PREFACE

The Children's Basic Health Plan (CBHP) Policy Board respectfully submits the following annual report to the Joint Budget Committee and the Health, Environment, Welfare, and Institutions Committees of the State of Colorado General Assembly. The report covers state fiscal year (SFY) 2000, which spans from July 1, 1999 to June 30, 2000, and is in accordance with the C.R.S. 26-19-104.6 (1)(c). The statute states the following:

> …the policy board shall…report on or before October 15, 2000, and on or before every October 1 thereafter, to the Joint Budget Committee and the Health, Environment, Welfare, and Institutions Committees of the House of Representatives and the Senate on enrollment, utilization and quality of health care services provided through the Children's Basic Health Plan; streamlining of children's program operations; concerns and recommendations; and any barriers related to enrollment, utilization, and quality.

In response to this legislative mandate, the CBHP Policy Board requested the assistance of staff at the State of Colorado Department of Health Care Policy and Financing (the "Department"). Those who prepared the report strove to accurately summarize activities over the past year by reviewing all relevant documents and interviewing key individuals involved in the administration of the Program.

Many programmatic changes have occurred since the SFY 2000 program year ended. These changes will have a significant impact on CBHP administration and enrollments and are not fully reflected in this retrospective review. They include:

- Revision of the cost-sharing structure;
- Revision of the eligibility income standards; and
- Pending implementation of a new joint CBHP/Medicaid application.

EXECUTIVE SUMMARY

CBHP (referred to also as the "Program") is a public/private partnership providing subsidized health insurance for children in low-income families statewide who are not eligible for Medicaid. By the end of SFY 2000, 25,337 children were enrolled in the program, representing an average monthly enrollment of 23,015. This constitutes an 80% increase from the SFY 1999 average monthly enrollment of 12,825.

In SFY 2000, the Program was administered by the State of Colorado Department of Health Care Policy and Financing through private contractors who provide various services. The CBHP Policy Board provided oversight and policy development. These organizations designed and implemented the eligibility, enrollment and premium rules enacted in this fiscal year, in addition to managing the routine administrative matters associated with CBHP. National data and two years of experience have shown that reaching out on a local level is the most effective way to reach eligible families. CBHP has continued its efforts to partner

with many community-based organizations throughout the year. CBHP created partnerships with approximately 1,600 community-based organizations including: schools; Head Start programs; family resource centers; community health centers; United Way agencies; public health departments; county departments of social services; Women, Infants, and Children programs; and many others. These extensive partnerships represent an extraordinary commitment statewide to enroll uninsured children as part of the Program's comprehensive marketing and outreach strategy.

In addition, CBHP initiated a targeted television advertising campaign and began testing employer-based outreach activities. All of these efforts represent the Program's interest in reaching families in every way possible.

The Program also has a strong commitment to quality health care services. This year the CBHP Policy Board's Quality Improvement Working Group recommended a specific Quality Improvement Plan. This plan will establish improvement measures relevant to children. Currently, utilization data are being compiled and analyzed for health indicators and will be reported by January 31, 2001.

For SFY 2000, the General Assembly allocated just over $25 million to CBHP. Benefits accounted for just over $20 million, while core administrative functions were approximately $3.8 million and the HMO risk pool was $1.2 million.

CBHP is poised to capitalize on the experiences gained from two years of operation. Administratively, CBHP is becoming more efficient and cost effective; organizational responsibilities are more defined, outreach is improving and the breadth of partners is increasing. Some of the successes identified in this report are:

Serving Families
- Achieved statewide coverage for all eligible families
- Enrolled over 25,000 children across Colorado
- Streamlined the joint CBHP/Medicaid application process
- Provided extensive managed care choices for most enrollees
- Coordinated services for children with special health care needs

Utilizing Effective Partnerships
- Worked with more than 1,600 community partners throughout the state
- Received strong support from state government officials

Improving Administration
- Designed an HMO risk pool
- Created initial quality improvement measures
- Improved contract accountability

Despite these successes, CBHP continues to face a number of challenges to perfect its implementation. These include:

Serving Families
- Developing effective marketing messages for the working poor versus the working proud
- Confusing families with a rapidly changing program

Utilizing Effective Partnerships
- Prioritizing program goals
- Defining program ownership
- Meeting federal requirements
- Confusing partners with a rapidly changing program

Improving Administration

- Exceeding the 10% federal matching limitation for administrative expenditures
- Assuring state mandated privatization and appropriate oversight
- Implementing anticipated statewide dental network
- Coordinating CBHP, Medicaid and the Colorado Indigent Care Program

As CBHP progresses it will not lose sight of its primary goal - to provide access to quality health care to all eligible families throughout the state.

A COMMITMENT TO CHILDREN: PROGRAM OVERVIEW

State Children's Health Insurance Programs Nationwide

Created in 1997 under Title XXI of the Social Security Act, the State Children's Health Insurance Program was allocated $48 billion nationally, over ten years, to expand health care coverage to uninsured children. The program enables states to insure children from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance, with some latitude to adjust upper-income limits.

The authorizing federal legislation allows states considerable discretion in designing a program to meet their particular needs. As of July 1, 2000, all 50 states, the District of Columbia, and five U.S. Territories had implemented a State Children's Health Insurance Program covering over two million children. Of these plans, 15 have created a separate child health program, 23 have expanded Medicaid, and 18 have developed a combination of the two.

