,279,000**	**100%**

Source: Information from the Department of Health Care Policy and Financing.
Notes:
[1] All pregnant women enrolled in CBHP are served through the State Managed Care Network, administered by Anthem.
[2] All children receive dental coverage through Delta Dental so the enrollees in the dental plan are included in the enrollment counts for each of the medical health plans.

Other Services. The Department contracts with other vendors for additional services related to CBHP. For example, for Fiscal Year 2007 the Department paid: (1) Leif and Associates, Inc., about $107,000 for actuarial and rate-setting services; (2) Health Services Advisory Group, Inc., about $85,000 for quality assurance reviews; and (3) Allianz about $547,000 for reinsurance for the Network to protect the State against catastrophic claims expenses.

Medical Services Board. The Medical Services Board (Board) has the statutory authority to adopt rules that govern the CBHP program. The Board consists of 11 members appointed by the Governor and confirmed by the Senate. According to Section 25.5-1-301, C.R.S., all of the members must have knowledge of medical assistance programs, one member must have experience in the delivery of health care, and one must have experience in caring for the medically underserved. Additionally, statute mandates that each congressional district be represented on the Board and that no more than six members be of the same political party.

Program Changes and Expansions

Over the past five years CBHP has undergone the following significant changes:

- In Fiscal Years 2003 and 2004 program growth was limited due to budget shortfalls. In May 2003 the General Assembly suspended new enrollments of pregnant women in the CBHP prenatal program and in November 2003 the Department suspended new enrollments of eligible children in CBHP but allowed children already in the program to renew their enrollments. Both enrollment caps were lifted at the beginning of Fiscal Year 2005.

- During the 2004 Legislative Session, the General Assembly increased the amount of the State's tobacco settlement monies allocated to CBHP from $17.5 million annually to between $17.5 million and $30 million annually beginning in Fiscal Year 2005.

- In Fiscal Year 2005, Amendment 35 to the State Constitution was enacted which provides additional revenue for CBHP and certain other health care programs through an increase in tobacco taxes. The CBHP program began receiving funds from this source in Fiscal Year 2006. At the same time, the General Assembly increased the income eligibility limit for CBHP from 185 percent to 200 percent of the federal poverty level and removed the asset test for eligibility in the Medicaid program. The asset test had been used along with income to determine Medicaid eligibility, and applicants had to have both income and assets that were below specified standards. Applicants whose assets exceeded the Medicaid standard were often eligible for CBHP. With the elimination of the asset test in Medicaid, some CBHP enrollees became eligible for Medicaid.

- During the 2007 Legislative Session the General Assembly further expanded eligibility for CBHP to 205 percent of the federal poverty level. The Department implemented the expansion in Fiscal Year 2008.

Program Revenue and Expenditures

Colorado receives federal matching funds for each state dollar spent on the CBHP program. Generally, CBHP expenditures are paid for with a 65 percent/35 percent split of federal and state dollars, respectively. Federal funding is authorized by Title XXI of the Social Security Act. Title XXI funds are allotted annually to states according to a formula based on each state's share of the total number of uninsured children at less than 200 percent of the federal poverty level, multiplied by a geographic cost factor. Funding to each state is available for a three-year period, after which funds not used are reverted and redistributed to states that have fully spent their allotments. As of October 1, 2007, Colorado had about $105.9 million in unspent federal funds that it may spend in Federal Fiscal Year 2008 and subsequent years.

In Colorado, funding for the State's share of CBHP expenditures is primarily from the following sources:

- **Tobacco Settlement Funds.** State statute allocates a portion of the tobacco settlement monies the State receives to the CBHP Trust Fund [Section 24-75-1104.5, C.R.S.]. First, the CBHP Trust Fund is allocated 24 percent of the total amount the State receives annually in tobacco settlement monies, with a minimum of $17.5 million and a maximum of

$30 million in any fiscal year. These funds are used to cover children and pregnant women whose family incomes do not exceed 185 percent of the federal poverty level, up to the level of the Fiscal Year 2004 enrollment caps (discussed above). Second, the CBHP Trust Fund receives 5 percent of the total amount the State receives annually in tobacco settlement monies for the specific purpose of covering all enrollees in CBHP whose incomes are between 200 and 205 percent of the federal poverty level. This additional 5 percent allocation began in Fiscal Year 2008 when eligibility for the program was increased to 205 percent of the federal poverty level.

- **Amendment 35 Tax on Tobacco Products.** Section 24-22-117, C.R.S., implemented Amendment 35, approved by Colorado voters in November 2004, which increased taxes on tobacco products to generate revenues for health-care related purposes. Amendment 35 funding for CBHP covers two groups of enrollees: (1) the number of enrollees that exceeds the 2004 capped levels and (2) all enrollees whose household incomes are between 185 and 200 percent of the federal poverty level.

- **State General Fund Monies.** The CBHP program receives varying amounts of General Fund monies to make up any shortfalls in funding from the two sources above so that Colorado can draw down its federal allotment of SCHIP funds.

Cost Sharing. As authorized by Section 25.5-8-107, C.R.S., the Department collects annual enrollment fees for children enrolled in CBHP whose families have incomes exceeding 150 percent of the federal poverty level. In Fiscal Year 2007, the Department collected a total of about $232,000 in enrollment fees. Families also share in the cost of the program by making copayments to providers at the time services are received. The following table shows the annual enrollment fees and copayment amounts established by the Department for Fiscal Year 2007. The Department updates the enrollment and copayment schedule annually.

Department of Health Care Policy and Financing
Children's Basic Health Plan
Annual Enrollment Fees and Copayments
Fiscal Year 2007

Family Income by Federal Poverty Level	Annual Enrollment Fees		Copayment per Visit [1]
	One Child	2 or More Children	
Below 101%	$0	$0	$0 [2]
101% - 150%	$0	$0	$1 to $3
151% - 200%	$25	$35	$3 to $15

Source: Department of Health Care Policy and Financing rules for the Children's Basic Health Plan.
Notes:
[1] Copayments vary by service. For example, families with incomes between 101% and 150% of the federal poverty level pay $1 per prescription, $2 per office visit, and $3 per emergency/urgent care visit.
[2] Enrollees under 101 percent of the federal poverty level are not required to pay any copays except for the $3 emergency and urgent/after hours care copay, which applies to all enrollees.

Federal and state laws limit the amount the State can spend on administrative costs for CBHP to 10 percent of total program costs. In Fiscal Year 2007, about 93 percent of total CBHP expenditures was for medical services for children and pregnant women and the remaining 7 percent was for program administration. The following table shows the program's total revenue and expenditures for Fiscal Years 2003 through 2007.

Department of Health Care Policy and Financing
Children's Basic Health Plan
Revenue and Expenditures
Fiscal Years 2003 through 2007

Category	Fiscal Year					Percent Change 2003 to 2007
	2003	2004 [1]	2005	2006	2007	
Revenue						
Title XXI Federal Grant	$40,335,600	$40,612,700	$40,591,100	$50,509,100	$65,666,000	63%
Tobacco Settlement Funds [2]	$17,500,000	$18,460,700	$20,629,500	$20,927,500	$19,214,800	10%
Tobacco Tax [3]	$0	$0	$0	$5,108,700	$9,597,700	NA
General Fund	$2,598,200	$1,143,500	$3,296,300	$2,000,000	$11,243,200	333%
Annual Enrollment Fees [4]	$217,500	$149,600	$122,600	$191,700	$232,100	7%
Other [5]	$1,356,800	$497,800	$744,800	$1,698,400	$378,500	-72%
Total Revenue	**$62,008,100**	**$60,864,300**	**$65,384,300**	**$80,435,400**	**$106,332,300**	**71%**
Expenditures						
Medical Services [6]	$56,814,100	$56,742,800	$56,685,300	$70,774,200	$95,945,300	69%
Contracted Personal Services [7]	$6,355,000	$4,309,100	$4,217,200	$5,197,700	$5,516,400	-13%
Division Personal Services [8]	$584,000	$629,100	$689,500	$800,200	$754,900	29%
Operating Expenses [9]	$417,500	$469,400	$412,100	$590,500	$626,600	50%
Indirect Costs [10]	$159,500	$136,100	$434,300	$386,500	$879,800	452%
Transfer to General Fund [11]	$2,001,100	$0	$0	$8,100,000	$0	NA
Total Expenditures	**$66,331,200**	**$62,286,500**	**$62,438,400**	**$85,849,100**	**$103,723,000**	**56%**

Source: Information from COFRS and the Department of Health Care Policy and Financing.

[1] Enrollment caps were in place in Fiscal Year 2004, which affected both the revenue and expenditures for CBHP.

[2] Statute allocates 24 percent of Colorado's Tobacco Litigation Settlement funding to the CBHP Trust Fund, stipulating a minimum of $17.5 million and a maximum of $30 million per fiscal year.

[3] Revenue from the Health Care Expansion Fund financed by increased tobacco taxes authorized by Amendment 35.

[4] CBHP requires families with incomes exceeding 150 percent of the federal poverty level to pay annual enrollment fees of $25 for one eligible child and $35 for two or more eligible children.

[5] Includes interest earned on the CBHP Trust Fund and other revenue, such as refunds of the prior year's reinsurance costs.

[6] In Fiscal Year 2007, includes about $32,700 in insurance premiums paid on behalf of enrollees in the CHP+ at Work Program.

[7] Includes payments to administrative contractors for services such as eligibility determination and enrollment, customer service, marketing and outreach, rate setting, and quality review.

[8] Includes salaries, benefits, and employment taxes. CBHP Division staff are paid from the appropriation to the Department's Executive Director's Office instead of from the appropriation for the CBHP program.

[9] Includes general operating expenditures, such as printing, travel and reinsurance coverage for the State Managed Care Network to protect the State against catastrophic claims expenses.

[10] Includes transfers to other Department divisions to cover indirect costs, such as expenditures for CBMS and MMIS.

[11] Transfers from the CBHP Trust Fund to the General Fund according to Senate Bill 03-190 for Fiscal Year 2003 and Senate Bill 05-211 for Fiscal Year 2006.

As the table shows, revenue for CBHP increased about 71 percent between Fiscal Years 2003 and 2007. This increase reflects the addition of tobacco tax monies beginning in Fiscal Year 2006 and growth in the amount of tobacco settlement monies received, both of which allow the Department to draw down more federal funding. Over the same period, expenditures rose about 56 percent, due almost entirely to a 69 percent increase in medical services provided to eligible children and pregnant women. Part of this increase reflects growth in enrollment of about 6 percent for children and 235 percent for pregnant women. On average, pregnant women require costlier services, at an average of $1,046 per month compared with about $120 for children for Fiscal Year 2007. In addition, medical costs have been rising. As noted earlier, according to the Federal Bureau of Labor

Statistics, medical costs for people living along the Front Range rose about 21 percent between 2003 and 2007.

Under Title XXI, nearly $40 billion in federal funds over a ten-year period (Federal Fiscal Years 1998 to 2007) was made available to states with approved SCHIP plans. The initial authorization for the SCHIP program ended on September 30, 2007. In late December 2007 the federal government extended federal funding for SCHIP through March 2009. Colorado received $71.5 million in federal SCHIP funds for Federal Fiscal Year 2007, which ended September 30, 2007. The Department expects the State to receive about the same amount for Federal Fiscal Year 2008.

Health Care Reform Efforts

In recent years the General Assembly has created two panels to study health care reform issues that could affect CBHP. First, Senate Bill 06-208 created a 24-member Blue Ribbon Commission for Health Care Reform (the Commission) for the purpose of "studying and establishing health care reform models to expand health care coverage and to decrease health care costs for Colorado residents." The Governor, the Senate President, and the Speaker of the House each appoint six members of the Commission and the minority leaders of the House and Senate each appoint three members. In combination, the members are to represent consumers, health insurance purchasers, and experts and business leaders in the area of health care, health insurance, and developmental disabilities. The Commission provided its report to the General Assembly on January 31, 2008, proposing five health care reform options that ranged from increasing the income limit for CBHP eligibles to 250 percent of the federal poverty level to merging Medicaid and CBHP into a single-payor system.

Second, Senate Bill 07-211 created a 15-member Advisory Committee (the Committee) within the Department to develop a plan to "provide health coverage for all low-income children in Colorado by the end of 2010." The Governor appointed nine members of the Committee, the Senate President and the Speaker of the House each appointed two members, and the House and Senate minority leaders each appointed one member. Members of the Committee include child health advocates, recipients of medical assistance, and medical care providers. The Committee is charged with: (1) developing and overseeing the implementation of a plan to ensure that all low-income children in Colorado have health coverage by the end of 2010, and (2) making recommendations for changes in legislation and rules to increase enrollment in Medicaid and CBHP. In accordance with requirements of Senate Bill 07-211, the Committee submitted its first annual report to the Senate and House Health and Human Services Committees and the Joint Budget Committee (JBC) in November 2007. The report suggested that the Department be provided adequate resources to determine relevant county-level data on the Medicaid and CBHP programs, such as the

number of children eligible for each program, the number enrolled, and the number who had experienced non-continuous coverage in either program.

Audit Scope and Methodology

This is the first of two reports on the Children's Basic Health Plan. This report includes the results of our audit of the overall structure and operations of the program, including:

- The effectiveness and efficiency of the CBHP program in meeting its stated goals (as required by Section 2-3-113(2), C.R.S.);
- Compliance with state and federal laws and regulations; and
- The Department's overall management and oversight of the program.

As part of this audit, we interviewed Department staff and collected and analyzed data from the Department, including data from the Colorado Benefits Management System and the Department's Medicaid Management Information System. We also visited seven county departments of human/social services and the two medical assistance sites to interview staff and review files. In addition, we interviewed and collected documentation from CBHP administrative contractors and from a sample of community-based organizations that provide assistance to CBHP applicants and enrollees. Finally, we contacted the federal Centers for Medicare and Medicaid Services and other states' SCHIP programs to better understand SCHIP requirements and to identify best practices. This audit did not include a review of coordination between CBHP and the Colorado Indigent Care Program or of medical services claims or payments made by the Department to the health plans.

The second audit report on CBHP will focus on claims processing, including:

- Payments made for CBHP's State Managed Care Network, which is administered by Anthem;
- Utilization management and case management practices used by Anthem for the Network; and
- The Department's management of the contract with Anthem.

This second report will be released later this year.

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Program Performance

Chapter 1

When children lack access to regular health care, the effects can be wide-ranging and long term. The General Assembly recognized the risks to uninsured children when it established the Children's Basic Health Plan (CBHP) in 1998. In the legislative declaration of the CBHP Act (Act) [Section 25.5-8-102, et seq., C.R.S.], the General Assembly stated:

> Lack of health insurance coverage decreases children's access to preventive health care services, compromises productivity of the state's future workforce, and results in avoidable expenditures for emergency and remedial health care. Health care providers, health care facilities, and all purchasers of health care, including the state, bear the costs of this uncompensated care.

Research reinforces the General Assembly's concerns. For example, a July 2007 report from the Department of Health Care Policy and Financing's (Department's) Medicaid Quality Improvement Section emphasizes the importance of children receiving regular and timely health maintenance visits to assess their physical and mental development and provide preventive care, such as immunizations. The report points out that identification and early treatment of potential developmental delays in children can prevent long term and costly disabilities and that management of chronic conditions can improve their quality of life and control long-term health care costs. A February 2007 study by Families USA, a national health care advocacy group, notes that ongoing health care improves a child's social and emotional development and ability to do well in school.

The General Assembly created CBHP to "support low-income, working parents and families in overcoming barriers in obtaining good quality, affordable health care services for their children." Each year the CBHP program provides critical health insurance coverage to low-income uninsured children and pregnant women. In Fiscal Year 2007, an average of more than 53,500 Coloradans were enrolled in CBHP each month who may otherwise not have had access to needed health care services.

The CBHP Act established CBHP as a private-public partnership. Within this partnership, the Department maintains the infrastructure of the CBHP program, in part by setting program goals and reporting on program effectiveness in accordance with state and federal requirements. The Department has partnered with public and private entities to carry out many of the day-to-day operations of

CBHP. For example, private contractors provide services such as eligibility determination, enrollment, marketing, and medical care, and county departments of human/social services process applications and determine eligibility. Notwithstanding this collaborative structure, the Department is ultimately accountable for effectively managing the operations and funding of the CBHP program in accordance with applicable laws and regulations, including:

- Assuring access to high-quality and appropriate covered services for children, including well-baby, well-child, and well-adolescent care; monitoring and treatment of chronic, complex, or serious medical conditions; adolescent immunizations; and emergency care, as required by State Children's Health Insurance Program (SCHIP) regulations [42 CFR 457.495], and

- Ensuring that the health services that low-income children receive through CBHP are cost-effective, of high quality, and promote positive health outcomes for enrolled children [Section 25.5-8-102, C.R.S.].

In order for states to assess and demonstrate the effectiveness of their SCHIP programs, federal regulations require states to establish program objectives. The Department has identified a variety of objectives related to CBHP in various documents and at different times, as shown in the following table.

Department of Health Care Policy and Financing
Department Objectives Related to the Children's Basic Health Plan
For Fiscal Years 2006 and 2007

Objective	Source/Date Established
To assure delivery of appropriate, high-quality care; design programs that result in improved health status for clients and improved health outcomes with a focus on preventive and early primary care treatment; and ensure responsiveness to the service needs of clients in a cost-effective manner.	Department's Fiscal Year 2006 and 2007 budget request documents;[1] 2005 State Plan Amendment.[2]
To decrease the proportion of children in Colorado who are uninsured.	2005 State Plan Amendment.[2]
To encourage employer-based coverage by implementing a pilot program for employer-sponsored insurance with two large employers by January 2007.	Department's Fiscal Year 2007 budget request document;[1] 2005 State Plan Amendment.[2]
To coordinate and consolidate with other children's health care programs to create a seamless health care delivery system for low-income children; offer health care services through the purchase of services in the most cost-effective manner possible; expand efficiencies, minimize waste, and eliminate discrepancies.	Department's Fiscal Year 2006 and 2007 budget request documents;[1] 2005 State Plan Amendment.[2]
To improve access to dental care for children.	2005 State Plan Amendment.
To decrease the rate of uninsurance among pregnant women and eligible infants and increase access to appropriate care for pregnant women and their children, including increasing immunizations for children.	February 2006 proposal for the prenatal waiver program, approved in September 2006.
To assure program payments are accurate and timely.	Department's Fiscal Year 2006 budget request document.[1]
To enhance customer satisfaction with program services and care; enhance provider and eligibility personnel's understanding of the program; and improve the usefulness of communications with clients, constituents, partners, and stakeholders.	Department's Fiscal Year 2007 budget request document.[1]

Source: Information from the Department of Health Care Policy and Financing.
Notes:
[1] We reviewed the strategic planning portion of the Department's budget request documents for Fiscal Years 2006 and 2007. Although some objectives may have been established prior to Fiscal Year 2006, this table indicates the earliest year for which the objective was identified in the budget documents we reviewed.
[2] This objective was included in the Department's original State Plan in 1998 and remained the same in the most recent State Plan amendment, which was effective July 1, 2005.

Both state and federal requirements call for the Department to evaluate its achievement of the CBHP objectives as well as the overall performance of the CBHP program. For example, in 2001 the General Assembly amended the CBHP Act to require the Department to "… develop and use quality assurance measures, such as the health employer data information set (HEDIS) … adapted to children's needs, to ensure that appropriate health care outcomes are met …" [Section 25.5-8-108, C.R.S.]. In addition, the federal Centers for Medicare and Medicaid Services (CMS) requires states to report on 10 core performance measures to evaluate the adequacy and appropriateness of health maintenance and treatment services provided by their SCHIP programs. CMS recommends, but does not require, that states use HEDIS to report on these core measures.

We evaluated the Department's objectives for CBHP and its processes for measuring and reporting on its progress in achieving the objectives. We identified concerns with the CBHP objectives themselves as well as with the

Department's mechanisms for assessing the program's overall performance to ensure that it contributes to appropriate health care outcomes and that the use of an average of more than $76 million annually in taxpayer funds for the last five years is justified, as required by statute [Section 25.5-8-108, C.R.S.]. These concerns are discussed in this chapter.

Access to Appropriate and Quality Care

One of the Department's objectives related to CBHP is to assure delivery of appropriate, high-quality care to improve the health status of clients served and improve health outcomes and ensure responsiveness to the service needs of enrolled clients in a cost-effective manner. To help evaluate its progress in achieving this objective, the Department contracts with Health Services Advisory Group, Inc., (HSAG), a health care quality review organization, to calculate a set of 13 HEDIS measures. HEDIS is a quality assurance tool developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization. HEDIS is used by both commercial and publicly funded health care plans to measure performance and help identify where improvement efforts are needed. Appendix B describes all the HEDIS measures the Department calculated and reported for Calendar Years 2004 through 2006.

Included in the 13 HEDIS measures the Department calculates are the 10 core performance measures that CMS requires states to report on each year. CMS intended the measures to allow states to evaluate their SCHIP programs and to motivate agencies, providers, and health plans to improve the quality of care delivered to SCHIP enrollees. These 10 core performance measures address the following three areas:

- **Well-Child Visits.** The Department calculates three measures in this area indicating the percentage of children in CBHP who had specified numbers of well-child visits with a primary care practitioner: (1) children who turned 15 months old but had **zero** well-child visits in their first 15 months of life (zero visits is an undesirable outcome); (2) children who turned 15 months old and had **six or more** well-child visits in their first 15 months of life; and (3) children aged 3 through 6 years who had **one or more** well-child visit(s) per year.

- **Use of Appropriate Medications for Children with Asthma.** The Department calculates three measures in this area indicating the percentage of children in CBHP who had persistent asthma and were appropriately prescribed medication: (1) children aged 5 to 9 years, (2) children aged 10 to 17 years, and (3) a combination of children aged 5 to 17 years.

- **Access to Primary Care Practitioners.** The Department calculates four measures in this area indicating the percentage of children in CBHP who had at least one visit with a CBHP primary care practitioner: (1) children aged 12 to 24 months, (2) children aged 25 months to 6 years, (3) children aged 7 to 11 years, and (4) children aged 12 to 19 years.

The following table shows the Department's HEDIS results for all 13 measures for Calendar Year 2006, the most current period for which the measures had been calculated at the time of our audit. The table also shows the national Medicaid 50th-percentile scores for each measure, which represents the median score for all Medicaid plans. The Department compares its HEDIS scores to this benchmark when reporting its quality review results. Appendix C contains the Department's HEDIS results for Calendar Years 2004 and 2005.

Department of Health Care Policy and Financing
Children's Basic Health Plan
Health Employer Data Information Set (HEDIS) Results
Calendar Year 2006

	HEDIS Measure[1]	State Managed Care Network	Colorado Access	Denver Health	Kaiser	Rocky Mountain HMO	Statewide Average	Nat'l HEDIS Medicaid 50th Percentile[5]
Well-Child Measures (Part of 10 Core Measures)								
1	Well-Child 0-15 mos. – **Zero** Visits[2,3]	14.2%	3.3%	NR[4]	NR[4]	NR[4]	9.5%	2.0%
2	Well-Child 0-15 mos. – **6 or More** Visits[3]	14.2%	50.0%	NR[4]	NR[4]	NR[4]	20.8%	50.0%
3	Well-Child Visits 3 to 6 yrs.[3]	40.8%	63.8%	62.0%	61.4%	61.9%	54.6%	64.8%
Access to Primary Care Practitioners Measures (Part of 10 Core Measures)								
4	Access to Primary Care (12 to 24 mos.)	79.4%	95.7%	NR[4]	97.0%	98.0%	87.9%	94.8%
5	Access to Primary Care (25 mos. to 6 yrs.)	68.1%	80.1%	83.1%	87.8%	86.8%	76.9%	85.4%
6	Access to Primary Care (7 to 11 yrs.)	85.3%	89.2%	85.3%	91.8%	88.8%	87.6%	84.9%
7	Access to Primary Care (12 to 19 yrs.)	86.9%	88.7%	86.0%	93.7%	90.6%	88.5%	83.4%
Asthma Measures (Part of 10 Core Measures)								
8	Asthma (5 to 9 yrs.)	NR[4]	100.0%	NR[4]	NR[4]	NR[4]	96.7%	90.2%
9	Asthma (10 to 17 yrs.)	87.5%	90.9%	NR[4]	NR[4]	NR[4]	90.8%	87.4%
10	Asthma (combined rate)	88.5%	94.5%	NR[4]	NR[4]	NR[4]	92.7%	87.1%
Adolescent Well-Care Measure (Department Selected Measure)								
11	Adolescent Well-Care Visits[3]	29.7%	48.0%	36.5%	51.3%	35.8%	39.9%	39.4%
Other Appropriate Treatment and Testing Measures (Department Selected Measures)								
12	Treatment – Upper Respiratory Infection	85.7%	88.1%	93.7%	95.5%	90.8%	88.0%	82.7%
13	Testing – Pharyngitis (sore throat)	61.7%	71.4%	85.5%	96.7%	78.3%	70.7%	56.2%

Source: 2007 Aggregate Report for Child Health Plan Plus Division issued by the Department of Health Care Policy and Financing.
Notes:
Shading indicates measures for which the State's results are worse than the national Medicaid 50th percentile.
[1] See Appendix B for a complete description of the measures.
[2] This is a negative measure. A score below the national Medicaid 50th percentile indicates the State performed better than the benchmark; a score above the percentile indicates performance worse than the benchmark.
[3] The State Managed Care Network and Rocky Mountain HMO used the "administrative method," which uses the health plan's full population of electronic claims to calculate these four measures. The other HMOs used the "hybrid method," which begins with the administrative method and validates the results through review of a sample of hard-copy medical records to calculate these four measures. All the health plans used the administrative method to calculate the other nine measures.
[4] For health plans with fewer than 30 children included in the measure, NCQA considers the sample to be too small to report, as indicated by "NR." The data for these measures are included in the calculation of the statewide weighted averages.
[5] The national HEDIS Medicaid 50th percentile represents the median score for all Medicaid health plans for each measure. The Department compares its HEDIS results with this percentile when reporting HEDIS measures.

Overall, these results indicate that the CBHP program is performing at or above the national Medicaid median on all of its optional measures (items 11 through 13 in the table) and on five of the core measures (items 6 through 10). However, the table also shows that the program's performance is falling below the Medicaid 50th percentile on the other five core measures (shown in the shaded portions of the table—items 1 through 5) which appears to indicate that the State's vulnerable population of children under the age of six may not be receiving the care they need. These results should prompt the Department to investigate the reasons for the apparently low performance. However, we found the Department has not analyzed the HEDIS data to investigate the results, identify areas in which the program needs to be strengthened, or evaluate questions about the performance of various plans, such as:

- Why the State Managed Care Network's (Network's) performance is significantly lower than the reported performance of the HMOs in the area of providing well-child care for children 0 to 15 months of age and access to primary care practitioners for children under 6 years of age.

- Why the Network's performance is substantially lower than that of the HMOs in providing appropriate testing for pharyngitis.

- Why there are large variances in the performance of the health plans on measures such as adolescent well-care and testing for pharyngitis.

The Department believes there are several factors that cause the Network's HEDIS results to be lower than those of the HMOs. The Department believes these same factors prevent any useful analysis of the measures to truly assess the performance of the program or determine where improvements are needed. The factors are described below.

Pre-HMO Period. All CBHP participants are initially served by the Network upon being approved for CBHP, but many move to an HMO within a few months of enrollment. The Department believes that, because many enrollees are temporarily served by the Network for up to several months before enrolling in an HMO (referred to as the pre-HMO period), the HEDIS measures do not capture all the enrollees who may have received services through the Network. In addition, some enrollees obtain medical services from non-CBHP providers between the time they submit their applications and the time they are approved for enrollment. The services they receive during this period are not reflected in the HEDIS measures. The Department does not know the extent to which the pre-HMO period affects the measures. Without further analysis, the Department also does not know whether other factors, such as the number of available providers, contribute to the variances.

Use of Different Methods to Calculate Some Measures. The Network and Rocky Mountain HMO used a different method than the other three HMOs to calculate 4 of the 13 HEDIS measures for Calendar Year 2006 (items 1 through 3, and 11 in the table above). For these measures, the Network and Rocky Mountain HMO used the *administrative method*, which determines the percentage of eligible enrollees who have received the measured service based on the full population of electronic claims, while the other HMOs used the *hybrid method*, which begins with the administrative method and validates the results through a review of hard-copy medical records for a sample of enrollees. The hybrid method is generally considered more accurate but is also more costly. The Department also believes the use of different calculation methods prevents the measures from being aggregated to produce an accurate statewide result. We contacted NCQA, which indicated that it considers measures to be comparable regardless of the calculation method used. Furthermore, this concern only applies to 4 of the 13 measures; for the remaining 9 measures, all the health plans used the administrative method.

Use of Unaudited HEDIS Process and Data for the Network Measures. The NCQA recommends that health plans conduct audits of their HEDIS data collection and reporting processes, as well as the data themselves, to ensure that the measures are determined in compliance with HEDIS technical specifications. The audits are designed strictly to review the information systems used to generate HEDIS data and the health plan's compliance with HEDIS standards; they are not meant to substitute for financial or compliance audits. The Department began requiring the HMOs to conduct NCQA audits for their 2005 HEDIS measures but has not implemented a similar requirement for the Network. Therefore, there is a risk that the Network's HEDIS data are less reliable. The Department believes the Network's unaudited data are less accurate than those of the HMOs and could account for some of the differences in the HEDIS results.

Any or all of these factors could have an impact on the accuracy of the HEDIS measures for the Network and, therefore, the Department's ability to use the measures as a true indicator of either the Network's or the CBHP program's performance. While the Department has been aware of these issues since the HEDIS measures were first calculated for Calendar Year 2004, the Department has only recently begun to address the problems. Specifically, beginning with the calculation of HEDIS measures in 2008 (using Calendar Year 2007 data), the Department is directing all the health plans to use the administrative method for all measures so they can be compared. However, the Department has not taken steps to address the issue of the Network's use of unaudited HEDIS data nor has it attempted to isolate the effect of the pre-HMO period on the Network's results. Given the nearly $104 million spent on the CBHP program in Fiscal Year 2007, the Department should investigate the costs and benefits of requiring an annual NCQA audit of the Network's HEDIS data. If the Department concludes that the cost of an NCQA audit of HEDIS data for the Network exceeds its current

resources, it should seek additional resources to cover the cost. Pursuing resources to have NCQA audits conducted for the Network's HEDIS measures is important because HEDIS is recommended in statutes and federal guidance, is nationally accepted as a reliable measurement method, and yields results that can be compared among health plans and states. Medicaid providers undergo NCQA audits of their HEDIS data for purposes of evaluating the Medicaid program. The Department should consider whether CBHP could benefit from these audits, which are already occurring. In addition, the Department needs to assess the extent to which the pre-HMO period affects the HEDIS measures. These steps are critical to maximize the usefulness of HEDIS for making program improvements.

According to the Department, another reason it has not analyzed the HEDIS results for CBHP is that none of the staff in the CBHP Division has the expertise to fully understand the HEDIS measures. The Division believes it needs more extensive knowledge about the meaning of the measures to analyze them appropriately and use them to inform program decisions. The Department is planning to merge the CBHP and Medicaid quality review contracts beginning in Fiscal Year 2009. According to the Department, Medicaid staff experienced in using HEDIS data will analyze the CBHP measures once this merger occurs. However, we believe it is important for the CBHP Division, which is responsible for administering CBHP, to remain involved in the quality review process to ensure that proper HEDIS measures are chosen for CBHP and that HEDIS results are used to improve the program.

Implementing consistent and reliable program measures, such as the HEDIS measures, and analyzing the results of the measures, are critical steps in ensuring that the CBHP program is making progress toward improving the health status of enrollees through the provision of appropriate and high quality health care. Understanding and using such measures to monitor the success of CBHP and improve program operations is a fundamental responsibility of the Department.

Recommendation No. 1:

The Department of Health Care Policy and Financing should improve its use of HEDIS measures to help ensure access to quality and appropriate care for CBHP enrollees by:

a. Assessing the costs and benefits of requiring the Network to undergo NCQA audits of its HEDIS data and seeking resources to cover the costs, if needed.

b. Continuing the requirement for all health plans to use the same method, either administrative or hybrid, to calculate all HEDIS measures if the Department continues to believe that the different methods make the results unusable.

c. Regularly analyzing the HEDIS results to assess the program's performance and identify needed improvements.

d. Using the analyses to formulate and implement changes to address deficiencies in the quality of and access to CBHP care.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation Date: July 2009. The Department will assess the costs and benefits of requiring the Network to undergo NCQA audits of its HEDIS data and will seek resources through the standard budgeting process if needed.

b. Implementation Date: January 2009. As recommended by HSAG, the CBHP External Quality Review Organization vendor, the Department will continue the requirement for all health plans to use the same method, either administrative or hybrid, to calculate all HEDIS measures. If at any point it makes sense for that requirement to be lifted, the Department will remove the requirement and inform the health plans. An assessment of the benefits of lifting this requirement will be completed by January 2009.

c. and d. Implementation Date: October 2008. CBHP will analyze results of the HEDIS measures annually to determine whether the CBHP program is making progress toward improving the health status of enrollees through the provision of appropriate and high quality health care. The contract manager(s) for the HMOs and Anthem (the Department's Administrative Services Organization, which is responsible for managing the State Managed Care Network) will use the HEDIS measures as well as additional information to monitor performance and identify needed improvements. The HMOs and Administrative Services Organization will be required to implement processes where improvement is needed, as indicated through the HEDIS data.

Network Adequacy

As mentioned at the beginning of the chapter, federal SCHIP regulations require that states assure access to all covered services for their SCHIP enrollees, and state statutes require the Department to ensure that the health services provided to low-income children through CBHP are cost-effective, high quality, and promote positive health outcomes. Ensuring an adequate network of CBHP providers is important to support the program's objectives of improving the health status of children and reducing the number of uninsured children in Colorado. While neither federal regulations nor state statute require CBHP to have specific network standards, federal and state requirements clearly make the Department responsible for ensuring the adequacy of the CBHP provider networks.

We reviewed the Department's practices for ensuring that CBHP provider networks are sufficient to serve the target population. Although the Department's contracts with each of the HMOs and with Anthem (for management of the Network) contain requirements for the health plans to maintain adequate provider networks, we found the Department does not monitor to ensure that the provider networks are sufficient to serve the CBHP population. First, we found that the Department does not assess the adequacy of a health plan's network when first contracting with the plan. According to Department staff, the Department relies on the licensing of health plans by the Division of Insurance in the Department of Regulatory Agencies to ensure the plans have adequate networks. Part of the licensing process involves an assessment of whether a health plan has appropriate network standards (e.g., member-to-provider ratios) for the county in which the plan intends to operate. However, the assessment associated with the licensing process does not address whether a network is adequate specifically for the CBHP program, which targets children. The Department should require health plans to provide detailed data on their existing or proposed networks for CBHP enrollees and eligibles. The Department should evaluate the data the health plans provide to assess whether their networks appear to have sufficient numbers of providers in each area to be served by the health plan before contracting with them.

Second, we found the Department is not monitoring the health plans on an ongoing basis to evaluate whether there are enough providers, particularly primary care practitioners, accepting new CBHP patients in all areas of the State. In February 2008 the Department submitted its first report to the General Assembly in accordance with a statutory requirement [Section 25.5-1-113.5, C.R.S.] to annually provide "data showing whether providers for children are participating in the [Medicaid and CBHP] programs and are accepting eligible children as patients on a regular basis." According to the report, for three of the five CBHP health plans, all providers were accepting new patients, while in the other two plans, 85 and 65 percent of providers, respectively, were accepting new patients. The report did not present data by region or type of provider (i.e.,

primary care or specialist). However, the Department does not routinely evaluate this type of information to determine whether enrollees in some plans may be encountering problems with finding a primary care provider to serve them and, therefore, that action is needed to improve access to primary care for current and future enrollees.

We conducted a summary-level analysis of information from the Department on the number of primary care providers in each health plan, the number accepting new patients, and the average number of enrollees in each plan. According to the information the Department provided, the ratio of providers to enrollees varies significantly among the plans. For example, some plans appear to have as few as 10 enrollees per primary care practitioner while others appear to have as many as 40. We also found that the proportion of primary care practitioners accepting new patients ranged widely; in some health plans all the providers were accepting new patients, while in others fewer than 60 percent were accepting new patients. Although this preliminary analysis is not sufficiently detailed to serve as a basis for program changes, it raises questions about whether all the networks serving CBHP are adequate and indicates a need for the Department to collect and analyze detailed network-adequacy data.

The Department's contracts with the HMOs and Anthem require the health plans to report provider information about each contracting physican (such as name, address, phone number, specialty, and whether the physician is accepting new clients) to Peregrine Management Corporation (Peregrine), a Colorado corporation that maintains databases of health care provider data for a variety of users. The health plans are required to report these data to Peregrine at least quarterly. The Department can then obtain reports from Peregrine that provide these details about each health plan's provider network. However, the Department has not used the data the health plans have reported to Peregrine in the last two years to evaluate the CBHP provider networks. We believe the Department should begin regularly obtaining and analyzing data from Peregrine on the provider networks of all the CBHP health plans, along with the number of enrollees by county, to identify potential inadequacies in the plans. The Department should also use these data, along with estimates of eligibles by county, to help ensure there is a sufficient number of providers for the program in the future. The Department could use these analyses to work with the health plans to recruit new providers, encourage the acceptance of new patients, expand the Network into underserved counties, or make other changes to improve the sufficiency of the networks as needed.

The SCHIP program in Kansas requires contracting HMOs to report the number of primary care providers per county and the number accepting new patients on a monthly basis. Kansas officials told us they use the reports to monitor trends. For example, if an HMO historically has 70 percent of its providers in a particular county accepting new patients, but the percentage begins to drop significantly in

the monthly reports, the program will work with the HMO to address problems and ensure the network remains adequate to serve the target population. The Department should develop a similar approach to help ensure that individuals enrolled in CBHP have access to services and that program objectives are met.

Recommendation No. 2:

The Department of Health Care Policy and Financing should improve its monitoring of network adequacy for the CBHP program by:

a. Requiring HMOs to provide information on their provider networks for the CBHP population, by county served, and evaluating whether the HMOs' networks are sufficient to serve the CBHP population, before contracting with the HMOs.

b. Regularly obtaining information from Peregrine about the provider networks of the CBHP health plans, such as the total number of providers in their respective networks serving CBHP enrollees and the number accepting new CBHP patients, by provider type and county.

c. Analyzing the data from Peregrine on an ongoing basis, along with information about the number of enrollees by health plan and county, to assess network adequacy. The Department should use these analyses to identify weaknesses in the networks and work with HMOs and the Network contractor as needed to address the weaknesses. The Department should also conduct analyses that include estimates of eligibles by county to help ensure there is a sufficient number of providers for the program in the future.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: October 2008.

a. and b. There is currently language in the CBHP contracts with the HMOs and Anthem (the Department's Administrative Services Organization, which is responsible for managing the State Managed Care Network) that, in addition to ad hoc requests from the Department for provider network reports, the HMOs and Anthem shall report the provider networks they maintain to Peregrine Management Corporation. This language will remain in the contracts. A new agreement is in process with Peregrine so that the HMO and Administrative Services Organization contract managers may have

access to the Peregrine system and be able to run reports as needed. At a minimum, the HMO and Administrative Services Organization contract managers will run network adequacy reports quarterly. Should any new HMOs look to contract with the CBHP program, they will be required to demonstrate network adequacy prior to contract execution. The Peregrine system will report on total number of providers, open panels, and provider type by county.

c. The Department agrees with the recommendation to use the number of enrollees when determining network adequacy. The CBHP Administrative Services Organization's contract manager will partner with the new Administrative Services Organization vendor to analyze enrollee data and create a report for the Department to evaluate and approve. Once the report has been approved, policies will be put into place to address any weaknesses that are found. The Department may utilize the same information if any new initiatives require future network development.