Children's Basic Health Plan in Colorado

The State of Colorado elected to develop a separate program that is not an expansion of Medicaid. The Program was enacted as the Children's Basic Health Plan (CBHP) through C.R.S. 26-19-101, et seq., and is marketed as the Child Health Plan *Plus* (CHP+). It replaced an existing, state-financed program called the Colorado Child Health Plan. This plan, developed by the University of Colorado Health Sciences Center, served primarily rural areas of the state, provided only out-patient services and utilized a fee-for-service network of providers.

CBHP provides subsidized health insurance coverage for low-income children under 19 years of age statewide who are not eligible for Medicaid. It offers a wide variety of services including:

- Check-ups and shots
- Other doctor visits
- Hospitalization and hospital services
- Prescribed medications
- Mental health services
- Hearing aids
- Glasses

By the end of SFY 2000, 25,337 children were enrolled, representing an average monthly enrollment of 23,015. This constitutes an 80% increase from the SFY 1999 average monthly enrollment of 12,825.

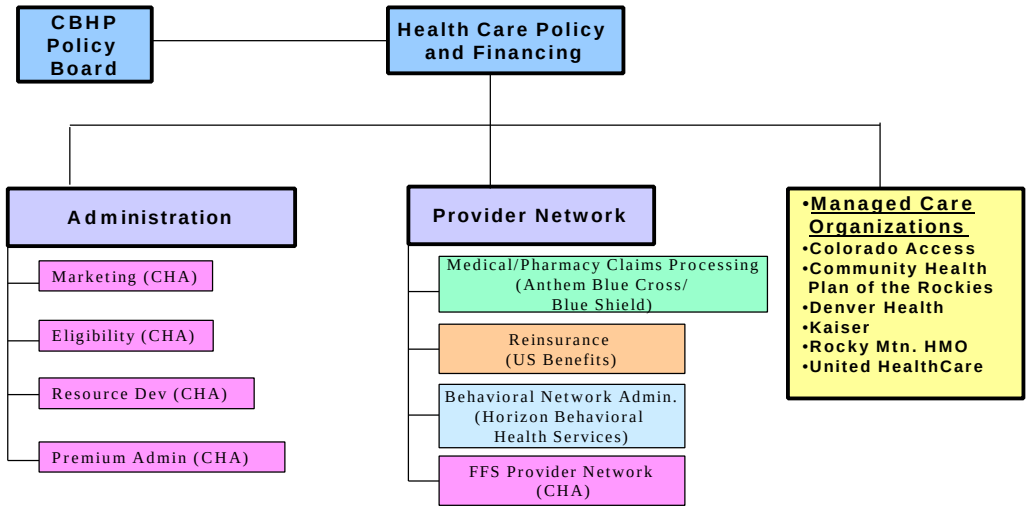
Since the state had a pre-existing, publicly-subsidized child health program infrastructure in place with the Colorado Child Health Program, it was able to respond quickly to the federally-funded opportunity that Title XXI presented. Colorado set the pace for other states in expanding health coverage to low-income children and was considered by many to be the national leader. In fact, Colorado was the first state in the country to have its state program approved by the Health Care Financing Administration. This also presented challenges that are discussed earlier in this report.

CBHP Administration

The CBHP, by statute and operation, is a non-entitlement, commercial-coverage health plan with largely privatized administration. (See SFY 2000 Administrative Structure Chart below.) Public/private collaboration and cooperation are hallmarks of CBHP. However, the combined efforts of the CBHP Policy Board, the Department, private contractors, as well as involvement from numerous community partners have contributed to the successful implementation of the program statewide. These working relationships are still developing as policy and operational issues occur.

In SFY 2000, CBHP received 24,152 applications, compared to 14,080 for the same time period the previous year. This represents an increase of 72%. Although all of these applications were processed, only some of them resulted in CBHP enrollments. Some children may be determined ineligible for CBHP primarily because their families are over the income limits or they are eligible for Medicaid.

SFY 2000 CBHP ADMINISTRATIVE STRUCTURE



CBHP Policy Board

State law established the CBHP Policy Board, which is authorized to adopt rules for the operation and financial management of the program. Other Board responsibilities include:

- Reporting on certain matters to the Joint Budget Committee;
- Approving the benefit schedule for the program; and
- Performing other policy-related functions

The board consists of 11 members, seven of whom are appointed by the Governor from designated businesses and health-care-related fields. The other four members are the Executive Directors of the Departments of Health Care Policy and Financing, Human Services, Public Health and Environment, and the Commissioner of the Department of Education. These members are listed on the first page of this report. All 11 members may vote on matters before the board. As required by C.R.S. 26-19-104.5(1), as of July 2000, the government agency representatives may not send a designee to board meetings.

Department of Health Care Policy and Financing

The State of Colorado Department of Health Care Policy and Financing is the agency responsible for three of Colorado's major, publicly-funded health care programs including:

- The Children's Basic Health Plan (CBHP);
- The Colorado Indigent Care Program; and
- Medicaid.

The Department was established in 1994 when the state restructured the health and human-service delivery systems for increased efficiency and more effective use of state and local resources. The agency works to improve access to health care services, quality of health care delivery, and health care cost control.

In SFY 2000, the Department received a total of over $25 million for CBHP: approximately $8.8 million in state appropriated funding and $16.4 million in federal matching funds. (Please refer to the report section entitled, "The Costs of Covering Children: Budget and Risk Pool," for more information on appropriated funding.) CBHP also received $843,823 in grant funding. (Please refer to the report section entitled, "Fundraising Partners: Working Together for Children's Health," for more information on grant funding.) Six full-time equivalent positions are allocated to the Department for CBHP administration. By statute, the Department fulfills the following responsibilities:

- Compliance with all related federal laws and regulations;
- Compliance with all related state laws and regulations;
- Establishment of the schedule of benefits, financial management rules and cost-sharing structures, and submittal of them to the board for approval;
- Contract procurement and management with providers that emphasizes a managed care model;
- Contract procurement and management for all other services;
- Evaluation and program development;
- Administrative support of the CBHP Policy Board; and
- Coordination with other public and private health care delivery and financing programs.

Child Health Advocates

Child Health Advocates is the state's main CBHP administrative services contractor and fulfills the following contractual obligations:

- Marketing and outreach, including statewide mass media, and community organization recruitment, training and support;
- Eligibility and enrollment, including processing mail-in applications, recruitment, training and support to statewide community partners, and referring non-eligible applicants to Medicaid or other resources;
- Statewide customer service, including application assistance, information and problem resolution for CBHP members, agencies and providers;
- Information systems management and development, including maintenance and user assistance for the Internet-based eligibility determination and enrollment network;
- Resource development, including obtaining foundation, corporate and United Way support for the CBHP program; and
- Family premium administration, and CBHP provider network administration.

Child Health Advocates has been the Department's contractor since March 1, 1999. In SFY 2000, the total amount paid under the contract was $4,549,652, including:

- $3,250,000 for core administrative functions;
- $405,730 for family premium administration and system development; and
- $893,922 for provider network administration.

Health Care Service Delivery

Managed Care Organizations

Statute requires CBHP to enroll children in managed care organizations for their health care services. The Department has contracted with six managed care organizations, which are available to 84% of the eligible population. In 37 Colorado counties, enrollees receive health care services through the following managed care organizations: Colorado Access, Community Health Plan of the Rockies, Denver Health Medical Plan, Kaiser Permanente, Rocky Mountain HMO, and United HealthCare. For SFY 2000, this represents an increase of nine counties since Colorado Access expanded its service area into Bent, Crowley, Custer, Fremont, Kiowa, Lincoln, Otero and Park. The managed care organizations listed above are under full-risk contracts with the Department.

Network

In counties where managed care organizations have been unable to offer coverage, the Department contracts directly with over 2,250 providers: 1,500 primary care physicians, 700 specialists, 51 hospitals and a number of ancillary services, which include essential community providers.

In SFY 2000, the Department contracted directly with Child Health Advocates, Anthem Blue Cross and Blue Shield of Colorado, and Horizon Behavioral Health Services to administer this network. Child Health Advocates is responsible for provider relations, training and contracting support, as well as customer service. Claims administration, utilization review and case management are provided through the contract with HMO Colorado, a subsidiary of Anthem Blue Cross and Blue Shield of

Colorado. Network behavioral health benefits are delivered through a contract with Horizon Behavioral Health Services.

The CBHP Policy Board and the Department have made a commitment to ensure statewide access for eligible children. CBHP will continue to maintain a network of providers until there is at least one managed care organization available in every county.

ELIGIBILITY AND APPLICATION REQUIREMENTS

Eligible Children

Children (and adolescents) are eligible for CBHP if they are under 19 years of age, live in a family earning up to 185% of the federal poverty level and are not eligible for Medicaid.

Estimated Eligible Population

The Department estimates that approximately 69,157 children are eligible for CBHP. This estimate was derived from Census data, data on uninsured populations and other relevant information. Due to the lack of reliable data, as well as the highly diverse and mobile nature of the eligible population, an estimate is difficult to derive. Efforts are underway, and supported by Governor Owens and his staff, to obtain further analysis of the data available to refine the estimate and make it more programmatically useful.

Eligibility Requirements

When CBHP began enrolling children in April 1997, no formal eligibility rules were in place. The Department used the eligibility criteria from the pre-existing Colorado Child Health Plan. These eligibility requirements were similar to those of the Colorado Indigent Care Program, which provides services to the same population. Using these guidelines, eligibility was determined based on household income with some income disallowances for child support, child and elder care, health insurance premiums, and medical costs paid during the previous three months.

The first formal CBHP eligibility rule was implemented December 1, 1999. This rule was promulgated on a legal analysis of the state statute implementing CBHP that required eligibility determination be based on gross family income, without any income disallowances. For instance, the definition of family was revised to include only those persons legally responsible for the child. This rule was a significant change to the previous eligibility guidelines and caused some families to no longer qualify for the program. With this new standard, there were three separate eligibility requirements for low-income children: Medicaid, CBHP and the Colorado Indigent Care Program. The General Assembly and the CBHP Policy Board recognized this caused a barrier to enrolling children because it was administratively complex.