Program Penetration

To measure the CBHP program's performance in achieving the objective of decreasing the proportion of children in Colorado who are uninsured, the Department calculates a penetration rate for CBHP. The penetration rate is the proportion of eligible children who are enrolled in the program. In its annual reports to the General Assembly, the Department has indicated that the penetration rate has decreased from about 58 percent in Fiscal Year 2003 to about 51 percent in Fiscal Year 2007.

Although the penetration rates appear to indicate that the program has become less successful in enrolling eligible children over the period, we identified serious problems with the Department's methodology for estimating the number of children eligible for CBHP and accurately calculating the penetration rate. Because of these problems, the Department lacks meaningful data to demonstrate whether the program has been successful in enrolling eligible children into CBHP. To determine the reliability of the Department's penetration rate for CBHP, we conducted an in-depth review of this measure for Fiscal Year 2007. We focused on a single fiscal year because the Department does not have adequate documentation to support its calculation of penetration rates in prior years. Our analysis and results are described in the following sections.

Calculation of Program Penetration Rates

We hired a consultant familiar with SCHIP programs to assist us in evaluating the data, assumptions, and calculations the Department used to estimate the number of children eligible for CBHP in Fiscal Year 2007. Accurately and consistently estimating the number of children eligible for CBHP is a critical part of the penetration rate calculation. Below, we describe each step of the Department's methodology for estimating the number of CBHP eligible children, and we discuss problems we found with both the methodology and the underlying data. These problems seriously compromise the reliability of the estimates and the penetration rates calculated and reported by the Department.

Use of a baseline that cannot be validated. According to the Department, it began the process of estimating the number of children eligible for CBHP in 2007 with estimates of eligible children for each county from Fiscal Year 2002. However, the Department does not know the derivation of the 2002 figures. The staff member who calculated the 2002 figures is no longer with the Department, and the Department did not maintain documentation that supports the methodology or sources used. Using baseline data that is not documented or understood is a significant flaw in the Department's methodology that, on its own, completely undermines the reliability of the estimates.

Unsupportable adjustments to the baseline data. The Department's first step in estimating the number of CBHP-eligible children for 2007 was to adjust the 2002 baseline numbers for each county by a combination of the inflation rate, the individual county unemployment rates, and the rate of change in each county's population. However, the Department could not provide a reasonable rationale for these adjustments. For example, to determine the factor to use for adjusting the 2002 baseline for Denver County, the Department added together the inflation rate for 2006 of 3.6 percent, the Denver County unemployment rate for 2006 of 4.9 percent, and the rate of Denver County's population change between 2002 and 2006 of 12 percent, for a total of 20.5 percent. The Department increased the 2002 baseline estimate of 9,854 eligible children in Denver County by 20.5 percent as the first step in estimating the number of Denver county children who were eligible for CBHP in 2007. According to the Department, the inflation, unemployment and population-change rates serve as proxies for growth in the number of children eligible for CBHP. While we recognize that changes in these factors would likely affect the number of children eligible for CBHP, it is unclear that simply adding these percentages together and using the sum as a multiplier is an appropriate methodology to estimate the number of eligible children. Also, the Department could not explain why, for the inflation and unemployment rates, using the rate for a single year (2006) would lead to an equivalent change in, and therefore a reasonable estimate of, the number of eligible children over the course of five years (2002 to 2007).

Additionally, the Department did not maintain documentation of its source data. We independently obtained data on the 2006 inflation and unemployment rates in Colorado and on the population-change rates for Colorado counties between 2002 and 2006. We were able to verify the source of the unemployment and inflation rates the Department used in its estimate but could not match the population-change rates.

Subjective adjustments. After increasing the baseline figures for inflation, unemployment, and population change as described above, the Department added a subjective number of eligible children, ranging from 3 to 1,700, to the estimates for 23 counties. According to the Department, these additions were intended to account for changes in some counties that would not be reflected in any other adjustments. The example the Department provided was the construction of a new health care facility that could attract more CBHP-eligible children to a particular county. The Department was unable to explain or provide supporting documentation for the assumptions underlying any of the adjustments to the 23 counties.

County size adjustments. The final step in the Department's estimation of eligible children was to apply one of two percentages to adjust the county figures upward. The Department increased the figures for most small counties (under 30,000 in population) by 15 percent and those for most large counties (over 30,000 population) by 23.8 percent. However, the Department was not entirely consistent in applying the percentages, with three counties that have populations under 30,000 being increased by 23.8 percent. In addition, the Department indicated that it used a study conducted by the state of Virginia's SCHIP program as the source for these percentages. The study involved an in-depth analysis of Virginia's demographics for uninsured children. The Department could not explain how the Virginia study was relevant to estimating the number of CBHP-eligible children in Colorado.

Supervisory Review

The Department does not have an adequate supervisory review process to ensure the quality and accuracy of its methodology for estimating the number of children eligible for CBHP. According to the Department, various staff and managers review the estimates of eligible children before publication. However, the methodology errors we found indicate that this review is not sufficient to ensure the reliability of the process or the accuracy of the resulting estimates. The Department should implement a more rigorous review process by a staff member who is knowledgeable about the source data and methods used to estimate eligibles. The review should be sufficiently detailed to identify any errors in the data or calculations and should be completed before the Department uses or reports any results.

We recognize that estimating the number of children eligible for SCHIP is challenging for all states because limited data exist regarding the health status, family incomes, family sizes, and citizenship status of children in specific geographic areas (e.g., counties). In Colorado, estimating the number of eligible children in each county is further complicated by the small population of many counties, which makes estimates based on sample data (when data on the full population is not available) less reliable. However, using an accurate and consistent method to estimate the number of CBHP-eligible children is critical to evaluating the impact of the program and justifying the continued use of taxpayer dollars, as required by statute [Section 25.5-8-108, C.R.S.].

Because the Department's method for estimating the number of children eligible for CBHP is flawed, the Department is unable to accurately determine or report on the program's penetration rate, which is an indicator of its success in enrolling eligible children. The consultant we hired to assist us in our evaluation provided a number of suggestions for data sources and methods the Department could use to more accurately estimate the number of children in Colorado who are eligible for CBHP. The suggestions include the following:

- Use county population estimates from the U.S. Census Bureau to identify the number of children under age 19.

- Estimate the number of children under age 19 who are under 200 percent of the federal poverty level using data from an annual survey of a sample of households conducted by the Census Bureau. These data provide detail that will allow the Department to estimate the number of children, by age, who are under 100, 133, and 200 percent of the federal poverty level. This detail is important for accurate estimation because the income criteria for CBHP vary for different age groups (e.g, children under the age of six and under 133 percent of the federal poverty level are eligible for Medicaid while children under six and at or above 133 percent of the federal poverty level are eligible for CBHP.)

- Use the Census Bureau's monthly population survey to estimate the number of children who are uninsured.

The consultant also suggested that Department staff responsible for estimating the number of children eligible for CBHP would need to be knowledgeable in using these data sources. Alternatively, the Department could consider hiring a contractor with the requisite expertise. Finally, the consultant indicated that more detailed data will be available from the Census Bureau in the future due to changes in some of its survey methodologies.

The penetration rate is a fundamental measure of the success of the CBHP program and is used to make policy changes and funding decisions that can affect the public health care services available to uninsured children in Colorado. The Department needs to develop a new methodology to estimate the number of children eligible for CBHP as the initial step toward calculating a meaningful penetration rate to measure the program's success in enrolling eligible children into CBHP. The Department should consider the suggestions from the consultant as a basis for its methodology and ensure that the final method eliminates the problems we identified. In addition, the Department should maintain all documentation related to its estimates and calculations and implement a rigorous supervisory review process that ensures the integrity of information reported to management, the General Assembly, and the public.

Recommendation No. 3:

The Department of Health Care Policy and Financing should discontinue the use of the current methodology for estimating the number of children eligible for CBHP. The Department should improve its processes for measuring the effect of the CBHP program on uninsured children by implementing a system to obtain valid, reliable estimates of the number of children eligible for CBHP. The system should include:

a. Use of a reliable, accurate, and verifiable method to estimate the number of children eligible for CBHP that considers the suggestions and data sources identified by the consultant in this report.

b. Documentation of all source data and calculations, along with written descriptions of the methodology and the rationale for each element of the methodology.

c. Rigorous oversight of the methodology and results by a Department staff member who is knowledgeable about the source data and methods used in the estimation process. Review of the method and results should be completed prior to reporting results.

d. Regular analysis of the penetration rates to assess program performance, identify needed improvements, and inform decisions about marketing and outreach.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation Date: October 2008. The Department previously consulted with national experts and other resources to forecast the number of uninsured eligibles. The Department will utilize outside resources such as the Colorado Health Institute (CHI) to obtain data on estimated eligibles by county. CHI's constituents include state policymakers, health planners, the business and nonprofit communities, advocacy and consumer groups, health care providers, foundations, the media, and the public. CHI is a non profit organization established in 2002 by local health foundations that recognized the State's need for unbiased health information. CHI uses a reliable, accurate, and verifiable method to estimate the number of children eligible for CBHP and the Department will ask them to consider the suggestions and data sources identified by the consultant in this audit report. The Department will verify the method used by CHI to estimate the children eligible for CBHP. The Department has also received funds from a local foundation to conduct a household survey in 2008 that will provide point in time information about the number of uninsured Coloradoans and the number of people that might be eligible for public health insurance programs but not yet enrolled.

b. Implementation Date: October 2008. The Department will develop a partnership with CHI so that the methodology and the rationale for each element are clearly defined and documented. Department staff knowledgeable in this area will become familiar with the methodology and will, along with the CBHP Policy Analyst, maintain documentation of all source data and calculations, along with written descriptions of the methodology and the rationale for each element of the methodology.

c. Implementation Date: October 2008. The Department will assign two staff knowledgeable in the area to institute a rigorous review of the methodology and results. The review process will be completed prior to the Department using the numbers for any reason.

d. Implementation Date: April 2009. The CBHP Policy Analyst will analyze the penetration rates regularly to assess program performance and identify needed improvements. The Marketing and Outreach contract manager will analyze the data to make informed decisions about marketing and outreach.

Reporting Program Information

The Department reports various statistics about CBHP to the General Assembly and CMS each year. In addition, the Department reports CBHP data to others, such as special study groups and committees, when requested. These data can be used in making policy decisions about CBHP and other public health care programs. For example, the Advisory Committee (Committee) established by Senate Bill 07-211 is responsible for studying CBHP and Medicaid to develop a plan to provide health coverage for all low-income children in Colorado by the end of 2010. The number of CBHP enrollees, the estimated number of children eligible for CBHP, and the penetration rate are all crucial pieces of information for this Committee in assessing how far the State is from its goal and what solutions are needed to achieve the Committee's purpose.

As noted previously, we identified serious flaws in the Department's calculation of the penetration rate. We also found that data reported to CMS and policy makers was sometimes inconsistent, inaccurate, and unreliable for evaluating the success of the program or informing policy decisions, as described below.

Differences between state and federal annual reports. We reviewed the state and federal annual reports for 2006 and 2007 and found inconsistencies in the reported numbers of children eligible for CBHP, the numbers of children enrolled in CBHP, and the resulting penetration rate, as shown in the following table.

Department of Health Care Policy and Financing
Children's Basic Health Plan
Data Reported in State and Federal Annual Reports
Fiscal Years 2006 and 2007

	Number of Children		Penetration Rate
	Enrolled	Eligible	
2006 State Annual Report	46,800	97,000	48%
2006 Federal Annual Report	70,000	116,300	60%
Difference	**23,200**	**19,300**	
2007 State Annual Report	52,200	102,100	51%
2007 Federal Annual Report	83,200	173,600	48%
Difference	**31,000**	**71,500**	

Source: Information from the Department of Health Care Policy and Financing.

The enrollment numbers are different because the Department reports the number of unduplicated children "ever enrolled" in CBHP during the year in the annual federal report, in accordance with federal requirements, but reports an average number of children enrolled during the year in the state annual report. These differences in defining enrollment result in substantial differences in the number of enrolled children. However, the Department could not explain the variances between the state and federal reports in the reported number of children eligible

for CBHP. In addition, none of the reports explain the differences among the numbers reported.

Retroactive changes to eligibles reported in federal reports. The federal annual reports contain statistics for the current year and the two previous years. We found that in its Federal Fiscal Year 2007 report to CMS the Department retroactively increased the estimated number of CBHP-eligible children for 2005 and 2006 by about 54 percent and 46 percent, respectively. The Department could not explain why the figures that had previously been reported to CMS were changed or provide documentation to show how the revised numbers had been calculated.

Failing to ensure the accuracy of data and to explain differences among various reports may cause confusion and raise questions about the efficient and effective management of the program. As discussed above, adequate supervisory reviews are crucial to ensure that publicly reported information is accurate and understandable. This is particularly important at a time when health care costs are rising and health care issues are being debated locally and nationally. Groups such as the Senate Bill 07-211 Advisory Committee and the Senate Bill 06-208 Blue Ribbon Commission have been charged with studying health care issues and identify ways to expand health care coverage in Colorado. These types of groups may rely on the Department's reports to help make policy decisions. Confusing, inaccurate, or inconsistent data could impair their ability to make decisions based on appropriate data. The Department should ensure that reports contain accurate data and clearly explain any data variances before making them public or submitting them to oversight bodies.

Recommendation No. 4:

The Department of Health Care Policy and Financing should improve the accuracy and consistency of the data it reports about the CBHP program by:

a. Either using consistent definitions as the basis for reporting program data such as enrollment, eligibles, and penetration rates in all reports, or explaining in its reports the basis for any differences in reported data.

b. Improving its supervisory reviews of the data and methods used to determine and report program information, including enrollment statistics and penetration rates. Reviews should be conducted before reports are used by the Department or issued to oversight bodies, CMS, or the public.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation Date: April 2009. The Centers for Medicare and Medicaid Services (CMS) requires reporting data of enrolled CBHP members that the Department does not feel is useful for reporting program data for other purposes. CMS requires that the data reflect those CBHP members who were ever-enrolled (meaning a child enrolled for one week counts the same as a child enrolled for the entire month), as opposed to reporting members who were enrolled for at least one full month. The Department will review all definitions used as the basis for reporting program data in an effort to utilize the data most appropriately. An explanation will be provided in any report where a definition may vary across reports.

b. Implementation Date: Implemented and Ongoing. In March 2008, a process was put into place to have qualified Department staff knowledgeable in the subject area review all data and methods used to determine and report program information, including enrollment statistics and penetration rates. These reviews will be conducted before any reports are used by the Department or issued to oversight bodies, CMS, or the public.

Marketing and Outreach

The ultimate intent of marketing and outreach efforts is to help the CBHP program achieve its objective of reducing the number of uninsured children in Colorado. Federal regulations allow states to allocate funding toward SCHIP marketing and outreach. In recent years, the General Assembly has placed growing emphasis on marketing CBHP to increase awareness of the program and thereby the number of enrollees. In 2005 the General Assembly passed House Bill 05-1262 which annually appropriates $540,000 from state tobacco tax revenue specifically for "cost-effective marketing to increase the enrollment of eligible children and pregnant women in the children's basic health plan." During the 2008 Legislative Session, the General Assembly appropriated an additional $1.4 million for increased marketing and outreach for CBHP. According to the Department's November 2007 budget request, this appropriation is intended to be used for outreach efforts, which may include activities such as increasing the availability of applications at health care locations and increasing CBHP's presence at community events.

The Department has periodically contracted for marketing services since the inception of the CBHP program. The Department paid Maximus, Inc., about $2.7 million for Fiscal Years 2006 and 2007 for marketing and outreach services and is contracted to pay Maximus $1.3 million in Fiscal Year 2008. According to the contract, Maximus conducts activities such as: (1) maintaining a plan and methodology to monitor the effectiveness of the marketing and outreach campaign, (2) conducting quantitative and qualitative analyses of marketing effectiveness in relation to enrollment growth and retention, and (3) analyzing and reporting to the Department on a number of performance measures. Among the performance measures is a specific standard for evaluating marketing effectiveness: a requirement that Maximus increase the number of new CBHP applications submitted to the program by 20 percent annually through its advertising and public relations work. The Department retains the ability to review and approve all marketing messages, campaign media, and training materials prior to their use.

We evaluated the Department's oversight of Maximus' marketing and outreach efforts and found that the Department has not evaluated the extent to which Maximus is meeting its contract requirements to increase the number of individuals enrolled in the program. As a result, it is difficult for the Department to ensure that the investment in marketing and outreach has been cost-effective, as required by statute. We identified two primary reasons the Department cannot demonstrate the effectiveness of Maximus' marketing and outreach efforts. First, the Department does not provide data to Maximus to allow the contractor to fulfill its monitoring and reporting requirements under the contract. Specifically, the Department does not give Maximus data on the numbers of applications, new enrollments, or redetermination enrollments over any given period. Without these data, Maximus cannot assess its own compliance with contract requirements including: (1) monitoring the effectiveness of its marketing and outreach campaign, (2) quantitatively analyzing marketing effectiveness relative to enrollment growth and retention, or (3) meeting the standard of increasing application submissions by 20 percent each year. In addition, the Department has not analyzed application submission, enrollment, or re-enrollment trends itself. Maximus does provide routine reports to the Department on its marketing activities, such as number and type of advertisements run, estimated viewership/listenership, number of website hits, and number of outreach events held. For example, according to Maximus' June 2007 Marketing and Outreach Annual Report, each Coloradan saw or heard some type of CBHP advertisement (e.g., a television ad) about five times in Fiscal Year 2007.

We obtained and analyzed data from the Colorado Benefits Management System (CBMS) on the number of CBHP applications submitted in Fiscal Years 2006, 2007, and 2008 (through February 2008). According to the data, application submissions increased from about 72,200 in Fiscal Year 2006 to about 92,200 in Fiscal Year 2007, or about 28 percent, meaning that Maximus met its 20 percent

standard for increasing the number of applications submitted. Neither the Department nor Maximus was aware that Maximus had met this contract standard because the Department did not use the CBMS data to determine if the metric had been met, nor did it provide these data to Maximus so that it could assess and report to the Department on this standard. According to CBMS data for July 1, 2007 through February 29, 2008, if submissions continue at their present rate, the number of CBHP applications submitted in Fiscal Year 2008 will likely increase about 12 to 13 percent over Fiscal Year 2007.

The second reason the Department cannot fully demonstrate the effectiveness of Maximus' marketing and outreach is that the Department lacks a mechanism to identify whether Maximus' marketing campaigns have a direct impact on the increase in the number of applications submitted to the CBHP program. Currently neither the Department nor Maximus has a way to determine how applicants learn about CBHP or whether applicants submitted their applications in response to a Maximus marketing activity. The Department does require Affilicated Computer Services (ACS), which receives inquiries about the program, to ask first-time callers how they found out about CBHP and to provide this information to Maximus. ACS reported that, during the 11-month period from March 2007 through January 2008, ACS only received about 2,900 inquiries from first-time callers. In contrast, more than 92,000 new CBHP applications were submitted in Fiscal Year 2007. The data ACS collects from phone inquiries is not sufficient to provide either Maximus or the Department with representative and meaningful information on whether applicants are learning about the Program from Maximus' marketing and outreach efforts or from other sources.