During the 2000 legislative session, the General Assembly revised state statute to resolve this issue. CBHP then developed a new CBHP eligibility rule that mirrors the

one in place for the Colorado Indigent Care Program (except in cases where federal law mandates otherwise). It allows families who were previously eligible for the program, but were denied coverage under the last rule, to be eligible again for the program. The new eligibility process enacted by this rule is effective October 1, 2000.

Pre-HMO Enrollment Period

A rule enacted August 1, 2000, stated that CBHP enrollees may access benefits and services immediately upon program eligibility determination in every county of the state. The CBHP Policy Board determined that this "pre-HMO enrollment period" was important because it enabled the Program to reach families when a child needs care. These initial services are delivered statewide through the CBHP Network until enrollment in a managed care organization is operationally possible (usually for a period of up to two months). This rule is feasible from an operational standpoint due to overlap between CBHP and managed-care-organization provider networks within managed care service areas.

Application Requirements

The Department designed a joint CBHP/ Medicaid application early in the program's development. This application responded to the federal requirement that CBHP screen for Medicaid to facilitate referral between the programs. In SFY 2000, the Department significantly reduced the documentation requirements associated with the joint CBHP/Medicaid application, so that the only documentation needed to accompany the application was the verification of the family's income for the prior month.

In SFY 2000, applications could be filed on-line from 11 locations statewide as part of an initial electronic development project. This on-line filing system will be phased-in across the state. Recently, CBHP expanded its pilot project of having satellite eligibility determination sites file applications electronically to 22 locations. Sites are typically community-based organizations that provide services to the low-income population, but they are outside of the conventional human-service environment. The original objective of the sites was to provide a familiar local setting where families could receive information about and apply for the CBHP at the same time they are receiving other services. This is commonly referred to as the "teachable moment" because, at that time, people are most aware of their need for additional services.

Currently, CBHP has a network of 82 satellite eligibility determination sites statewide, including multiple locations for one site. These sites comprise community health centers, county nursing services, school-based health centers and other community providers.

Finally, SFY 2000 represents a turning point regarding the joint application form itself. The Department, in collaboration with the Department of Human Services, Covering Kids Colorado, Child Health Advocates, Colorado Community Health Network, local county departments of social services and satellite eligibility determination sites, applied for and received a grant from the Rose Community Foundation to redesign the joint CBHP/Medicaid application. The Joint Application Redesign Committee contracted with a professional designer and a marketing firm to develop a form that incorporates the most current application concepts and evaluates those concepts through client-centered focus groups.

It is CBHP's goal to have a new application available to families that will provide a simpler format and better guidance for applicants to follow by the middle of SFY 2001.

COST SHARING

SFY 2000 Cost-Sharing Structure

State law required the Department to develop "…a structure of periodic premiums…" for participants in the program based on a scale that varies in relation to an enrollee's family income. During SFY 2000, the CBHP cost-sharing (premium) structure was one of the highest in the nation. The fee scale ranged from $0 to $30 per month, depending on the family's resources and number of children, and was due the first day of the month for coverage in that month. The initial cost-sharing rule was implemented December 1, 1998.

Cost Sharing Schedule SFY 2000

FEDERAL POVERTY LEVEL	PREMIUM BY NUMBER OF CHILDREN		CO-PAY AMOUNT BY BENEFIT/SERVICE TYPE*	
	ONE CHILD	TWO OR MORE CHILDREN	BENEFIT/SERVICE TYPE	CO-PAY
Below 101%	Waived	Waived	All	Waived
101% - 150%	$9 per month per family	$15 per month per family	1) Prescriptions 2) Office/outpatient/ mental health/substance abuse/ physical/occup/speech therapy visit; vision visit 3) Emergency/urgent/after hours care	1) $1 per prescription 2) $2 per visit 3) $5 per event
151% - 170%	$15 per month per family	$25 per month per family	1) Prescriptions 2) Office/outpatient/mental health/substance abuse/ physical/occup/speech therapy visit; vision visit 3) Emergency/urgent/after hours care	1) $3-generic; $5-brand name 2) $5 per visit 3) $15 per event
171% - 185%	$20 per month per family	$30 per month per family	1) Prescriptions 2) Office/outpatient/mental health/ Substance abuse/physical/occup/speech therapy visit; vision visit 3) Emergency/urgent/after hours care	1) $3-generic; $5-brand name 2) $5 per visit 3) $15 per event

The CBHP Policy Board revised this cost-sharing rule to include a penalty for non-payment to be effective August 1, 2000, so that it would comply with rules, regulations and statutes that apply to all past-due debt for all state programs. The rule stated that if a family's premium is 45 days past due, then the covered child would be disenrolled the first day of the following month and the account would be remitted to the State's Central Collections Service.

New Cost-Sharing Structure and Debt Forgiveness

Upon passing the cost-sharing rule, the CBHP Policy Board expressed concern about the impact this cost-sharing structure could have on families and the administrative complexity it presented. In addition, the State Auditor's Office in its CBHP performance audit identified the cost-sharing structure to be significantly complex and costly.

Recognizing that this cost-sharing structure was a barrier to the effective operation of the program, Governor Bill Owens requested that State Treasurer Mike Coffman forgive the premium debts families had accrued under the state's CBHP. Also, the Governor proposed that an alternative cost-sharing approach be developed for implementation by January 1, 2001. The General Assembly, particularly the Joint Budget Committee, in addition to the Governor and State Treasurer, played essential roles in resolving this cost-sharing issue.

The intent was to construct a fee structure that is simpler to administer and less of a deterrent to client enrollment. An annual enrollment fee of $25 for one child and $35 for two or more would be charged, along with a small co-payment for each provider visit. The enrollment fee would apply to families between 151% and 185% of the federal poverty level. Families at 150% of the federal poverty level and below would not be subject to the enrollment fee.

ENROLLMENT

Enrollment

As of June 30, 2000, more than 25,000 (25,337) children were enrolled in CBHP, more than one-third (37%) of those eligible. Over the course of SFY 2000, the total program enrollment increased by 80% to an average monthly enrollment of 23,015 from an average monthly enrollment of 12,825 in SFY 1999.

However, since its inception in April 1997, the total number of children who have ever participated in the program is about 38,000. Approximately 12,663 children have disenrolled over 26 months of program operation for many reasons, including gaining access to other insurance or becoming eligible for Medicaid. This represents a 33% disenrollment rate as of June 2000, and demonstrates the fact that CBHP has a consistently fluctuating number of enrollees. Despite this disenrollment rate, the Program has achieved reasonably steady enrollment growth.

By County

After two years of operation, with the combined effort of the state and its partners, 40 (63%) of the state's 63 counties have exceeded the statewide enrollment average of 37%. The outreach strategies employed by these counties vary significantly.

However, some of the recurring themes include community-wide involvement from all agencies serving the eligible population, school-based support, strong leadership from a core team of community activists and commitment from all levels of the involved organizations.

Counties with Enrollment Meeting or Exceeding the State Average Enrollment Rate:
(Computed as a proportion of total CBHP eligible children for the county)

37%-59%:	**60%-79%:**	**80%-99%**	**100% and over*:**
Adams-42%	Alamosa-65%	Lincoln-85%	Baca-156%
Denver-45%	Archuleta-66%	Mesa-83%	Cheyenne-118%
Dolores-49%	Bent-62%	Phillips-94%	Conejos-117%
Grand-54%	Chaffee-70%	Sedgwick-86%	Crowley-125%
Huerfano-59%	Costilla-79%	Washington-98%	Kit Carson-140%
Kiowa-58%	Custer-72%		Mineral-111%
La Plata-55%	Delta-63%		Prowers-135%
Larimer-41%	Fremont-70%		Yuma-116%
Las Animas-56%	Montezuma-67%		
Logan-59%	Montrose-63%		
Moffat-37%	Otero-63%		
Morgan-55%			
Rio Grande-54%			
Saguache-46%			
San Juan-58%			
Weld-44%			
Total: 16 counties	Total: 11 counties	Total: 5 counties	Total: 8 counties

*The fact that some counties have penetration rates exceeding 100% demonstrates that eligibility totals are estimates, not exact counts.

In SFY 2000, the program made significant strides in metropolitan Denver counties, notably in Denver County, due in large part to concerted efforts by Denver Covering Kids and Community Voices. Nearly two-thirds (42,729) of the eligible population lives in the Denver metropolitan area, and CBHP will continue to focus enrollment efforts on this region of the state.

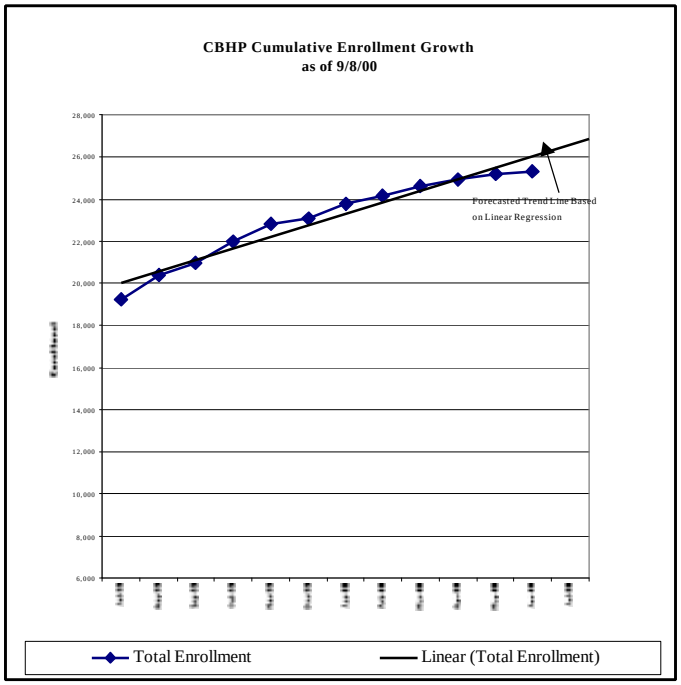
Application Submissions

Applications are collected through the following sources: satellite eligibility determination sites; county departments of social services; and the mail. Satellite eligibility determination sites are community partners who are given the tools to determine eligibility on site, in some cases having on-line capability, and are required as part of their contract to provide CBHP outreach to their community. In turn, CBHP pays them for completed applications.

Approximately 53% of applications in SFY 2000 continue to be mailed directly to the CBHP processing offices. Families obtain applications directly from a variety of sources including schools, Child Health Advocates, and county departments of social services. Satellite eligibility determination sites submit approximately 25% of

applications, while county departments of social services account for approximately 22% of applications submitted. CBHP continues to experience a time lag with some of these applications, which indicates additional support and training are needed to address the reasons for delays.