The Department believes that Maximus' marketing and outreach efforts have been successful. For example, in CBHP's 2006 State Annual Report, the Department reported that from the time Maximus implemented its marketing efforts in April 2006 through June 2006, application submissions had increased by 30 percent. In addition, in the 2007 Federal Annual Report to CMS, the Department attributed the increase of about 13,000 children (or about 19 percent) in the unduplicated number of children "ever enrolled" in CBHP between 2006 and 2007 to "extensive marketing and outreach." It is possible that these increases in enrollment are related to Maximus' marketing and outreach efforts. However, the Department currently has no mechanism to prove these assertions.

To improve its oversight of Maximus and ensure that marketing and outreach are effective, the Department should begin routinely extracting application and enrollment data from CBMS and providing them to Maximus for use in evaluating and reporting on the overall effectiveness of marketing and outreach in increasing enrollment. According to the Department, a CBMS report was developed in January 2008 that will provide information on an ad hoc basis on the number of new applications submitted by county. The Department should provide this information, along with data on the number of new and

redetermination enrollments, to Maximus on a quarterly and/or semi-annual basis to allow Maximus to track and report on the success of its efforts. To enhance Maximus's ability to analyze and report its success, the Department should also provide county-level program penetration rates to Maximus once the Department implements a reliable and verifiable method to calculate the rate, as discussed previously. These data are important to help Maximus target its marketing strategies. For example, if certain counties have low penetration rates, Maximus may want to focus increased marketing or outreach toward those counties. In its 2007 annual report, Maximus stated that the lack of county-level data on application submissions, enrollments, and re-enrollments made it difficult to properly focus or evaluate the effectiveness of marketing and outreach efforts. Maximus also indicated that it would like to receive data on the number of new applications submitted by zip code. These data could help Maximus evaluate the success of particular marketing and outreach efforts in specific geographic areas.

In addition, the Department should establish a mechanism for more directly determining the extent to which Maximus' marketing campaigns are increasing application submissions. The Department could modify the application to ask applicants how they learned about the CBHP program (i.e., if they saw or heard a CBHP television or radio advertisement, encountered a CBHP brochure, visited CBHP's website, or heard about the program from a friend, community-based organization, or physician). Currently the application form does not ask for this information and CBMS does not have a data field to capture it, so the application form would need to be revised and a programming change made to CBMS. The change request would be considered along with other requests submitted by CBHP and the other public assistance programs that process eligibility through CBMS. Alternatively, the Department could conduct periodic surveys of applicants to collect information on how they became aware of CBHP. Although the Department currently receives some information from first-time callers to ACS, as discussed above, the Department could expand this effort to periodically survey CBHP applicants about what motivated them to apply for the program.

The Department needs to improve its mechanisms for overseeing its marketing and outreach contractor and ensuring that these efforts are cost-effective, as directed by the General Assembly. The Department's appropriation for activities such as marketing and outreach is increasing beginning in Fiscal Year 2009. Accordingly, it is increasingly important for the Department to ensure that marketing and outreach efforts are based on comprehensive, program-specific information, as described above, to maximize the effectiveness of marketing and outreach expenditures, and to meet program performance goals and objectives related to enrolling eligible children.

Recommendation No. 5:

The Department of Health Care Policy and Financing should ensure the effectiveness of marketing and outreach activities for CBHP by:

a. Working with the marketing and outreach contractor to identify key outreach-related data.

b. Extracting key data from CBMS including the number of new application submissions, enrollments, and re-enrollments, by county and/or zip code, on a quarterly or semi-annual basis.

c. Developing additional methods to collect data on results of specific marketing efforts to measure how applicants learned of CBHP and making changes to CBMS to record and report these data.

d. Providing the data described in Parts a through c, above, as well as the penetration-rate data described in Recommendation No. 2, to the contractor for use in evaluating marketing activities and modifying strategies, as necessary.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation Date: Implemented. The Department has worked with Maximus, Inc., and has identified key marketing-related data needs.

b. Implementation Date: September 2008. In April 2008, the Department implemented a series of reports that detail new application submissions, enrollments, and re-enrollments by county on a monthly basis. The enrollment by county report in the CBHP Annual Report has been used in the Marketing and Outreach Plans since the inception of the contract to target outreach efforts. The application submission by county report has been given to Maximus, Inc., and it is using the data to validate and realign marketing and outreach efforts, which will be reflected in the Fiscal Year 2009 Marketing and Outreach Plan. This plan is due September 2008.

c. Implementation Date: October 2009 depending on funding. The eligibility and enrollment contractor currently tracks how applicants heard about CBHP when they call the customer service number. The collected data are reported on a monthly basis to Maximus, Inc., and are used in planning efforts. The Department will implement a survey dependent upon funding, as a survey would require development, testing, printing, distribution, and follow-up analysis.

d. Implementation Date: December 2008. The Department has presented the contractor with the application submission and enrollment report by county and will do the same with the retention rate report when available.

Strengthening the Measurement System

Both state and federal requirements hold the Department accountable for ensuring that the CBHP program operates efficiently and effectively in accomplishing its purpose. As discussed earlier, under state statute and federal regulations the Department is given broad responsibility to ensure that CBHP offers high-quality, appropriate health care services that promote positive health outcomes. To fulfill this directive, the Department must have appropriate program objectives, measures that assess the program's success in achieving the objectives, and processes to analyze and use the measures to produce a cost-effective program that provides essential health care services to low-income children and pregnant women.

In reviewing the Department's CBHP objectives and measures, and its progress in accomplishing the objectives, we identified weaknesses in some of the objectives, as well as in the related measures and reporting of program results. In addition to the concerns discussed earlier in the chapter related to analyzing and using the HEDIS measures to evaluate progress in improving the health status and outcomes of clients, and the methodology used to calculate the CBHP penetration rate, we found that the Department could strengthen other areas of its measurement system for CBHP.

First, the Department has not established any way to measure or report on its progress toward the objective of improving access to dental care for children. This objective is directly related to a statutory requirement to provide dental care to children in the CBHP program, which became effective in January 2001.

Second, the Department has not provided required quarterly reports to CMS on the accomplishment of its objective to decrease uninsurance among pregnant

women and eligible infants and to increase access to appropriate care for pregnant women and their children through the prenatal waiver program. According to the Department, it has not yet established reports in CBMS to obtain data to measure its progress toward this objective. The average monthly enrollment in the prenatal program grew more than 230 percent between Fiscal Years 2003 and 2007 and the Department paid approximately $16.8 million for the prenatal program in Fiscal Year 2007. As such, it is important for the Department to measure and report on its achievements in ensuring access to appropriate, high-quality care in this program.

Finally, the Department has not established objectives or measures related to ensuring access to immunizations and emergency care. Federal regulations require that states have methods to assure access to these services. The Department should be evaluating access to these services to ensure that children and adolescents are receiving immunizations and appropriate emergency care and to comply with federal requirements.

Measuring program effectiveness is one of the most important responsibilities of management, particularly in programs that are publicly funded. Without targeted objectives and appropriate measurement and reporting processes, the Department does not have a complete picture of the quality and adequacy of the CBHP program and whether the statutory intent of the program is being met. The Department should strengthen its measurement system to require the collection and analysis of CBHP performance data related to all CBHP objectives and services and use the analysis in future initiatives to improve health care for low-income children.

As part of this effort, the Department should review its objectives to ensure they are relevant and, taken together, will demonstrate the overall effectiveness of CBHP and provide information needed for decision making. The objectives should be precise, measurable, related to outcomes the program can affect, and include key covered services. Once these objectives are established, the Department should develop measures to assess the program's performance against each objective. For example, the Department could consider using HEDIS measures to evaluate the program's success in meeting objectives related to dental care, prenatal care, immunizations, and emergency room visits. If the Department chooses not to use HEDIS measures for all these services, it needs to determine other appropriate means for collecting and analyzing the necessary data to measure performance and improve the program. Colorado's Medicaid program is working with the University of Colorado (University) to obtain information from the University's immunization database to determine the percentage of children in Medicaid who have received their immunizations. The Department should consider expanding this effort to include CBHP enrollees. Regardless of the approach used, the Department must develop a comprehensive and effective

system for monitoring, reporting on, and improving the performance of the program and ensuring public monies are well spent.

Recommendation No. 6:

The Department of Health Care Policy and Financing should strengthen its objectives, measures, and reporting for CBHP to help ensure access to quality and appropriate care for enrollees and fully comply with state and federal requirements by:

a. Ensuring its objectives are targeted to the program, are measurable, and are clearly tied to key health care services delivered through CBHP. This should include services to which the Department is specifically required to assure access under federal regulations.

b. Establishing measures that reflect the program's progress in accomplishing each objective.

c. Routinely analyzing the measures to identify program weaknesses and develop and implement solutions to address such weaknesses.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation Date: Preliminarily August 2008 and ongoing. The Department is already engaged in the process of developing and ensuring its objectives are targeted to the program, are measurable, and are clearly tied to key health care services delivered through CBHP, including access to services required under federal regulations.

b. Implementation Date: Preliminarily August 2008 and ongoing. The Department will establish measures that reflect the program's progress towards each objective.

c. Implementation Date: April 2009 and ongoing. The Department will periodically analyze the measures to identify weaknesses and address such weaknesses.

Eligibility and Enrollment

Chapter 2

In accordance with the statutory design of the Children's Basic Health Plan (CBHP) as a private-public partnership, the Department of Health Care Policy and Financing (Department) partners with private and public entities for a variety of services. With respect to eligibility determination and enrollment, the subject of this chapter, the Department partners with counties and two medical assistance sites – Denver Health and Affiliated Computer Services (ACS)—to serve as eligibility sites which determine CBHP eligibility and enroll participants. The Department also contracts with ACS to collect enrollment fees and disenroll participants when they are no longer eligible for the program. Regardless of these arrangements, the Department retains ultimate accountability for CBHP, including ensuring that eligibility determinations and enrollments are accurate, timely, and conducted in accordance with federal and state laws and rules.

A key component in the Department's oversight of eligibility determination and enrollment should be a comprehensive monitoring program. The Department's monitoring of public and private partners is fundamental to ensuring that public funds are spent effectively to accomplish the CBHP program's purpose of providing health care for eligible uninsured children. Statutes specifically state that the Department must monitor the contractors that carry out administrative duties for CBHP and supervise county departments of human/social services for effective administration of medical assistance programs [Sections 25.5-8-111 and 25.5-1-114, C.R.S., respectively].

We reviewed the Department's monitoring of its public and private partners and found that, overall, the Department lacks a comprehensive monitoring program for CBHP. First, the Department conducts almost no monitoring of eligibility screening practices at eligibility sites or of its contractor's processes to disenroll individuals who are no longer eligible for CBHP. Due to the lack of monitoring in these areas, we identified significant eligibility-determination and disenrollment error rates in the samples we tested, which resulted in questioned costs totaling about $133,600 in our samples. We expanded our testing in areas where we identified eligibility-determination and enrollment problems which resulted in the identification of an additional $24,100 in questioned costs. Therefore, the total questions costs we identified based on our sample testing and expanded reviews is about $157,700.

Second, the Department has provided inadequate oversight to ensure timely determination of eligibility and proper handling and recording of enrollment fees, leading to delays in eligible individuals being able to access services and problems with processing of fees. Third, the Department has not monitored the retention of participants in the program to determine why a significant proportion of individuals do not re-apply for CBHP. Finally, the Department has not ensured that the implementation of the federal Deficit Reduction Act of 2005, as it affects CBHP enrollment, complies with federal requirements. Failure to comply could result in disallowances of some expenditures for federal reimbursement. We discuss these concerns in detail in this chapter.

Eligibility Determinations

According to federal regulations for State Children's Health Insurance (SCHIP) programs, the Department must design its screening and enrollment procedures to allow only eligible individuals to participate in the program. To be eligible for CBHP, all applicants must meet specific income guidelines. Additionally, federal rules prohibit the Department from enrolling applicants who are eligible for Medicaid, have third-party insurance, or are children of state employees.

To apply for public medical assistance in Colorado, including CBHP, families and individuals submit joint Medicaid/CBHP applications either to their local county department of human/social services or to one of the two medical assistance sites (collectively referred to as eligibility sites). Upon receipt, the eligibility sites review each application for completeness and enter the information into the Colorado Benefits Management System (CBMS). CBMS processes the applicant's eligibility information for both Medicaid and CBHP simultaneously, and eligibility workers review and approve the eligibility determinations. Since the end of Fiscal Year 2004, when enrollment caps were lifted, CBHP has been able to enroll all applicants who are determined eligible each year. During Fiscal Year 2007, the CBHP program spent about $96 million on medical services for a monthly average of about 1,300 pregnant women and 52,200 children.

We reviewed state, county, and medical assistance site practices to evaluate the State's overall compliance with CBHP eligibility-determination requirements. In addition to reviewing both of the medical assistance sites, we selected a sample of seven counties of various sizes and in different geographic regions of the State. We then chose a sample of applications for 203 applicants that had been processed by the seven counties and two medical assistance sites. We chose the sample of applicants from a list of all individuals enrolled in CBHP at some point between July 1, 2006 and March 31, 2007, including both pregnant women and children. In our review of applications, we found eligibility determination errors or insufficient documentation to support the eligibility decision for 21 of the 203 applicants (10 percent) in our sample, leading to questioned costs of about

$24,200. For some applications, we identified multiple errors. We expanded our testing related to the applicants for whom we identified eligibility-determination errors to review payment information through September 30, 2007. As described in detail below, we identified about $24,100 in additional questioned costs from our expanded testing, resulting in total questioned costs due to eligibility determination errors of $48,300 related to the sample of applications we reviewed. The exceptions we identified primarily resulted from staff errors at the eligibility sites.

Eligibility-Determination Errors. We identified eligibility-determination errors for 17 applicants in our sample. Of these 17 applicants, 16 were not eligible for CBHP but were erroneously enrolled in the program. The remaining applicant was eligible for CBHP but was erroneously denied enrollment. We list the specific errors that occurred with respect to these 17 applicants below:

- Five applicants did not meet all the program requirements for CBHP. One applicant's family income exceeded the CBHP income limits, one applicant was ineligible due to having private insurance coverage, and the other three applicants were ineligible because they are children of a state employee. In the first case, CBMS erroneously indicated that the applicant was eligible for CBHP. In the second case, the eligibility worker did not enter the family's private insurance into CBMS. In the last three cases, the eligibility workers did not enter information into CBMS regarding one parent being a state employee. Between July 1, 2006 and March 31, 2007, the Department made payments totaling about $10,100 for these ineligible individuals. We reviewed further payment information through September 30, 2007 and found the Department made additional payments between April 1 and September 30, 2007 of about $1,800 for these ineligible enrollees.

- Eleven applicants had family incomes that were low enough to qualify them for Medicaid but were instead enrolled in CBHP. For seven of these applicants, eligibility workers incorrectly entered income data into CBMS that was higher than the incomes the families reported on the applications. For the remaining four cases, the information in CBMS matched the information in the applications, indicating that the errors were not caused by eligibility workers incorrectly entering data. Therefore, it appeared that CBMS incorrectly indicated that the applicants were eligible for CBHP. Between July 1, 2006 and March 31, 2007, the Department made CBHP payments totaling about $12,200 for these 11 ineligible enrollees. Of these 11 enrollees, 5 also had incomplete applications, as discussed in the next section. We reviewed further payment information through September 30, 2007, and found that the Department made additional payments between April 1 and September 30, 2007 of about $14,300 for these ineligible enrollees.

- One applicant in our sample met the requirements for the CHP+ at Work program but was erroneously denied enrollment. Under this pilot program, the Department pays a portion of the health insurance premiums for children whose parents meet CBHP income-eligibility guidelines and are employed by a participating employer. CHP+ at Work applications are not processed by CBMS so, in this case, the eligibility worker incorrectly denied the applicant.

We informed the Department and the county departments of these errors during our review. The Department reports that it disenrolled all the ineligible CBHP recipients we found and enrolled those who were eligible for Medicaid into that program. In addition, the Department enrolled the one child who was eligible for CHP+ at Work and paid the child's family $500 to cover medical insurance premiums for the five months when the child should have been enrolled in the pilot program, but was not.

Lack of Documentation. For 9 applicants in our sample of 203, the application files were missing key documentation to support the information in CBMS and therefore the eligibility decision. For four of the applicants, the files did not contain their applications or any documentation showing the families' incomes. Federal regulations require states to "include in each applicant's record facts to support the State's determination of the applicant's eligibility for SCHIP." The Department made payments totaling about $1,900 between July 1, 2006 and March 31, 2007 for these four individuals. We reviewed further payment information through September 30, 2007 and found the Department made additional payments between April 1 and September 30, 2007 of about $8,000 for these ineligible enrollees. For the remaining five applicants, files showed the families met the income qualifications for Medicaid, but the applications were missing pages or required signatures. Payments for these five applicants for the same time period totaled about $6,700. We reviewed further payment information through September 30, 2007 and found the Department made additional payments between April 1 and September 30, 2007 of about $1,500 for these ineligible enrollees. These amounts are included in the questioned costs for the 11 applicants who qualified for Medicaid, discussed above.

The high number of errors identified in our sample indicates a need for the Department to take comprehensive steps to improve practices at counties and medical assistance sites and reduce eligibility-determination and documentation errors. Specifically:

- **Monitoring and follow-up.** The Department has not historically monitored eligibility sites to ensure that they screen applicants for CBHP in accordance with federal and state laws and rules. Recently, the Department has initiated efforts that involve monitoring CBHP eligibility decisions. First, in 2007 the Department included reviews of a sample of

CBHP files as part of its Medicaid Eligibility Quality Control (MEQC) review. The Department conducted reviews of two samples of CBHP files in 2007 (one sample of 46 files in May and one of 58 files in December) to evaluate the accuracy of eligibility determinations and the adequacy of program documentation within MEQC. Second, in July 2008 the Department will complete its first review of a statistical sample of about 700 randomly selected CBHP case files as part of the new federally required Payment Error Rate Measurement (PERM) program. This review, required every three years, checks eligibility files and payments for compliance with program requirements. To obtain the maximum benefit from these monitoring programs, the Department will need to: (1) target eligibility sites with high volumes of applications and compliance problems, (2) review recent files and data to assess current practice patterns, (3) determine the frequency of eligibility site reviews necessary to provide adequate and ongoing oversight, (4) analyze the results, and (5) implement corrective action plans for eligibility sites with eligibility-determination errors and make changes to CBMS to correct any processing errors.

- **Training and technical assistance.** The Department currently works with the Department of Human Services to provide twice-yearly trainings on all public assistance programs (e.g., Food Stamps, Temporary Assistance to Needy Families, Medicaid, and CBHP). In addition, the Department offers webcasts, holds monthly informational meetings, and issues letters to eligibility sites to communicate program changes. Although the trainings and correspondence provide important basic information about the purpose and requirements for CBHP, the Department could improve its training and technical assistance related to determination of CBHP eligibility. Specifically, the Department should train county and medical assistance site staff on CBMS income calculations and eligibility criteria. Staff at all seven of the county departments we visited reported that they are not familiar with the income levels that qualify families for Medicaid or CBHP or that trigger annual CBHP enrollment fees and, therefore, do not assess whether CBMS' calculations and eligibility results appear accurate or reasonable. In addition, the Department should provide focused training on specific problems identified through its monitoring programs, including the MEQC and PERM processes.

- **Quality/Supervisory Review.** The seven county departments of human/social services we visited, and the two medical assistance sites, all have some type of quality-review process. The processes involve supervisors or other workers reviewing a sample of files to assess whether data were correctly entered into CBMS and eligibility determinations were made properly. However, given the errors we found, these quality

reviews do not sufficiently ensure accurate data entry and eligibility determinations. The Department should ensure that counties and the medical assistance sites have adequate quality or supervisory review processes to ensure accurate eligibility determinations.

In Fiscal Year 2007, a total of almost $104 million in public funds was spent on the CBHP program. Ensuring that only eligible individuals are enrolled is a critical aspect of responsible program management. At the same time, enrolling all applicants who are eligible is fundamental to accomplishing the program's purpose of providing health care for eligible uninsured children and pregnant women. Since state and federal funds for CBHP are limited, it is crucial for the Department to monitor eligibility-determination practices at eligibility sites to ensure that monies are spent appropriately for only those individuals who are eligible for services.

Recommendation No. 7:

The Department of Health Care Policy and Financing should reduce eligibility-determination errors for CBHP by improving oversight and training of eligibility sites. Specifically, the Department should:

a. Expand efforts to establish a comprehensive program for monitoring the CBHP eligibility-determination process. The program should identify and target high-volume and high-risk eligibility sites, compare case files with information in CBMS, focus on identifying and addressing eligibility sites with high error rates and recurring problems, and follow up with corrective action plans and changes to CBMS, as appropriate.

b. Expand CBHP training and technical assistance provided to eligibility sites to target the key issues identified through the Department's monitoring program. The training should include information on CBMS income calculations and other processes for determining eligibility.

c. Require eligibility sites to improve their quality/supervisory review processes to ensure that workers correctly enter data into CBMS and review and approve CBHP eligibility determinations.

d. Investigate to determine the causes of the CBMS errors identified in the audit and modify CBMS as needed to correct the errors.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation Date: November 2008. As mentioned in the audit report, the Department has conducted and now completed two Medicaid Eligibility Quality Control (MEQC) pilot studies (reviewing a total of 104 CBHP files in the two studies) and conducted 709 CBHP eligibility reviews as part of the Payment Error Rate Measurement (PERM) Program. This has been part of the Department's monitoring program established in Fiscal Year 2007. The eligibility pilot studies directly compared case files with the information in CBMS and focused on identifying and addressing issues with high error rates and recurring problems. The results of the eligibility pilot studies will be sent to the eligibility sites and will allow the eligibility sites the opportunity to analyze and trend information and develop effective and meaningful quality improvement plans as necessary. It is expected that quality improvement plans will be in place by late fall 2008. It is important to point out that county departments of human/social services may not have the resources to implement such quality improvement plans uniformly. The Department will need additional resources to focus and continue a robust look at the CBHP eligibility determination process. The Department will request resources through the standard budgeting process.

b. Implementation Date: Ongoing. The Department is reviewing the current trainings and expanding these trainings as issues are identified either through formal monitoring or other avenues such as feedback from the eligibility sites. Income miscalculation has already been identified as an area with a high error rate through the Department's eligibility pilot studies referenced above. To improve accuracy, entry of income is taught in CBMS trainings prior to the user having access to the system. There have also been Knowledge Transfer calls, ongoing CBMS training classes, and ad hoc trainings continuously offered to users. In addition, training on entry of income was conducted at the Social Services Technical and Business Staff conference in April 2008. The Department will continue to assess the need for further training on data entry of income.

c. Implementation Date: January 2009. The Department will work with County Departments of Social/Human Services to implement a quality improvement plan related to data entry accuracy. It is important to point out that county departments of human/social services may not

have the resources to implement such a quality improvement plan uniformly. It is expected that the Department will implement this procedure by September 2008 and that counties will operationalize their quality improvement plans by January 2009. The Department will continue to require medical assistance sites to have quality improvement plans to monitor data entry accuracy.

d. Implementation Date: July 2008. The Department will investigate and determine the cause of the four errors identified as CBMS errors in the audit and take necessary corrective action. The investigation will be completed in July 2008.

Timeliness of Processing Applications

Monitoring the timely processing of CBHP applications is important for ensuring eligible children and pregnant women have prompt access to health care services. An October 2007 report by the Kaiser Family Foundation (a nonprofit health policy, communications, and research organization) indicates that when individuals do not have insurance coverage, they may forego preventive and routine health care and instead seek services for serious and catastrophic medical conditions in emergency rooms.

To facilitate timely processing, federal regulations generally require states to make CBHP eligibility decisions within 45 days of the submission date of the application. If additional documentation is needed to complete the application, CBHP policies allow applicants an additional 14 calendar days to provide the documentation. If the applicant owes an annual enrollment fee (due from CBHP-eligible individuals with family incomes over 151 percent of the federal poverty level), the state CBHP rules extend the deadline an additional 30 days to allow time for the applicant to supply the payment. During Fiscal Year 2007, about 92,200 CBHP applications were processed in Colorado.

When an eligibility site receives a CBHP application, eligibility workers are expected to enter information from the application into CBMS immediately. CBMS processes the applications and the eligibility worker approves the eligibility determination. CBMS then generates notices to inform the applicants that they: (1) have been approved for CBHP, (2) have been denied for CBHP, or (3) must provide additional documentation and/or an enrollment fee before the eligibility determination can be completed. For applications that lack documentation, eligibility workers are responsible for updating CBMS and either enrolling applicants who submit the required documents or denying those who do not submit their documents within the 14 calendar days permitted. For applications that require an enrollment fee, ACS workers are responsible for

updating CBMS and enrolling applicants who pay their enrollment fees or denying those who do not pay their enrollment fees within the 30 days permitted. Enrollment-fee processing by ACS is discussed in more detail later in this chapter.

We reviewed the timeliness of CBHP application processing by eligibility sites to determine whether the Department ensured that eligibility decisions were made in accordance with federal and state deadlines. Overall, we identified significant delays in processing CBHP applications. Additionally, we found the Department lacks sufficient monitoring controls or data to fully determine the proportion of CBHP cases that do not meet application processing timelines or the reasons for processing delays. These delays may prevent eligible applicants from receiving needed medical services and they create a risk of federal sanctions against the State for noncompliance with federal regulations.

We analyzed the timeliness of eligibility determinations for CBHP by reviewing a sample of applications and weekly "Exceeds Processing Guidelines" (EPG) reports generated by CBMS. We identified eligibility-determination delays in both samples, as explained below:

- **Applications.** We reviewed a sample of 86 applications for individuals who were enrolled in CBHP and had submitted new applications (i.e., not redetermination applications) during the nine-month period covering July 1, 2006 through March 31, 2007. We compared the application submission dates with the dates the eligibility workers approved the eligibility determinations. We found that 8 of the applications (9 percent) were processed late, between 16 and 91 days after their deadlines had passed.

- **EPG reports.** We reviewed a sample of 13 weekly EPG reports for the period July through September 2007. These reports list every CBHP application that was entered into CBMS but that has been pending (i.e., eligibility has not been determined) for more than 45 days. The average number of pending applications on the 13 weekly reports we reviewed was about 1,900. This represents about 2 percent of the approximately 92,200 CBHP applications processed annually. According to the sample of EPG reports we reviewed, an average of about 5 percent of the total applications on the reports were more than a year old. The applications listed on the EPG reports could be pending due to eligibility sites not completing the processing of the applications timely or to applicants not providing required documents or enrollment fees timely.

In addition to reviewing the application and EPG report samples, we interviewed staff at seven counties and the two medical assistance sites about their application processing practices. Two of the counties reported that, due to heavy workloads,

they often are unable to immediately enter CBHP applications into CBMS to begin the eligibility-determination process. Rather, these counties sometimes did not begin entering the applications into CBMS for at least two to three months after the application submission dates, resulting in the eligibility determinations being delayed for at least two to three months. The Department has no way to identify or track the number of applications that are not processed timely due to eligibility sites not entering the applications into CBMS. These applications are in addition to those reflected in the Department's EPG reports.

The Department provides the weekly EPG reports to the eligibility sites and several Department staff monitor them and work with the eligibility sites to resolve the pending applications. This monitoring is intended to help reduce the number of pending applications. However, we found that the Department lacks basic statistics tracking the proportion of applications processed timely, the proportion of applications processed late, and the reasons why some applications are still pending. Pending applications stay in CBMS until an eligibility worker manually identifies and investigates them and determines whether each should be approved or denied. Therefore, it is possible that documentation or fee payments for some of the applications on the EPG reports have been received, but the eligibility site has not updated CBMS to reflect their receipt. As we discuss later in the chapter, we found that ACS (one of the eligibility sites) does not always enter the receipt of enrollment fees into CBMS in a timely manner, which could account for some of the pending applications on the EPG reports.

We raised similar concerns about the timeliness of CBHP application processing in our Fiscal Year 2006 and 2007 Statewide Single Audits. Additionally, a July 2007 review of CBMS by the federal Centers for Medicare and Medicaid Services (CMS) noted that "the significant proportion of applications [the Department reports as] exceeding the regulatory timeframes for processing do not reflect … effective and efficient administration [and] … the delay in processing time can delay access to medical care considerably and cause delays in provider payments." The Department needs to improve its monitoring procedures so it can develop strategies to effectively correct timeliness problems and ensure that eligible individuals are able to access services in a timely manner.

First, the Department needs to improve reporting from CBMS so it can compile basic statistics on program performance in terms of timely eligibility determinations. This should include generating information on the percentage of applications processed timely and processed late, by county and medical assistance site. For applications processed after required deadlines, the Department should obtain aging statistics to measure the extent of processing delays.

Second, the Department should identify eligibility sites that have backlogs of CBHP applications, enrollment fees, and documentation that have not been

entered into CBMS. The Department should work with these sites to determine whether additional training or technical assistance could help reduce backlogs and improve the timeliness of application processing. To help eliminate the current backlog, the Department could consider expanding its eligibility and enrollment contract on a temporary basis to process more applications until the backlog is eliminated. Similarly, if the counties receive too many applications on an ongoing basis to process on time, the Department could consider expanding the eligibility and enrollment contract on a permanent basis. In Fiscal Year 2007, the Department paid ACS a total of about $4 million to process medical assistance applications. Expanding the contract will generate additional costs for the Department but may prevent the Department being assessed penalties by the federal government for failing to comply with federal requirements.

Recommendation No. 8:

The Department of Health Care Policy and Financing should improve its monitoring of application processing for CBHP by eligibility sites to ensure eligibility decisions are made timely, in accordance with federal and state rules and guidelines. Specifically, the Department should:

a. Develop reports in CBMS and compile statistics on program performance with respect to timely processing of applications. The statistics should include the proportion of applications processed timely or late, and the aging of delayed applications.

b. Work with the eligibility sites to investigate the underlying factors contributing to processing delays, including the reasons CBHP applications, supporting documentation, or enrollment fees have not been entered or processed in CBMS.

c. Further target training and technical assistance to address the underlying problems of late processing.

d. Consider the costs and benefits of expanding the eligibility and enrollment contract on either a permanent or temporary basis to reduce backlogs at the eligibility sites.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation Date: December 2008. The Department has implemented a series of CBMS reports, and in April 2008, made modifications to them that detailed the number of applications processed timely or late, and the aging of delayed applications by county or medical assistance sites on a monthly basis. These reports can be further modified to include the percentage proportion of timely versus late applications processed to conform to this audit finding by December 2008.

b. Implementation Date: January 2009. The Department has formed an eligibility quality team that will be identifying new methods for improving timely processing and will look at the underlying factors contributing to processing delays.

c. Implementation Date: January 2009. The Exceeding Processing Guidelines Unit offers technical assistance routinely to assist with cases truly exceeding processing guidelines. Based on the information obtained from the Department's recently completed eligibility pilot studies, which had a focus on timely processing and other relevant data, training or technical assistance will be conducted. This will be part of the focus of the eligibility quality team.

d. Implementation Date: July 2009. The Department will analyze the costs and benefits of expanding the scope of work in the CBHP eligibility and enrollment contract to reduce backlogs at county eligibility sites. This analysis will be conducted after a contract is awarded in March 2009. If the Department finds that it is cost effective to expand the contract to include this function, the Department will seek additional resources to support this recommendation through the standard budgeting process.

Program Retention

Children are eligible for CBHP for 12 months and families must reapply and have their eligibility redetermined annually for their children to continue to receive benefits under the program. The Department, through CBMS, sends redetermination applications to families about 80 days prior to the date on which their 12-month enrollment period expires. Families are instructed to return their completed applications to ACS. The redetermination process only applies to children in CBHP; pregnant women remain eligible for the program from the time they are enrolled until 60 days post-partum and do not undergo the redetermination process.

We found that the Department does not adequately oversee the redetermination process to promote program retention. The Department does not analyze information on program retention or calculate retention rates for the CBHP program. The Department has not determined the retention rate for CBHP since Fiscal Year 2004, before CBMS was implemented, because CBMS was not programmed to produce a routine report on CBHP retention. In addition, the Department does not have any mechanisms to determine why some enrollees do not reapply for CBHP.

To determine the current retention rate for CBHP, we obtained CBMS data from the Department on the approximately 32,000 children who were due for redetermination at some time between April 1, 2006 and March 31, 2007. We found that about 39 percent of the enrollees (about 12,600 children) reenrolled in CBHP without any lapse in coverage, about 26 percent (about 8,200 children) enrolled in Medicaid, and about 11 percent (about 3,400 children) were determined ineligible for either CBHP or Medicaid. The remaining 24 percent of children eligible for redetermination (about 7,800 children) either did not reapply for the program or experienced a lapse in their coverage. Specifically:

- About 16 percent of those eligible for redetermination (about 5,300 children) did not reapply for the program. There is no information indicating whether these children no longer needed CBHP coverage or if they remain uninsured. We determined that none of these children had either reenrolled in CBHP or enrolled in Medicaid as of March 31, 2007.

- About 8 percent of those eligible for redetermination (about 2,500 children) were reenrolled in CBHP but had a lapse in coverage of up to six months because their families sent in new applications after coverage had ended instead of submitting the redetermination application by the deadline.

It is concerning that almost one-quarter of the enrollees we reviewed either did not reapply at all or reapplied late, causing lapses in coverage, and that the Department has not been analyzing retention data to identify these problems. Research suggests that people without health care or with gaps in coverage are less likely to seek medical care and may use more expensive options when care is needed. For example, according to a 2007 report issued by the Colorado Children's Campaign, families that lose CBHP or Medicaid coverage are likely to become uninsured, which shifts the costs of health care services to other programs and private payors. The report estimated that Colorado's almost 180,000 uninsured children cost local, state, and federal governments and the private sector about $79 million annually, in part due to families seeking care through providers such as community health centers and emergency rooms, which are often more costly than being served through Medicaid or CBHP.

The application process used for redeterminations may contribute to problems with retention in CBHP, as described below.

Redetermination Application. We reviewed the redetermination application packet and found that it appears to include multi-purpose instructions that relate to more than just the CBHP program. As a result, the instructions are not clear about what documentation enrollees must submit to reapply for CBHP or what information they need to report while enrolled. For example, the instructions contain conflicting information about whether CBHP enrollees must provide documentation proving their household circumstances, income, age, or citizenship. According to CBHP rules, applicants may attest to their citizenship and the only documentation required is evidence of income, such as pay stubs. The rules do not require other documentation, such as for age or other household circumstances. Also, the application directs applicants to report any changes in their circumstances that occur after they submit their redetermination applications, but it does not specify what changes must be reported. According to CBHP rules, enrollees remain in the program for 12 months unless they obtain other insurance coverage or move out of the State, so these are the only changes in circumstance a CBHP enrollee must report.

Many of the community-based organizations and advocacy groups we contacted, including the Colorado Center on Law and Policy and the Colorado Coalition for the Medically Underserved, expressed concerns about the redetermination process. They reported hearing that families are often confused by the term "redetermination" and require help with completing the redetermination application. Complaint data maintained by ACS and the Department's marketing contractor reflected the same confusion. For example, one family complained to ACS saying:

> Neither my wife nor I could understand the [CBHP redetermination] letter we were sent. We are relatively intelligent people and we literally could not understand what the letter said. . . . We are one catastrophic illness away from homelessness. Please streamline the process.

Redetermination Reminders. The Department's contracts with ACS for Fiscal Years 2006 through 2008 have required the contractor to send reminder postcards to families 45 days before their enrollment lapses. The contract specifically states that this requirement is conditional on "the creation of the necessary report from CBMS or a reasonable substitute." To date, no reminder postcards have ever been sent because the Department has not developed a function in CBMS to identify only families that have not reapplied by the date the postcards would be sent (i.e., 45 days before eligibility expires). We believe that developing such a function is unnecessary. CBMS already has a report to identify families that need to receive redetermination applications; the same report could be used to send out

the reminders. The postcards could instruct families to disregard the reminder if they have already reapplied. If the Department chooses not to use the current report in CBMS it should expedite the development of a new function to allow ACS to begin sending reminders as soon as possible.

The Department should improve its oversight of the redetermination process by analyzing and monitoring program retention and encouraging eligible families to reapply. These efforts could include periodic surveys, focus group meetings with enrollees, or review of existing research to identify why some families do not reapply for the program or reapply late, and why they do not always use their redetermination applications. The Department could use the results of these mechanisms to address weaknesses in the redetermination process. The Department should also clarify the redetermination application and begin sending reminders as soon as possible. Finally, the Department could consider methods used by other states' SCHIP programs, such as sending multiple reminders, contacting families by phone, asking providers to remind their patients, and issuing monthly newsletters that contain reapplication reminders.

Recommendation No. 9:

The Department of Health Care Policy and Financing should improve the redetermination process and improve retention for the CBHP program by:

a. Routinely calculating program retention rates and analyzing data on program retention.

b. Modifying the redetermination application to clarify the requirements for documentation and reporting of changes in circumstances. The Department should further assess the redetermination application for any additional changes to make it more user-friendly.

c. Beginning to send reminders to families regarding the submission of their redetermination applications as soon as possible.

d. Considering the use of periodic surveys, focus groups, or review of existing research to identify barriers to reapplication, as well as other methods to remind families to reapply, such as those used by other SCHIP programs.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation Date: July 2008. CBHP will develop a process to use data to evaluate retention. CBHP is currently researching other State's Children's Health Insurance Programs' retention rates to help determine the most appropriate retention oversight for Colorado. Efforts to develop a process will begin July 2008.

b. Implementation Date: May 2009. The Department will work with the Department of Human Services to modify the CBMS generated client notice regarding redetermination requirements for documentation and reporting of changes in circumstances.

c. Implementation Date: May 2009. The Department is working with the Department of Human Services to automatically generate a notice to clients (households) when information in CBMS shows that a redetermination application packet has been generated but not returned. The notice will specifically state that the client will lose benefits unless the packet is returned before the redetermination due date. Additionally, in September 2008 the CBHP health plans will begin to receive the renewal due date for members in the enrollment information that is sent to them daily. The health plans will assist the Department in supporting members to complete and return the renewal packets.

d. Implementation Date: October 2009. The Department's marketing and outreach contractor, Maximus, Inc., has conducted focus groups to evaluate outreach and marketing efforts and barriers to applying and re-applying. With adequate funding, additional focus groups and/or surveys may be developed and analyzed.

Disenrollment Procedures

According to federal and state law, children are eligible for the CBHP program until they reach 19 years of age and pregnant women are eligible until 60 days after the end of the month in which they give birth. ACS is responsible for disenrolling all CBHP participants once they are no longer eligible for the program; CBMS is not programmed to automatically disenroll children once they reach 19 years of age or pregnant women at the end of their 60-day post-partum period. For both women and children, ACS staff must manually enter certain data into CBMS to disenroll individuals who are no longer eligible. To disenroll a woman from the CBHP prenatal program, ACS must enter the date on which she gave birth (typically provided by the woman or the provider) into CBMS. CBMS then schedules the disenrollment to occur 60 days following the end of the month in which she gave birth. To disenroll children who have reached the age of 19,

ACS uses a monthly report from CBMS that lists all CBHP enrollees whose 19th birthdays occur in that month and manually disenrolls each one.