Satellite eligibility determination site applications have declined from SFY 1999 and that raises concerns because of the community partnership they represent. Both national information and CBHP's experience support strong community partnerships as the most effective foundation for building enrollments. CBHP will evaluate the nature of these partnerships over the next year and determine the most effective role for community partners.

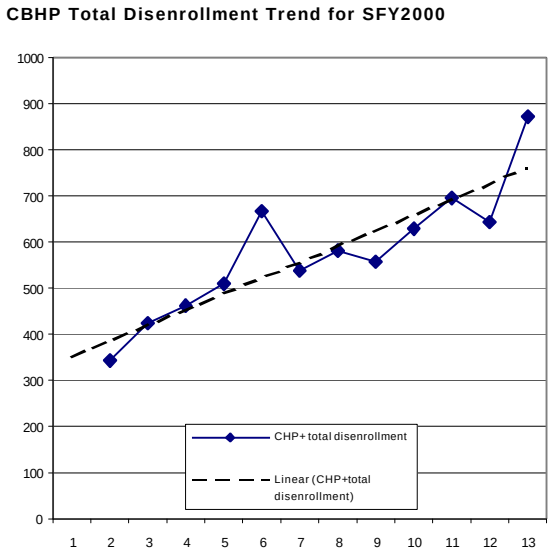


Disenrollment

Approximately 33% of CBHP membership has left the program since its inception. Although more than 38,000 have actually been in the Program at one time or another, approximately 25,000 were enrolled by the end of SFY 2000. Given these facts, it would appear that member retention should be a high priority for CBHP.

However, data analysis over the past year has indicated that the majority of surveyed disenrollees (79%) leave CBHP because they found other health insurance. This indicates that CBHP is serving as a "bridge" for families in need, and that families leave the program for what policymakers and activists alike would consider the "right" reasons.

CBHP intends to use these data cautiously since the sample surveyed to date is quite small. More in-depth analysis will be taking place in SFY 2001 to better understand the issues and to focus on appropriate solutions.



PARTNERSHIP TO PROMOTE ENROLLMENT

The CBHP has created an extensive marketing and outreach program encompassing strategies that range from grassroots networking to mass-market advertising campaigns. These efforts have been implemented to reach families in many different ways with different messages. Marketing research conducted for CBHP in SFY 1999 indicated that eligible families respond to two competing messages: some are eager to participate in a government program and receive support while others want to support themselves through a private program. CBHP can offer both, but needs to tailor the right message to the right families. Community partners who are familiar with the needs and interests of families can help CBHP met all of these families' needs.

To better evaluate the effectiveness of these strategies, CBHP implemented a large-scale, application-source tracking system in March 2000. The system allows an application to be traced back to the initial source without relying on self-reported referral data. This tracking system will continue to be used to monitor trends and results from marketing and outreach campaigns.

A cornerstone of the CBHP outreach strategy is to maintain and build on community partnerships. To reach all eligible families through as many avenues as possible, CBHP is working with more than 1,600 partners. These include: schools; Head Start programs; family resource centers; community health centers; United Way agencies; public health departments; county departments of social services; Women, Infants, and Children nutrition programs; and a myriad of others. This represents an extraordinary commitment statewide to reach uninsured children at the local level. So far, the most effective efforts in actually enrolling families are through schools, doctor's offices, health departments, community health centers, and departments of social services. Also, friends and neighbors are spreading the word. Experience has shown that multiple contacts throughout the community are key to the eventual enrollment of an eligible child.

Managed Care Organizations

Managed care organizations have increased their CBHP outreach. Most exciting this year was the implementation of a joint media campaign in which four of the six managed care partners participated. These purchased advertisements were structured so that each partner received air time when marketing would be most effective. Preliminary results suggest that well-targeted advertisements can be a cost-effective outreach tool. While the analysis is not complete, advertisements resulted in more than 450 applications at approximately $26 per application. (For more information, please see the report section, "Advertising and Earned Media" below.)

In addition, Denver Health Medical Center piloted a premium subsidy program. Colorado Access has committed extensive time and effort to reach disenrollees, as well as to find new enrollees through advertisements, partnerships and events. All of CBHP's managed care partners have participated in various community events throughout the state.

Advertising and Earned Media

CBHP has experienced an increased number of applications from concentrated advertising campaigns. CBHP consistently notes spikes in requests for information after television advertisements or newspaper stories about the program appear. In Spring 2000, CBHP and managed care organizations teamed together to purchase targeted television advertisement time. Preliminary results show a significant increase (more than 10%) in total application requests in that time period compared to months when no television advertising ran. In addition, television went from seventh on the list of referral sources for callers in March to second in May, when the complete, television advertising schedule was running.

Also in Spring 2000, a newspaper advertising campaign targeting neighborhood and ethnically-oriented, weekly and monthly newspapers represented one of the top ten sources of referral for callers. While not as high as that for television, this is an indication that with a more focused campaign, newspaper advertising can lead to increased visibility.

County Departments of Social Services

County departments of social services provide support to low-income families in communities ranging from food stamps and Women, Infants, and Children programs to child care and Colorado Works. Many CBHP referrals come from these programs. In addition, since federal law mandates linkage between CBHP and Medicaid, about 22% of CBHP applications are submitted through the Medicaid application process managed by county departments of social services. In order to reduce the referral time, the program will focus on ways to minimize delays in referral.