We reviewed procedures for disenrollment and found that many women are not being disenrolled when their 60-day post-partum period has ended and some children are not being disenrolled when they turn 19. As a result, the Department makes payments for enrollees who are not eligible for CBHP. We estimate that, during the 22-month period covering January 1, 2006 through October 31, 2007, the Department made payments totaling at least $109,400 for enrollees after their eligibility for CBHP had expired. This amount is a questioned cost. The problems we found with disenrollments are described below.

Late Disenrollments from the Prenatal Program: We found significant problems with women not being disenrolled from the CBHP prenatal program on time. We reviewed a CBMS report of all women who remained enrolled in CBHP more than 60 days post-partum over the 22-month period between January 1, 2006 and October 31, 2007 and found that 831 pregnant women were not disenrolled on time. Over the same period, an average of about 1,300 pregnant women were enrolled in the CBHP prenatal program each month. We found these 831 women remained enrolled for between 1 and 24 months, or an average of more than 4 months, after their eligibility had ended. We estimate the Department made payments totaling about $104,300 for these 831 women after they should have been disenrolled from CBHP. Although our review indicates that a significant number of women were not disenrolled on time, the report does not capture all of the women for whom payments may have been made after their eligibility had ended. We found the Medicaid Management Information System (MMIS) may make payments for participants even after they are disenrolled in CBMS because the interface between CBMS and MMIS does not always communicate disenrollments to MMIS.

Late Disenrollments for Children: To determine whether children were being disenrolled from CBHP upon reaching 19 years of age, we requested data from MMIS on enrollees aged 19 and older who were in the program at some point between January 1 and July 31, 2007. Since children are only eligible for CBHP until they reach the age of 19, there should not be any enrollees who are 19 or over, except women in the prenatal program. We only included enrollees in the State Managed Care Network (Network) because MMIS has an edit that prevents payments for enrollees aged 19 and older who are in an HMO. MMIS does not have the same edit for enrollees in the Network, which serves all women enrolled in the prenatal program, because such an edit would prevent payments for all eligible pregnant women aged 19 or older. The MMIS data listed 54 enrollees who were not pregnant women but were 19 years of age or older at some point during the six-month period we reviewed. During this same six-month period, there was an average of about 54,340 children enrolled in CBHP each month. We found the 19-year olds were enrolled for between 1 and 10 months, or an average

of almost 3 months, after their eligibility had ended. We estimate the Department made payments totaling about $5,100 for these 54 individuals after they should have been disenrolled.

The Department should review the 885 cases discussed above (the 831 pregnant women and the 54 children) and ensure that all of these ineligible enrollees have been properly disenrolled. The Department should also identify and recover any inappropriate payments for these ineligible individuals.

The Department does not have performance standards in its contract with ACS requiring timely or accurate disenrollment of individuals who are no longer eligible for CBHP. In addition, we found that the disenrollment reports ACS provides to the Department each month in accordance with contract requirements contain significant errors. These monthly reports show: (1) the number of new disenrollments due for processing (e.g., for children, the number turning 19 years of age), (2) the number of disenrollments actually processed, and (3) the number of disenrollments outstanding at the end of the month (i.e., not yet disenrolled). We reviewed a sample of the monthly reports from July 2006 through March 2007 and found substantial errors in eight of the nine reports. In general, the numbers of disenrollments due for processing, the numbers processed, and the numbers outstanding did not track from month to month. As a result, the reports are useless for monitoring the accuracy and timeliness of disenrollments. Neither the Department nor ACS could explain the errors. Furthermore, because the Department does not review the reports or conduct any other oversight of the disenrollment process, it was unaware that many pregnant women and some 19-year-olds were not being disenrolled from CBHP on time.

The Department should work with ACS to develop accurate monthly reporting on disenrollments. The Department should then review these monthly reports for reasonableness and accuracy and require ACS to explain in each month's report any outstanding disenrollments. Further, the Department should periodically run and review CBMS reports that list all post-partum women and 19 year olds who have not been disenrolled as a control to ensure that disenrollment processes are operating as intended.

In August 2007, we notified the Department of the disenrollment problems we found. Since our notification the Department reported that it:

- Directed ACS to begin using different information in the existing CBMS report on all children who are 19 years of age or older each month, when disenrolling children. This will help ensure that if ACS failed to disenroll a child during the month of his or her 19th birthday, ACS can identify those children and disenroll them in a subsequent month. This change was made in September 2007.

- Plans to further modify CBMS to automatically disenroll children and pregnant women once their eligibility has expired. These automatic changes will replace the manual disenrollment process for which ACS is currently responsible and are scheduled to begin in May 2008.

- Plans to modify CBMS and MMIS to move information on the enrollment period of each enrollee from CBMS to MMIS. This will enable MMIS to manage the CBHP enrollment periods for CBHP as it does currently for Medicaid. The Department has not determined when this change will occur.

Given the significant error rate identified by our audit and the high cost of serving individuals in CBHP when they are not longer eligible, we encourage the Department to expedite the planned CBMS and MMIS changes. These improvements are particularly important for pregnant women, since we found that the Department's manual disenrollment method did not consistently disenroll the women in a timely manner. Until these changes are in place, there is an ongoing risk that the Department is paying for ineligible enrollees and may be subject to repayments to the federal government.

Recommendation No. 10:

The Department of Health Care Policy and Financing should ensure ineligible women and children are properly and timely disenrolled from CBHP. Specifically, the Department should:

a. Review the 885 individuals identified during our audit who were not disenrolled on time, ensure any ineligible individuals identified through the review have been properly disenrolled, and review and recover payments made for the ineligible individuals.

b. Strengthen efforts to ensure that, until the planned changes to CBMS and MMIS are fully implemented and working properly, participants are disenrolled from CBHP as soon as their eligibility ends. This should include modifying the contract with ACS to include performance standards for timely and accurate disenrollments, monitoring and enforcing ACS' compliance with the performance standards, identifying and actively monitoring individuals due for disenrollment, and working with ACS to improve the accuracy of disenrollment reports.

c. Prioritize changes to MMIS and CBMS to ensure disenrollments occur timely and accurately in the future.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation Date: June 2008. The Department has already begun review of the 885 clients identified in the audit. It is anticipated that it will be completed by June 2008. The Department continues to review recovery of any improper claims paid.

b. Implementation Date: September 2008. The new CBHP eligibility and enrollment contract effective September 1, 2008 will include performance measures for the timely and accurate disenrollment of ineligible members. The contract manager will monitor performance carefully.

c. Implementation Date: May 2008. Currently a CBMS generated alert informs the CBMS technician to run eligibility review results, and authorize the resulting termination from the appropriate CBHP program for these clients. CBMS Change Request 1890 is scheduled to be implemented by May 2008. The implementation of this change request provides functionality that if the alert has not been resolved in ten days after the alert date, the system will automatically run the eligibility determination calculation for these clients and authorize the termination from the appropriate CBHP program. No changes are required to the Medicaid Management Information System (MMIS) for this recommendation.

Enrollment Fees

As mentioned earlier, one of the functions ACS, the Department's eligibility and enrollment contractor, is responsible for is the collection and deposit of CBHP enrollment fees paid by applicants and the posting of payments into CBMS. Under CBHP rules, families whose incomes exceed 150 percent of the federal poverty level pay an annual fee of $25 for one child or $35 for two or more children before their children can be enrolled in CBHP. Pregnant women are exempt from the enrollment fee requirement.

Families can pay their enrollment fees by: (1) mailing payments to a designated bank lockbox, (2) mailing payments to ACS, or (3) bringing payments in person to the ACS office in Denver. Payments mailed to the lockbox are automatically deposited into the Department's CBHP bank account, and the bank furnishes ACS

a daily listing of all amounts received and deposited. Payments mailed to ACS are recorded in a receipt log by mailroom staff, and payments received from families who bring their fees to ACS in person are recorded on a multi-copy cash receipt, one copy of which is given to the payor. The ACS receptionist uses the mailroom receipt log and the multi-copy receipts to create deposit slips; these payments are deposited into the Department's CBHP bank account. The ACS receptionist is also responsible for entering all enrollment-fee information into CBMS, regardless of whether the payment was made to the bank lockbox or to ACS by mail or in person. In Fiscal Year 2007, the Department collected about $232,000 in CBHP enrollment fees.

Proper handling and recording of enrollment-fee collections is important for two reasons: to ensure state assets are safeguarded and to ensure eligible applicants are enrolled into CBHP and therefore able to receive program services. If an applicant pays the CBHP enrollment but the fee is not recorded in CBMS, the applicant will not be enrolled in the program and will be unable to access services.

We reviewed ACS policies and procedures for collecting, depositing, and recording enrollment fees into CBMS. In addition, we reviewed the Department's oversight of the CBHP bank account and of ACS's responsibilities related to enrollment fees. We found that neither ACS nor the Department has adequate controls in place to ensure that all enrollment fees are deposited into the bank and properly recorded in CBMS. As a result, there is a risk that enrollment fees may be lost or misappropriated. There is also a risk that program participants could be denied services, even in cases where they have paid the annual fee. In addition, because of the lack of controls over enrollment-fee information posted to CBMS, there is a risk that an applicant who is required by program rules to pay an enrollment fee could be enrolled without having paid the fee.

Lack of controls over receipt of fees and information recorded in CBMS. We performed testing in two ways to assess whether effective controls were in place to ensure all fees paid were deposited in the bank and posted to CBMS and that only applicants who had paid the enrollment fee were entered into CBMS. We found the following problems.

- **Enrollment fee received but not recorded in CBMS.** To determine if all enrollment fees paid to ACS were recorded into CBMS, we attempted to match 1,109 payments listed on ACS's May and June 2007 deposit slips to enrollment-fee information in CBMS. Out of these 1,109 payments, we were unable to locate within CBMS or otherwise resolve 62 of the payments (6 percent). Therefore, although these 62 applicants had paid the enrollment fee, they were at risk of being denied CBHP services. According to data maintained by Maximus, the Department's marketing contractor, between July 2006 and March 2007 six applicants complained

that they had paid their enrollment fees but were denied services because there was no record in CBMS of their payments. As we discuss in Chapter 3, the Department does not have a comprehensive method for recording or compiling complaints related to CBHP, so data are not available to determine how many complaints of this nature have occurred.

- **Enrollment fee recorded in CBMS but no record of deposit.** We also attempted to determine if all enrollment fees recorded in CBMS were deposited into the Department's bank account. We compared fees recorded in CBMS during May and June 2007 with enrollment fees listed on ACS deposit slips and on lockbox reports from May through July 2007. We were unable to locate deposit information or otherwise account for 312 of the 1,342 fee payments (23 percent) logged into CBMS in May and June 2007. ACS and Department staff report that these discrepancies could be caused by staff entering payment records into CBMS multiple times. Until March 2008, payments were sometimes recorded in CBMS more than once as a temporary fix to a CBMS processing problem. In any case, the inability to track all enrollment fees entered into CBMS back to deposit records means there is a risk that some enrollment fees were not deposited into the Department's CBHP bank account. Alternatively, there is the possibility that applicants are being improperly enrolled into CBHP when they have not paid the annual enrollment fee.

These problems result from neither the Department nor ACS performing routine reconciliations to ensure all fees are deposited into the bank account and appropriately recorded in CBMS. First, the Department does not reconcile its bank statements with ACS deposit records and bank lockbox records, nor does it reconcile enrollment-fee receipts with payments logged into CBMS. Second, ACS does not routinely reconcile enrollment-fee receipts and logs with deposit slips for those fees mailed or brought into ACS.

Since January 2007 ACS has had a policy in place that requires monthly reconciliations of the enrollment fees received with enrollment fees deposited. According to the Department and ACS, during 2005 and 2006 ACS was unable to account for about $2,000 in enrollment fees, and this policy was intended to help prevent such problems in the future. We requested copies of all ACS's reconciliations between January 2007, when the policy became effective, and August 2007. We found that ACS had only conducted four monthly reconciliations during this eight-month period—in March, May, June, and July 2007. Further, we reviewed the March 2007 reconciliation and found two problems. First, the reconciliation was conducted by an ACS staff member who had access to both the safe where the cash, checks, and money orders are stored, and to the payment logs and deposit records. Appropriate segregation of duties requires that an individual performing a reconciliation be independent of the receipt, processing, and recording of payments. Second, the reconciliation was

not complete. Out of the 325 payments received during the month, there were 115 instances (35 percent) in which the receipt and deposit records did not match. ACS did not document how these discrepancies were resolved. ACS staff indicated that all the discrepancies were addressed, but without documentation, we could not confirm the resolution.

ACS reports that the May, June, and July 2007 reconciliations were conducted by an employee who had no involvement with collecting, recording, or depositing enrollment fees. We reviewed these reconciliations and found that they included documentation showing that all discrepancies had been resolved.

Lack of controls over handling of receipts. We observed ACS procedures for logging and securing enrollment fees on two separate occasions in May and July of 2007 and reviewed deposit records for all ACS deposits of CBHP fees in Fiscal Year 2007. During our observations we found that cash, checks, and money orders were stored during the day in an unlocked drawer accessible to numerous individuals instead of in a secure location, such as the safe that ACS maintains for this purpose. Failure to log and secure fees immediately on receipt increases the risk that monies can be lost or stolen. Additionally, our review of deposit records revealed that enrollment-fee collections were typically being deposited only once or twice a month, further increasing the risk of loss or misappropriation. According to ACS policies as well as good business practices, all CBHP enrollment fees should be deposited daily.

The Department has not established adequate controls over the collection of CBHP enrollment fees or the posting of fee information into CBMS. The Department should conduct monthly reconciliations to ensure all enrollment fees paid are deposited into the bank and entered into CBMS, and that CBMS reflects payments only for those who have paid the enrollment fee. In addition, the Department needs to improve its oversight of ACS to ensure that ACS has adequate controls over enrollment fees. The Department should strengthen its contract with ACS to require that the contractor: (1) implement cash-control policies and procedures that include keeping payments secured at all times, (2) log all payments into CBMS and deposit them daily, (3) perform and document regular monthly reconciliations of enrollment-fee receipts and logs with deposit slips and resolve all discrepancies in a timely manner, and (4) maintain adequate segregation of duties. In addition, the Department should periodically perform reviews of the contractor to verify compliance with these requirements and take corrective action if necessary.

Recommendation No. 11:

The Department of Health Care Policy and Financing should strengthen controls over the handling and safeguarding of CBHP enrollment-fee collections and information recorded into CBMS by:

a. Amending the contract to require the eligibility and enrollment contractor to establish and follow specified cash-control policies and procedures, particularly with respect to securing and depositing enrollment fees in a timely way, posting enrollment-fee information to CBMS promptly, completing timely and fully documented monthly reconciliations between fees received and deposits, and maintaining segregation of duties.

b. Periodically verifying that the contractor follows through in all areas and taking corrective action if necessary.

c. Performing monthly bank reconciliations to ensure all enrollment fees paid are deposited into the CBHP bank account and that CBMS fee records are accurate and complete. The Department should work with the contractor to resolve all discrepancies.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: September 2008.

a. The Request for Proposal that was issued for the eligibility and enrollment contract February 8, 2008 included language requiring specified cash control policies. The new contract to be effective September 2008 will include specific language with respect to securing and depositing enrollment fees in a timely way, posting enrollment fee information to CBMS promptly, completing timely and fully documented monthly reconciliations between fees received and deposits, and maintaining segregation of duties.

b. The contract manager will periodically verify that correct procedures are being followed and take corrective action as necessary. This verification process will include conducting site visits to ensure that procedures are being followed correctly. This process will be implemented with the new contract to be effective September 2008.

c. The contract manager will perform monthly bank reconciliations beginning September 2008 to ensure all enrollment fees paid are deposited into the CBHP bank account and that CBMS fee records are accurate and complete. The contract manager will work with the contractor to resolve all discrepancies.

Requirements of the Deficit Reduction Act

The federal Deficit Reduction Act of 2005 (Act) requires individuals to provide citizenship and identity documents when applying for certain public or medical assistance programs. Examples of required documents include an original birth certificate and a copy of a driver's license with photo issued by a U.S. state or territory. Under the Act, these documentation requirements apply to Medicaid applicants but not to SCHIP applicants. However, the Act can indirectly affect SCHIP programs. For example, when the Department implemented the Act for the Medicaid program in July 2006, it began enrolling Medicaid-eligible applicants into CBHP if they did not provide the required documents within the Department's deadlines.

The Centers for Medicare and Medicaid Services (CMS) issued an interim rule to implement the Act effective July 6, 2006 and a final rule on July 13, 2007. The final rule clarifies how the Act affects separate SCHIP programs such as Colorado's, stating:

> A Medicaid application is not complete without the submission of all documentation, including documentary evidence of citizenship and identity… ***it is not permissible under federal regulations to enroll a potentially Medicaid eligible child into a separate SCHIP program pending submission of citizenship and identity documents necessary to complete the Medicaid application process.*** [Emphasis added].

CMS conducted a review of the CBHP program in July 2007 and found that "Colorado's current practice of enrolling Medicaid eligible children into SCHIP while awaiting Deficit Reduction Act documentation violates Medicaid screen and enroll requirements" and requested a corrective action plan. To correct the violation, the Department made a temporary change to its procedures, effective January 1, 2008, as well as a permanent change effective April 1, 2008. Under the temporary change, the Department extended the deadline for Medicaid applicants to provide identity and citizenship documents but still enrolled applicants into CBHP if they did not provide the documents by the deadline. The permanent change was to entirely discontinue the practice of enrolling any Medicaid-eligible individual into the CBHP program in cases where the applicant

does not provide the citizenship and identity documentation required for Medicaid.

It appears that the Department's permanent changes, effective April 2008, may comply with CMS' final rule. However, we question whether the Department's procedures from July 2007 through March 2008 (the period between the final rule becoming effective and the Department implementing its permanent corrective action) were compliant because the Department continued to enroll Medicaid-eligible individuals into CBHP if they did not provide the citizenship and identity documents required for Medicaid. Therefore, all claims and capitated payments paid on behalf of Medicaid-eligible individuals enrolled into CBHP while the temporary procedure was in place, from July 2007 through March 2008, are potentially questioned costs.

To determine the effect of the Department's procedures for implementing the Deficit Reduction Act on the CBHP program after the final rule went into effect in July 2007, we analyzed data from ACS on the approximately 17,200 joint Medicaid/CBHP applications it processed for the seven-month period covering July 1, 2007 through January 31, 2008. According to the information ACS provided, about 1,500 met all the Medicaid eligibility criteria but were enrolled into CBHP because they did not provide required documents within the Department's deadline. On average, ACS processes about 16 percent of all joint applications submitted in Colorado each year, so these figures do not represent the total number of Medicaid-eligible individuals potentially enrolled in CBHP. Because the other eligibility sites, such as the counties, do not keep records on the numbers of Medicaid-eligible individuals enrolled into CBHP due to lack of citizenship and identity documentation, we were not able to determine the impact of the Department's temporary procedures on CBHP enrollment statewide for the period reviewed.

In its October 2007 corrective action plan to CMS, the Department stated that it had "no documentation that any claims [for federal reimbursement] have been made incorrectly." As of March 2008, CMS had not notified the Department whether the corrective action plan was acceptable. According to the Department, the lack of response from CMS indicates acceptance of the plan. The Department should continue to work with CMS to ensure the corrective action plan and the procedures that went into effect in April 2008 are acceptable.

Recommendation No. 12:

The Department of Health Care Policy and Financing should ensure its procedures for approving applicants for CBHP are consistent with federal regulations by continuing to work with the Centers for Medicare and Medicaid

Services (CMS) to ensure the corrective action plan, including both the temporary and permanent procedures for implementing the Deficit Reduction Act as it affects CBHP, is acceptable.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: Ongoing. The Department will continue to work with the Centers for Medicare and Medicaid Services to ensure the corrective action plan is acceptable.

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Program Management and Oversight

Chapter 3

As discussed throughout the report, the General Assembly designed the Children's Basic Health Plan (CBHP) as a private-public partnership and specifically authorized the Department of Health Care Policy and Financing (Department) to deliver services and manage program functions through private contractors and public partners. As such, the Department has structured its role around managing the CBHP program's infrastructure and providing oversight of and accountability for the many services and functions delegated to contractors, county departments of human/social services, and medical assistance sites. The CBHP private-public partnership model, as implemented by the Department, significantly elevates the importance of the Department's oversight function. The model requires that the Department have a systematic and robust method for overseeing contractors and other organizations that carry out the operations of CBHP to make sure they perform in compliance with applicable requirements and that eligible children and pregnant women receive quality services within available funding.

Throughout the audit we found indications of an overall lack of proactive and effective management of the CBHP program. For example, Chapter 1 raised concerns with the Department's objectives for CBHP and its methods for measuring the program's success in accomplishing the objectives. These objectives are related to the underlying intent of the program to provide medical insurance coverage and access to health care services to low-income children and pregnant women. Chapter 2 noted problems with the Department's oversight to ensure that key functions—such as eligibility determination, enrollment, and disenrollment—are carried out in an accurate and timely manner. These problems create a risk that eligible children and pregnant women will not receive health services in a timely way and that payments will be made for ineligible individuals. Finally, this chapter discusses weaknesses in two of the Department's principal responsibilities with respect to the CBHP program: managing the contractors that essentially administer the program and using data to improve program performance. This chapter also discusses problems with the Department's fraud and abuse detection and investigation mechanisms and complaints management for CBHP.

Contract Management

Consistent with the statutory intent of utilizing a private-public partnership to operate CBHP, the Department contracts for a wide range of administrative services, including: (1) application processing, eligibility determination, and enrollment services; (2) marketing and outreach; (3) quality review; (4) rate setting; and (5) management of the State Managed Care Network (Network). In Fiscal Year 2007 the Department spent an estimated total of about $12.8 million on contract payments for these administrative services. In contrast, we estimate the Department spent about $2.3 million in Fiscal Year 2007 for its administration and oversight of CBHP.

Because CBHP is essentially administered by contractors, contract management is fundamental to ensuring the program operates efficiently, effectively, and in compliance with applicable laws and regulations. However, when we reviewed the Department's practices for managing CBHP contracts, we found significant weaknesses in the completeness of contract provisions and the adequacy of contract oversight.

The Colorado Department of Personnel & Administration provides guidance to state agencies on writing contract specifications and overseeing executed contracts in its *Contract Procedures and Management Manual*. Some of the key guidelines in the *Manual* are for agencies to:

- Include measurable performance requirements in contracts along with standards for use in determining whether the contract requirements have been met.

- Monitor the contractor's performance, such as by conducting reviews and audits during the course of the contract.

- Evaluate contract results to prevent and identify any breaches of contractual provisions, and document efforts to correct such breaches.

- Maintain complete contract administration files, including correspondence, notes of all meetings, all contractor-submitted reports, and payment records, in part so that documentation exists for settling claims or disputes.

We evaluated the Department's Fiscal Year 2006 and 2007 contracts with Affiliated Computer Services (ACS); Maximus, Inc.; and Health Services Advisory Group, Inc. (HSAG); and conducted a limited review of the contracts with the HMOs, as described below. We did not review the Department's management of contracts with individual health care providers that furnish

medical services to CBHP enrollees. We found numerous instances of contracts and contract oversight activities that do not follow the guidance provided in the *Contract Procedures and Management Manual.* As a result, the Department is not fully able to demonstrate accountability for the many functions carried out by contractors and the public monies spent for those functions. The problems we found are described below. We also reviewed the Department's management of the Anthem contract, which will be discussed in a subsequent audit of CBHP claims to be released later in 2008.

Lack of Contract Requirements and Performance Standards to Ensure Contract Performance. All of the contracts we reviewed lacked some requirements and performance standards that would enable the Department to effectively manage the contracts. This means the Department does not have the information it needs to monitor the contractors' performance and hold them accountable for carrying out contracted duties. For example:

- The ACS contract lacks requirements and performance measures for timely and accurate disenrollments and for proper handling of enrollment fees, as discussed in Chapter 2.

- The contracts we reviewed did not contain specific requirements for the contractors to investigate and report on all suspected fraud or abuse in CBHP or to handle complaints related to CBHP. However, the Department indicated that it expects contractors to carry out these functions. These problems are discussed in greater detail later in this chapter.

Lack of Ongoing Monitoring and Evaluation. We identified problems with the Department's monitoring of the ACS contract and its processes to evaluate the overall performance of the contractors. Specifically, in Chapter 2 we noted that Department staff do not thoroughly review the monthly disenrollment reports submitted by ACS and do not independently verify the timeliness and accuracy of ACS' disenrollment processes. We also discussed previously that the Department is not overseeing ACS' handling of enrollment fees. In addition to the concerns about oversight of the ACS contract discussed in Chapter 2, we found that the enrollment-fee reports ACS submits to the Department in accordance with its contract are not always complete. We reviewed all the monthly enrollment-fee reports for the 21-month period covering July 1, 2005 through March 31, 2007 and found they do not include details required by the contract, such as the number or amount of fees refunded to families (e.g., due to overpayments) or year-to-date collections by month. Due to the lack of oversight, the Department cannot ensure that all fees received are deposited into the bank and recorded in CBMS, creating a risk that monies will be lost or misappropriated and that eligible individuals will be denied access to CBHP medical services.

Lack of Contract Monitoring Documentation. In general, we found that CBHP contract managers do not maintain documentation of their contract monitoring activities, interactions with contractors, or decisions that affect the contracts. For example, the Department's original contract with HSAG, which was for Fiscal Year 2005, required the contractor to submit monthly status reports. According to the Department and HSAG, both parties agreed soon after the contract was executed that monthly phone calls would replace the reports. However, the Department has no documentation regarding this agreement, or of the monthly phone calls that replaced the reporting. In addition, the Department has continued to include the reporting requirement in its contracts in Fiscal Years 2006 through 2008. Documentation of the contract oversight process is important to demonstrate accountability for the adequate performance of contractors and the appropriate use of public funds.

During Fiscal Years 2006 and 2007, seven different Department staff managed five CBHP administrative contracts. In Fiscal Year 2007 these contracts were worth a total of about $12.8 million. However, the Department does not ensure that all contract managers receive adequate training regarding their contract oversight duties. Specifically, for the single largest CBHP administrative contract, worth about $7.4 million in Fiscal Year 2007, the Department had no record of the Fiscal Year 2006 contract manager having received any contract training, while the Fiscal Year 2007 contract manager only received an abbreviated, one-hour brown-bag session on contract oversight. The other contract managers had attended more extensive training on contract oversight from the Department of Personnel & Administration.

The private-public partnership design of CBHP means that contract management is a primary responsibility of the Department. Unless it has a rigorous and well-defined contract management process, the Department cannot ensure that public monies are used efficiently and effectively to serve eligible children and pregnant women. The Department should develop and implement policies and procedures to outline the responsibilities of contract managers and ensure quality management of contracts for CBHP. The policies and procedures should require, at a minimum, that:

- Contracts address all statutory requirements and include performance standards and measures for all key functions for which the contractor is responsible.

- Contract managers assess the contractor's performance against the performance standards on a regular basis, including prior to contract renewal.

- Contract managers maintain comprehensive contract monitoring files that include, at a minimum, evidence of communication with the contractor,

follow-up on problems, decisions regarding contract changes, and performance assessments.

In addition, the Department should train contract managers on the policies and procedures and provide adequate supervisory review of contract management activities. Finally, the Department should follow up on and resolve all cases in which contractors are not meeting contract requirements.

Recommendation No. 13:

The Department of Health Care Policy and Financing should improve accountability for the CBHP program by establishing and implementing policies and procedures for contract management that, at a minimum, include requirements for:

a. Contracts to include performance standards for all key functions for which the contractor is responsible.

b. Contract managers to follow established procedures for monitoring and enforcing contract provisions, including conducting ongoing assessments of contractors against performance standards, particularly before renewing contracts.

c. Documentation to be maintained in contract files to fully demonstrate the Department's oversight of contractors, including records of all communications and contract-related decisions.

d. All staff with contract management responsibilities to be adequately trained.

e. Staff to take timely action to address instances in which contracts lack needed provisions and contractors do not meet contractual requirements.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation Date: January 2009. Performance standards for all key functions will be included in all CBHP contracts.

b. Implementation Date: October 2008. The Department will establish and implement a policy on contract management that will clarify

Departmental standards regarding the importance of utilizing the State of Colorado Contract Procedures and Management Manual for contract monitoring and enforcing contract provisions, especially prior to contract renewals. A training by knowledgeable staff in this area will be provided to CBHP contract managers by October 2008. The Department will request additional resources through the standard budgeting process to supplement the contract management process.

c. Implementation Date: Implemented and Ongoing. In April 2008 the Department began maintaining documentation in contract files to fully demonstrate the Department's oversight of contractors, including records of all communications and contract-related decisions.

d. Implementation Date: October 2008. Training on contract management will be made available to contract managers.

e. Implementation Date: October 2008. CBHP staff will take timely action to address instances in which contracts lack needed provisions. The Department will evaluate the feasibility of developing a contract management Individual Performance Objective (IPO) for all contract managers. The IPO will specifically address contract managers' responsibilities to take timely action to address instances in which contracts lack needed provisions and contractors do not meet contractual requirements.

Program Data

In addition to managing the contracts of all the organizations that carry out the day-to-day functions of the CBHP program, a second principal duty of the Department is to compile and analyze data on program operations to ensure that CBHP is effective in accomplishing its objectives and fulfilling state and federal requirements. However, as we have discussed throughout the report, the Department lacks essential data to effectively manage the CBHP program. For example, we found the following weaknesses:

- As discussed in Chapter 1, the Department has not developed measures and therefore does not have the data needed to assess its achievement of all the stated objectives for CBHP or its progress in providing mandated services. In addition, the Department's data and methods for evaluating some of the CBHP objectives are problematic. Furthermore, the Department does not generate and analyze the data it needs to evaluate the effectiveness of marketing and outreach for CBHP.

- As discussed in Chapter 2, the Department does not have complete information on the proportion of: (1) CBHP applications that are not processed on time, (2) participants who are not disenrolled on time, or (3) CBHP enrollees who do not reapply for the program. Additionally, the Department does not have information on why the processing for many CBHP applications is delayed and why some enrollees do not reapply for the program.

- As discussed later in this chapter, the Department does not know the extent to which fraudulent or abusive activities are occurring and does not have the data it needs to establish controls to reduce or prevent such activities. Furthermore, the Department does not have information on complaints related to CBHP for use in correcting operational problems in the program.

In addition to the concerns discussed elsewhere in the report, we found the Department does not routinely obtain and review detailed application and enrollment data from CBMS. For example, the Department does not regularly analyze CBMS information on the: (1) total numbers of applications received by date or the total numbers denied; (2) total numbers of individuals disenrolled by reason; (3) total enrollment by county, family size, income, and/or health plan; or (4) total numbers of enrollees who were previously in CBHP but experienced a lapse in coverage.

In its Fiscal Year 2006 and 2007 contracts with ACS, the Department required reporting of this type of data. However, when we reviewed the reports ACS submitted to the Department for the 21-month period between July 1, 2005 and March 31, 2007, we found the reports did not contain any of this detailed information. In its Fiscal Year 2008 contract with ACS, the Department eliminated virtually all of the requirements for reporting of detailed application and enrollment information. According to the Department, ACS could not provide these kinds of data because CBMS has not been programmed to produce them. The Department reported that it has no plans to update CBMS programming to generate these data in the near future. However, some of these data are important for the Department to effectively manage CBHP and relate to issues we found during the audit. For example, data on when applications were received is useful in tracking timely processing and data on enrollment by income and county could be used to help target outreach efforts.

The Department should systematically identify the data it needs to manage the CBHP program effectively, including the specific types of data needed, the best source for the data, and how the data will be used to manage CBHP. The Department should then establish data collection and analysis processes to meet the identified needs. Finally, the Department should review, analyze, and use the data it gathers to evaluate the efficiency and effectiveness of the program and to identify and design needed improvements.

Recommendation No. 14:

The Department of Health Care Policy and Financing should ensure it has adequate and accurate information to effectively manage CBHP by:

a. Systematically identifying the data needed to effectively manage CBHP, the sources of such data, and how the data will be used.

b. Establishing data collection and analysis processes to meet the identified needs.

c. Reviewing, analyzing, and using the data it gathers on an ongoing basis to evaluate the program and to identify and implement needed improvements.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation Date: Implemented and Ongoing. The Department has identified the data needed to effectively manage CBHP. The sources of such data include but are not limited to the Medicaid Management Information System and the Colorado Benefits Management System, as well as other systems maintained by CBHP vendors. CBHP program staff will continue to use the existing reports, as well as develop new reports, to manage the program; identify program trends and anomalies; and provide detail necessary to implement programmatic and system enhancements.

b. Implementation Date: June 2009. The Department will continue to establish data collection and analysis processes to meet the identified needs and will pursue implementing additional reports for analysis to further support and guide program goals. Currently the Department uses several sources of data and analyses to understand how the program operates in a changing legislative environment. These analyses also provide the impetus for exploring future legislative action. The Department will begin to implement these reports by June 2009.

c. Implementation Date: June 2009. Please see responses to Parts a and b above.

Fraud and Abuse

Federal regulations require states to implement program integrity procedures for their State Children's Health Insurance (SCHIP) programs [42 CFR 457.900 and 457.915], including effective methods and criteria to detect and investigate suspected fraudulent or abusive activity and report such activities to law enforcement agencies. Examples of potential fraudulent activity in CBHP include applicants misreporting their income and providers requesting payments for services they did not furnish. States are also required to report to the Centers for Medicare and Medicaid Services (CMS) each year on the number of suspected fraud and abuse cases in their SCHIP programs that were investigated and the number referred to law enforcement. Program integrity procedures are crucial to ensure that limited public funds are used appropriately to pay qualified providers to furnish covered services to eligible individuals.

We found the Department does not have adequate mechanisms to safeguard the CBHP program as directed by federal regulations. For example, as we discussed in Chapter 2, the Department has not historically monitored eligibility sites to ensure that adequate controls are in place over the eligibility-determination and disenrollment processes and the handling of enrollment fees. We also identified weaknesses in the Department's processes for identifying and following up on suspected fraud and abuse in CBHP, as described below.

Detection, Investigation, and Reporting of Suspected Fraud and Abuse. The Department does not have controls to ensure that potential fraud and abuse in CBHP are detected and investigated or that confirmed cases are reported to the proper authorities. According to the Department, the health plans (i.e., the HMOs and the State Managed Care Network) and county departments of human/social services should identify, investigate, and report potential fraud and abuse in CBHP. Although the county staff we contacted during the audit were aware that they should be investigating potential fraud or abuse, the Department has not clearly and formally communicated fraud and abuse duties to the health plans. The contracts with the health plans include requirements that the contractors comply with all applicable state and federal laws, and the contract with Anthem requires notification to the Department of potentially fraudulent claims situations. However, none of the contracts contain provisions that clearly identify all the contractors' duties related to the detection, investigation, or reporting of fraud and abuse in CBHP.

It appears that Colorado is not unique in expecting health plans to carry out fraud and abuse oversight duties. A March 2007 report by the U.S. Department of Health and Human Services, Office of Inspector General, found that all six of the

states it reviewed were meeting federal requirements for preventing and detecting fraud and abuse in separate SCHIP programs largely by assigning the establishment of fraud and abuse safeguards to health plans or administrative contractors. The report also stated that all six states contractually required their SCHIP health plans to have written fraud and abuse plans.

Formalization and Oversight of Delegated Duties. Unlike the states reviewed by the Office of Inspector General, discussed above, the Department does not have contractual requirements for its health plans or other contractors to have and follow written fraud and abuse plans. The Department has documents from each of the HMOs that contain some information related to their procedures for dealing with suspected fraud and abuse. However, because the contracts do not require such procedures and provide no guidance on what the procedures should include, the Department is not ensuring that the health plans have adequate fraud and abuse processes. In addition, the Department has no procedures in place to verify that health plans or counties are identifying or investigating potential fraud or abuse in CBHP. For example, the Department does not require the health plans or counties to report all fraud and abuse information to the Department. As a result, the Department does not know the extent to which potential fraud and abuse may be occurring in the program. Further, the Department cannot accurately report required information to CMS on the number of cases of fraud and abuse in CBHP that are investigated and referred to law enforcement each year. To fulfill this reporting requirement, the Department calls the health plans when it is preparing each year's annual report to CMS to request the number of fraud and abuse allegations related to CBHP. The Department does not require the plans to provide any documentation related to the allegations or investigations nor does the Department follow up on the allegations or referrals. The report by the Office of Inspector General, mentioned above, noted that five of the six states reviewed required their SCHIP health plans to regularly report their fraud and abuse investigation and referral activities to the state.

The Department's Federal Fiscal Year 2006 and 2007 reports to CMS reported that 14 cases of fraud or abuse were investigated in 2006 and 1 case in 2007. In response to our inquiries, the Department asked the health plans for detailed information on these cases. The Department was only able to obtain the following information for four of the allegations from 2006, three of which involved eligibility fraud and one of which involved provider fraud:

- In one case, a patient allegedly provided fraudulent information to CBHP. The Department had no additional details on the situation, including whether or how it was resolved.

- In one case, an individual had received CBHP membership cards for her children, although she had not applied for CBHP. The health plan that reported this case indicated it had terminated the children from the plan.

When the Department asked the health plan for details on this situation, the Department did not request identifying information for the children involved. As a result, the Department is unable to verify that the children were disenrolled from CBHP.

- In one case, an individual had allegedly obtained CBHP services by falsely claiming the identity of someone who was legitimately enrolled in CBHP. The Department indicated that it had not taken any further action regarding this case.

- In one case, several patients had not received eyeglasses from a provider after the provider had already been reimbursed for them. The health plan reported that it subsequently covered the cost for these patients to obtain glasses from another source. Despite reports that the provider apparently failed to furnish services on several occasions, the Department has not required that the health plan investigate the provider or remove the provider from its network. We found the provider was still part of the CBHP network as of April 2008.

The Department was unable to obtain further information on the other 10 allegations in 2006 and the 1 allegation in 2007.

Department management and staff reported that they believe the risk of fraud or abuse in CBHP is very low. However, since the Department does not adequately oversee the fraud and abuse detection and investigation activities of contractors or counties, and does not have a formalized process for contractors and counties to report allegations, the Department has no reliable information on which to assess the overall risk.

Due to the lack of sufficient fraud and abuse oversight procedures, the Department is not fulfilling its obligation to ensure that the approximately $76 million spent on CBHP on average each year in Fiscal Years 2003 through 2007 is being used for qualified services to eligible individuals in compliance with federal program requirements. Failing to comply with the requirements increases the risk that federal funds may be improperly used and have to be repaid.

To adequately protect the CBHP program and ensure funds are used appropriately, the Department should strengthen its oversight of potential fraud and abuse in CBHP by:

- Developing written policies and procedures that clearly define the Department's responsibilities for preventing, detecting, and investigating allegations of fraud and abuse, as well as the functions delegated to counties or contractors. The Department should then revise its contracts with the health plans and administrative contractors to include language

that specifies the contractors' duties related to fraud prevention, detection, and investigation and inform the counties of their duties in this area.

- Implementing procedures to monitor compliance with the contract provisions, including requiring contractors to submit documentation to the Department on all allegations of fraud or abuse related to CBHP on a regular basis. The Department should require similar reporting by the counties. The Department should also follow up on all allegations to ensure they are investigated and reported to law enforcement authorities, as appropriate.