Satellite Eligibility Determination Sites

As mentioned above, CBHP has a network of 82 satellite eligibility determination sites statewide, including multiple locations for some sites. For example, Denver Health and Hospitals has 12 individual community clinics. Satellite eligibility determination sites comprise community health centers, county nursing services, school-based health centers and other community providers, and have been an essential component of the program's outreach and enrollment activities. As part of their contract with CBHP, they are required to provide outreach to their community. About 40% of the applications received from satellite eligibility determination sites are from community health centers.

A concerted effort was made in SFY 2000 to increase the number of satellite eligibility determination sites and improve access for families. However, some sites generate virtually no enrollments for the Program. The State Auditor identified this issue in its performance audit and recommended that CBHP perform a comprehensive review of the satellite eligibility determination site program to determine its cost effectiveness. In SFY 2001, CBHP is evaluating the role of these sites from both an eligibility and outreach standpoint.

Schools

Schools are consistently one of the most frequently cited sources of referral by applicants. Clearly, schools are an effective vehicle for getting information out to families with children. However, the direct results of school outreach efforts are hard to identify. For example, in SFY 2000, only

84 enrollments resulted from this year's Free and Reduced-Price School Meal Program campaign, during which nearly 8,000 applications were sent out. Further, the back-to-school campaign in Fall 1999 did not produce the same level of enrollment spike as it did in Fall 1998.

Community Health Centers

The Colorado Community Health Network has made involving its members in CBHP outreach a priority. Community health centers are the largest group of primary care providers throughout the state serving low-income children. Some serve as satellite eligibility determination sites. Others participate in community coalitions that strive to enroll children in CBHP.

Covering Kids Colorado

A significant partner in developing community-based outreach has been Covering Kids Colorado, which is a Robert Wood Johnson Foundation funded grant program administered by the Department of Public Health and Environment. The program has focused on three distinct communities, Denver City and County along with Adams and Prowers Counties, to assure all children eligible for CBHP and Medicaid are enrolled in their respective programs. Covering Kids has employed a community-based partnership strategy similar to the one used by CBHP. CBHP is working closely with Covering Kids to evaluate strategies that have worked so effectively in their targeted communities and to find ways to replicate these strategies elsewhere.

Community Voices

Denver Health's Community Voices program is another important partner responsible for CBHP outreach and enrollment in the metropolitan area. This is a joint Kellogg Foundation and Colorado Trust funded program, which has among its goals to improve the health of Denver's medically underserved through innovations in community outreach, enrollment in publicly funded health insurance programs like CBHP, as well as small employment health plans, and clinical case management. Community Voices' efforts are designed to demonstrate that culturally sensitive community outreach to underserved populations improves enrollment of eligible individuals into plans, while engaging and empowering communities to assume greater responsibility for health. Staff at the Department meet regularly with the Denver Health Community Voices team to explore program successes and resolve potential administrative problems which might impede enrollment and access to care. This has been an effective method of early problem identification and solution, and has enabled CBHP to test the feasibility of program changes in a controlled setting.

FUNDRAISING PARTNERS: WORKING TOGETHER FOR CHILDREN'S HEALTH

One of the primary advantages of a public/private partnership to improve the health of children is the ability to maximize community resources statewide in a concerted effort. This was explicitly anticipated in the enabling CBHP statute. During SFY 2000, fundraising efforts were accelerated. Highlights include: hiring a Resource Development Specialist, partnering with Mile High United Way, and expanding CBHP's relationship with Rose Community Foundation. CBHP's first

resource development manager joined Child Health Advocates in November 1999 to develop and implement a fundraising strategy that includes both cash and in-kind support for the program. This position serves as the basis for a growing fundraising effort.

Mile High United Way

The Mile High United Way has made a significant and valuable commitment to the success of CBHP. They have worked with their 90 partner agencies to get information out about CBHP at the community level, including a series of program "summits" designed to convene a broad range of community partners to share information on enrollment activities and program issues. This represents an exceptional outreach model that could be replicated in other areas of the state. In SFY 2000, Mile High United Way raised $22,500 from 79 donors in support of CBHP. For SFY 2001, the organization has pledged more fundraising assistance.

Rose Community Foundation

Rose Community Foundation has been the most significant private, financial supporter of CBHP. In February 1999, it awarded the program a grant of $327,662, and in-kind technical assistance valued at $100,000. The grant was used in part to develop and expand the number of satellite eligibility determination sites (as mentioned in the "SFY 2000 Enrollment" section of this report). The foundation was also instrumental in funding the efforts to redesign the joint CBHP/Medicaid application anticipated for January 2001.

SFY 2000 Contributions

As of June 2000, the community committed $843,823 to current and future CBHP outreach and enrollment activities. These additional resources will make an important contribution to expanding the network of agencies and organizations supporting CBHP.