- Reviewing and analyzing the fraud and abuse data reported, along with the results of the Department's own program-integrity efforts, to identify areas where program controls should be strengthened.

The Department should also consider requesting counties and contractors to report all allegations and/or confirmed instances of fraud or abuse related to other public assistance programs, such as Food Stamps, TANF, or Medicaid, that involve CBHP enrollees. The Department could flag these enrollees and monitor their circumstances more closely to help prevent fraud in the CBHP program. The Department could also share information about potential fraud or abuse in CBHP with other public assistance programs, including those administered by the Department of Human Services, which could help in successful prosecution of fraud and abuse cases.

Recommendation No. 15:

The Department of Health Care Policy and Financing should establish a system to address suspected fraud and abuse activities in CBHP by:

a. Developing and implementing written policies and procedures that define strategies to prevent, detect, and investigate fraud. This should include defining activities for preventing, detecting, and investigating fraud or abuse allegations that will be performed by the Department and those that will be delegated to counties and contractors.

b. Modifying contracts to specify each contractor's duties for suspected fraud and abuse prevention, detection, investigation, and reporting.

c. Ensuring that contractors and county departments routinely report to the Department all allegations, investigations, and referrals of fraud and abuse related to CBHP. This should include cases of fraud in other public programs that involve CBHP enrollees.

d. Reviewing fraud and abuse data reported by counties and contractors on an ongoing basis to ensure that allegations are properly investigated and referred to law enforcement, if appropriate, and to identify areas in which program controls may need to be strengthened.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation Date: April 2009. The Department will develop and implement written policies and procedures that define strategies to prevent, detect, and investigate fraud for CBHP. Development of these policies and procedures will start immediately.

b. Implementation Date: September 2008. All CBHP health plan contracts will be modified with an effective date of July 1, 2008 and the eligibility and enrollment contract will be modified with an effective date of September 1, 2008 to specify each contractor's duties for suspected fraud and abuse prevention, detection, investigation, and reporting.

c. Implementation Date: April 2009. The Department will work with contractors and county departments to have them routinely report to the Department all allegations, investigations and referrals of fraud and abuse. It is important to point out that county departments of human/social services may not have the resources to implement such a process uniformly.

d. Implementation Date: June 2009. The Department will review available fraud and abuse data quarterly to examine that all allegations are properly investigated and referred to law enforcement as appropriate and to identify areas in which program controls may be strengthened.

Complaints

Another element of effective program management is the implementation of a complaint-handling system that includes policies and procedures for accepting, logging, investigating, and resolving complaints, as well as using complaints information to make program improvements. We found the Department does not have a comprehensive system to accept, document, investigate and resolve

complaints related to CBHP. Currently various organizations, including the medical assistance sites, the health plans, the Department's marketing contractor, and the Department itself will accept complaints. However, the Department has not clearly defined the complaint-handling responsibilities of its own staff or any of its contractors. None of the Department's contracts with CBHP administrators or health plans clearly assign complaint-handling duties, require documentation or resolution of complaints, or call for information on complaints to be reported to the Department. As a result, the management of complaints is fragmented and inconsistent. For example, staff at the medical assistance sites reported that they make case-by-case decisions on whether to handle a complaint themselves, forward it to another staff member, or refer it to another agency that they believe can best address the complaint. In addition, the Department has no comprehensive information on aspects of the CBHP program that are problematic from the viewpoint of applicants, enrollees, providers, or eligibility staff.

The Department's marketing contractor, Maximus, logs and tracks complaints from the providers, county workers, and community-based organizations it works with on a regular basis, although this is not a requirement of its contract with the Department. Maximus staff use feedback forms to document and notify the Department about questions, comments, and complaints they receive related to CBHP. We reviewed the 105 comments and complaints recorded on feedback forms for the nine-month period of July 1, 2006 through March 31, 2007. We found that about one-third of the items recorded in the forms were questions or comments while the remaining two-thirds were complaints. The complaints ranged in nature from difficulty getting in touch with one of the medical assistance sites to delayed processing of applications that resulted in significant health problems for applicants. Examples of the more serious complaints noted in the feedback forms include the following:

- In one case, a county worker helped a family complete a CBHP application for a child who needed surgery for an ovarian cyst and requested that the child's enrollment into CBHP be expedited. The worker attempted to contact the Department on the day prior to the surgery to ensure the child had been enrolled into CBHP but was on hold for over an hour and was never able to learn the status of the application. The surgery was cancelled because the hospital had no information confirming the child's enrollment in CBHP.

- In one case, the mother of an enrollee reported she did not receive a CBHP redetermination packet and instead submitted a new application in May 2006 to continue enrollment for her son, who has cerebral palsy and requires expensive medication. The mother was notified that additional documentation was needed to complete the application. The mother reported that she drove to Denver from Pueblo to submit the documents and was told the application would receive expedited processing.

However, the application was not processed until two months later and was then denied. The mother appealed the denial but, at the time of the complaint in October 2006, had not been informed of any resolution.

- Several community-based organizations had contacted Maximus regarding a shortage of CBHP providers in one county. The community-based organizations reported concerns that the lack of providers may have prevented some eligible individuals from enrolling in CBHP.

In addition, more than one-third of the complaints related to customer service problems with ACS, the Department's eligibility and enrollment contractor. These complaints related to issues such as long wait times when calling ACS and receiving inaccurate and conflicting information about CBHP. These complaints were referred to the Department. According to the Department, staff attempt to resolve each individual problem referred by Maximus but do not compile the referrals. Additionally, the Department does not formally track or follow up on the problems cited in the feedback forms and did not know how or if any of the complaints recorded by Maximus, including those discussed above, had been resolved.

Without a system for accepting, documenting, tracking, and resolving complaints for CBHP, the Department cannot adequately ensure that the program is operating effectively and efficiently. As the examples above illustrate, CBHP does experience problems with enrollees receiving the services they need in a timely manner, health plans offering an adequate number of providers, and individuals being able to access Department and contract staff to answer questions and resolve problems. Further, failing to periodically analyze complaint data prevents the Department from identifying and correcting systemic problems. The Department needs to implement a comprehensive system for managing complaints that includes defining responsibilities for complaints handling; providing guidance to all organizations and Department staff who have complaint-handling duties; establishing requirements for documenting, resolving, and reporting complaints; and using complaint data to improve the CBHP program.

Recommendation No. 16:

The Department of Health Care Policy and Financing should implement a comprehensive complaints-management system for CBHP. As part of the system the Department should:

a. Clearly define the roles and responsibilities of counties, medical assistance sites, contractors, and Department staff for accepting,

documenting, and resolving complaints related to CBHP. The Department should include provisions in contracts, as necessary, to reflect complaint-handling duties.

b. Develop guidance on referring complaints among organizations for proper handling.

c. Establish a mechanism for the Department to collect, log, track, and ensure the resolution of all CBHP-related complaints.

d. Periodically analyze complaint data and use the data to make improvements to CBHP operations.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation Date: January 2009. The Department will build on the process in place to more clearly define the roles and responsibilities of counties, medical assistance sites, contractors, and Department staff for accepting, documenting, and resolving complaints related to CBHP. Provisions for handling complaints will be incorporated into the relevant contracts once the policies and procedures are finalized.

b. Implementation Date: January 2009. The Department will build on the established processes to further develop guidance on referring complaints among organizations for proper handling.

c. Implementation Date: Implemented and Ongoing. The Department has established a mechanism to collect, log, track, and ensure the resolution of CBHP-related complaints. An access database was created for these purposes and implemented within the CBHP Division in March 2008.

d. Implementation Date: January 2009. The Department currently analyzes the feedback log provided by the Regional Outreach Coordinators (ROCs), employed by Maximus, Inc., and uses the data to identify areas of improvement. Effective January 2009, CBHP personnel will periodically analyze the complaints logged into the CBHP database as well as continue to analyze the ROC feedback log to identify areas for improvement.

Appendices

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Appendix A

The table below shows the counties covered by the HMOs and the State Managed Care Network for the Children's Basic Health Plan (CBHP) program. The coverage areas represent services provided to children. All pregnant women enrolled in the program are served by Anthem under the State Managed Care Network, and all enrolled children receive dental benefits through Delta Dental.

Department of Health Care Policy and Financing
Children's Basic Health Plan
HMO and State Managed Care Network[1] Coverage Areas[2]
Fiscal Year 2007

HMOs			Colorado Access or State Managed Care Network		State Managed Care Network Only	
Denver Health, Kaiser, & Colorado Access[3]	**Colorado Access Only**	**Rocky Mountain Only**				
Adams	Alamosa	Delta	Bent	Lincoln	Archuleta	La Plata
Arapahoe	Costilla	Mesa	Clear Creek	Mineral	Baca	Las Animas
Boulder	Gilpin	Montrose	Conejos	Morgan	Chaffee	Moffat
Broomfield	Kiowa		Crowley	Otero	Cheyenne	Montezuma
Denver	Logan		Custer	Park	Dolores	Ouray
Douglas	Phillips		Elbert	Pueblo	Eagle	Pitkin
Jefferson	Prowers		El Paso	Rio Grande	Garfield	Rio Blanco
	Saguache		Fremont	Teller	Grand	Routt
	Weld		Huerfano	Washington	Gunnison	San Juan
			Larimer	Yuma	Hinsdale	San Miguel
					Jackson	Sedgwick
					Kit Carson	Summit
					Lake	

Source: Information from the Department of Health Care Policy and Financing.
[1] As part of the State Managed Care Network, the Department contracts with about 4,800 providers to serve enrollees in these counties. Under its contract with the Department, Anthem manages the State Managed Care Network.
[2] The coverage areas in this table are for services provided to children in CHP+. All pregnant women enrolled in CBHP receive services through the State Managed Care Network.
[3] Enrollees in these counties can choose among Denver Health, Kaiser, and Colorado Access, except for Adams, Boulder, Broomfield, and Douglas, which do not have access to the Denver Health plan.

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Appendix B

Health Employer Data Information Set (HEDIS) measures are calculated following specifications established by the National Committee for Quality Assurance. The definition of each of the measures used by the Department of Health Care Policy and Financing for the Children's Basic Health Plan (CBHP) is as follows:

- Measure 1: Well-Child Visits (0 to 15 months) – no visits. The percentage of enrolled children who turned 15 months old during the measurement year and had no well-child visits with a primary care practitioner during their first 15 months of life.

- Measure 2: Well-Child Visits (0 to 15 months) – six or more visits. The percentage of enrolled children who turned 15 months old during the measurement year and had six or more well-child visits with a primary care practitioner during their first 15 months of life.

- Measure 3: Well-Child Visits (3 to 6 years). The percentage of enrolled children who were 3 through 6 years of age who received one or more well-child visit with a primary care practitioner during the measurement year.

- Measure 4: Access to Primary Care Practitioners (ages 12 to 24 months). The percentage of enrolled children aged 12 to 24 months who had a visit with a primary care practitioner during the measurement year.

- Measure 5: Access to Primary Care Practitioners (ages 25 months to 6 years). The percentage of enrolled children aged 25 months to 6 years who had a visit with a primary care practitioner during the measurement year.

- Measure 6: Access to Primary Care Practitioners (ages 7 to 11 years). The percentage of enrolled children aged 7 to 11 years who had a visit with a primary care practitioner during the measurement year or the year prior to the measurement year.

- Measure 7: Access to Primary Care Practitioners (ages 12 to 19 years). The percentage of enrolled adolescents aged 12 to 19 years who had a visit with a primary care practitioner during the measurement year or the year prior to the measurement year.

- Measure 8: Asthma (ages 5 to 9 years). The percentage of enrolled children aged 5 to 9 years who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year.

- Measure 9: Asthma (ages 10 to 17 years). The percentage of enrolled children aged 10 to 17 years who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year.

- Measure 10: Asthma (combined rate). The percentage of enrolled children aged 5 to 17 years who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year.

- Measure 11: Adolescent Well-Care Visits. The percentage of enrolled adolescents aged 12 to 21 years who had at least one comprehensive well-care visit with a primary care practitioner or OB/GYN practitioner during the measurement year.

- Measure 12: Appropriate Treatment of Children with Upper Respiratory Infection. The percentage of children aged 3 months to18 years who were given a diagnosis of upper respiratory infection (URI) and were *not* dispensed an antibiotic prescription on or three days after the episode date. According to the guidelines for HEDIS, pediatric clinical guidelines do not support the use of antibiotics for a majority of upper respiratory tract infections. A performance measure of antibiotic use for URI sheds light on the prevalence of inappropriate antibiotic prescribing in clinical practice and raises awareness of the importance of reducing inappropriate antibiotic use to combat antibiotic resistance in the community. A higher score indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were *not* prescribed).

- Measure 13: Appropriate Treatment of Children with Pharyngitis (Sore Throat). The percentage of children aged 2 to 18 years who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus test for the episode. A higher rate represents better performance (i.e., appropriate testing).

Appendix C

The following two tables show the Health Employer Data Information Set (HEDIS) measures for the Children's Basic Health Plan for Calendar Years 2004 and 2005. See Appendix B for descriptions of the HEDIS measures.

Department of Health Care Policy and Financing
Children's Basic Health Plan
Health Employer Data Information Set (HEDIS) Results
Calendar Year 2004

	HEDIS Measure[1]	State Managed Care Network	HMO Aggregate	Statewide Average	Nat'l HEDIS Medicaid 50th Percentile[4]
Well-Child and Well-Adolescent Measures (Part of 10 Core Measures)					
1	Well-Child 0-15 mos. – **Zero** Visits[2,3]	12.2%	1.3%	8.6%	2.4%
2	Well-Child 0-15 mos. – **6 or More** Visits[3]	26.2%	32.5%	28.3%	46.3%
3	Well-Child Visits 3 to 6 Years[3]	45.2%	50.3%	48.4%	61.2%
Access to Primary Care Practitioners Measures (Part of 10 Core Measures)					
4	Access to Primary Care – 12 to 24 mos.	84.3%	94.5%	90.5%	94.9%
5	Access to Primary Care – 25 mos. to 6 yrs.	76.2%	79.3%	78.1%	84.7%
6	Access to Primary Care – 7 to 11 yrs.	86.8%	89.1%	88.3%	83.3%
7	Access to Primary Care – 12 to 19 yrs.	88.6%	89.6%	89.2%	82.2%
Asthma Measures (Part of 10 Core Measures)					
8	Asthma (Ages 5 to 9 yrs.)	67.3%	83.0%	77.2%	64.8%
9	Asthma (Ages 10 to 17 yrs.)	71.8%	71.4%	72.2%	63.5%
10	Asthma (combined rate)	70.4%	75.1%	73.8%	65.5%
Adolescent Well-Care Measure (Department Selected Measure)					
11	Adolescent Well-Care Visits[3]	30.5%	35.0%	33.4%	35.9%
Other Appropriate Treatment and Testing Measures (Department Selected Measure)					
12	Treatment – Upper Respiratory Infection	83.0%	90.5%	87.8%	80.9%
13	Testing – Pharyngitis (sore throat)	66.2%	71.6%	69.6%	54.8%

Source: 2005 Aggregate Report for Child Health Plan Plus Division issued by the Department of Health Care Policy and Financing, based on the results of data from Calendar Year 2004.

Notes:

[1] None of the health plans performed a National Committee for Quality Assurance (NCQA) recommended audit of their Calendar Year 2004 HEDIS data.

[2] This is a negative measure. A score below the national Medicaid 50th percentile indicates the State performed better than the benchmark; a score above the percentile indicates performance worse than the benchmark.

[3] The State Managed Care Network calculated these four measures using the "administrative method" which uses the health plan's full population of electronic claims to determine the percentage of children in the category who received the measured service. The HMOs calculated these four measures using the "hybrid method" which begins with the administrative method and validates the results through review of a sample of hard-copy medical records. All the health plans calculate the other nine measures using the administrative method.

[4] The National HEDIS Medicaid 50th Percentile represents the median score for all Medicaid health plans for each measure. The Department compares its HEDIS results with this percentile when reporting HEDIS measures.

Department of Health Care Policy and Financing
Children's Basic Health Plan
Health Employer Data Information Set (HEDIS) Results
Calendar Year 2005

	HEDIS Measure[1]	State Managed Care Network	Colorado Access	Denver Health	Kaiser	Rocky Mountain HMO	Statewide Average	Nat'l HEDIS Medicaid 50th Percentile[5]
Well-Child and Well-Adolescent Measures (Part of 10 Core Measures)								
1	Well-Child 0-15 mos. – **Zero** Visits[2,3]	19.6%	6.6%	NR[4]	NR[4]	NR[4]	12.9%	2.1%
2	Well-Child 0-15 mos. – **6 or More** Visits[3]	14.6%	48.7%	NR[4]	NR[4]	NR[4]	26.3%	46.4%
3	Well-Child Visits 3 to 6 Years[3]	25.1%	55.3%	53.1%	60.9%	60.6%	33.6%	64.1%
Access to Primary Care Practitioners Measures (Part of 10 Core Measures)								
4	Access to Primary Care – 12 to 24 mos.	65.8%	87.3%	NR[4]	100.0%	93.3%	72.9%	94.6%
5	Access to Primary Care – 25 mos. to 6 yrs.	49.5%	82.1%[9]	80.8%	86.4%	89.0%	61.8%	84.7%
6	Access to Primary Care – 7 to 11 yrs.	75.3%	87.7%	NR[4]	94.1%	92.4%	81.5%	83.9%
7	Access to Primary Care – 12 to 19 yrs.	76.9%	87.8%	NR[4]	94.3%	93.5%	82.1%	82.1%
Asthma Measures (Part of 10 Core Measures)								
8	Asthma (Ages 5 to 9 yrs.)	70.8%	97.6%	NR[4]	NR[4]	NR[4]	80.3%	66.6%
9	Asthma (Ages 10 to 17 yrs.)	61.9%	90.8%	NR[4]	NR[4]	NR[4]	69.8%	64.0%
10	Asthma (combined rate)	63.9%	92.0%	NR[4]	NR[4]	NR[4]	72.2%	66.0%
Adolescent Well-Care Measure (Department Selected Measure)								
11	Adolescent Well-Care Visits[3]	15.6%	42.1%	30.3%	52.3%	39.2%	21.2%	38.0%
Other Appropriate Treatment and Testing Measures (Department Selected Measure)								
12	Treatment – Upper Respiratory Infection	83.1%	85.0%	99.1%	89.0%	90.8%	85.6%	81.5%
13	Testing – Pharyngitis (sore throat)	63.5%[9]	68.4%	92.3%	81.2%	78.4%	68.7%	56.7%

Source: 2006 Aggregate Report for Child Health Plan Plus Division issued by the Department of Health Care Policy and Financing, based on the results of data from Calendar Year 2005.

Notes:

[1] The State Managed Care Network did not perform an NCQA recommended audit of its Calendar Year 2005 HEDIS data but the other health plans did conduct such audits.

[2] This is a negative measure. A score below the national Medicaid 50th percentile indicates the State performed better than the benchmark; a score above the percentile indicates performance worse than the benchmark.

[3] The State Managed Care Network calculated these four measures using the "administrative method" which uses the health plan's full population of electronic claims to determine the percentage of children in the category who received the measured service. The HMOs calculated these four measures using the "hybrid method" which begins with the administrative method and validates the results through review of a sample of hard-copy medical records. All the health plans calculate the other nine measures using the administrative method.

[4] For health plans with fewer than 30 children included in the measure, NCQA considers the sample to be too small to report, as indicated by "NR." The data for these measures are included in the calculation of the statewide weighted averages.

[5] The National HEDIS Medicaid 50th Percentile represents the median score for all Medicaid health plans for each measure. The Department compares its HEDIS results with this percentile when reporting HEDIS measures.

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