ORGANIZATION/ INDIVIDUAL DONATING MONEY OR TIME	TYPE OF DONATION	DONATIONS RECEIVED SFY 2000
Intern	In-kind	$1,500
Channel 4	In-kind	$13,400
Federal Employee Volunteers	In-kind	$1,720
Rose Community Foundation	Cash	$243,744
	In-kind	$25,000
Senior Volunteers	In-kind	$2,520
U.S. Department of Human Health Services	Cash	$70,000
Denver Health Authority	Cash	$104,531
Kellogg Foundation/ Colorado Trust	Cash	$78,526
	In-Kind	$154,306
High Plains Community Health Center	In-kind	$7,000
	Cash	$66,967
K-Mart, Inc.	In-Kind	$160
Mile High United Way	In-Kind	$48,000
The People's Clinic	Cash	$22,449
	In-Kind	$4,000
Subtotal In-Kind		$257,607
Subtotal Cash		$586,216
TOTAL		**$843,823**

Three of the primary goals of the CBHP program are to:

- Provide quality health care services to all enrollees;
- Assure that utilization is appropriate for the services offered; and
- Evaluate the program for improved service delivery.

Quality

Throughout SFY 2000, the Quality Improvement Working Group of the CBHP Policy Board met on a regular basis to review and discuss relevant quality improvement trends, programs and opportunities, and then to develop goals and objectives for inclusion in the CBHP Quality Improvement Plan. The working group is composed of representatives from private industry, participating managed care organizations, the Health Care Financing Administration, the Department of Public Health and Environment, and the Department.

The group has developed two sets of recommendations for the CBHP Quality Improvement Plan based upon the following considerations: lack of traditional quality improvement measures for an exclusively young population, inclusion of all federal and state requirements, and minimizing the administrative burden. The group also established that the quality improvement process should be collaborative in nature, encouraging the sharing of best practices along with program and plan improvement.

Several short- and long-term objectives have been developed for SFY 2001 and beyond. They include assuring that CBHP:

- Enrollment and access are timely;
- Plans have a quality improvement process in place;
- Preventive health care guidelines are adopted for all child and adolescent age groups;
- Member concerns and grievances regarding health care delivery meet the Department of Regulatory Agencies' Division of Insurance requirements; and
- Collaboration with the Children's Comprehensive Care (CCC) grant project monitors complaints for children with special health care needs, such as diabetes, asthma and attention deficit hyperactivity disorder.

Utilization

Based on the recommendations of the Quality Improvement Working Group, the Department recently requested encounter data from all contracting CBHP managed care organizations for SFY 2000. These data are currently being compiled by the organizations and will be reported by January 31, 2001. From these data, the Department will be able to begin to analyze utilization trends and establish a baseline for CBHP enrollee utilization. These indicators will include: utilization patterns for outpatient preventive, specialty and mental health visits; inpatient acute care and mental health hospital length of stay; and use of services in the pre-managed-care enrollment period. Due to the small number of children enrolled in each managed care organization, it is not possible to begin collecting Health Plan Employer Data and Information Set (HEDIS) measures or other quality indicators that require a minimum number of enrollees.

Evaluation

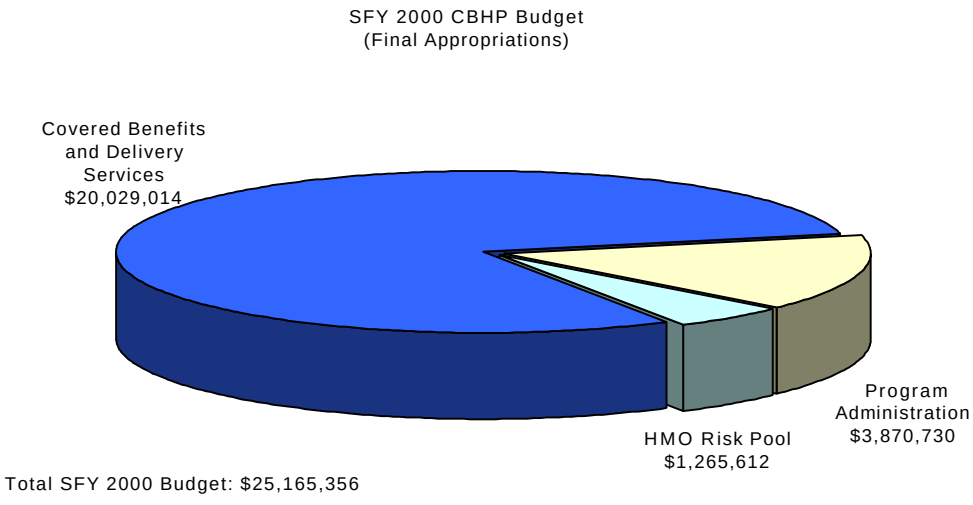
During SFY 2000, the Evaluation Working Group of the CBHP Policy Board met regularly to discuss evaluation needs and activities relevant to program development and growth. Working group members include experts in evaluation and health care from state agencies, provider offices, teaching hospitals and managed care organizations. Some of the primary actions taken by the committee have included:

- Reviewing and providing advice on the content of the March 2000 Evaluation of CBHP required of all states by the federal government;
- Reviewing several key evaluation studies conducted on the CBHP population (two Sundel studies and two Kempe studies on retention issues, and a Denver Health study on the effects of CBHP premium subsidies on retention and utilization);
- Providing guidelines to the CBHP Policy Board for interpretation of research on the eligible population; and
- Working with CBHP researchers and evaluators on the design and interpretation of their projects.

Upcoming projects for this working group include assistance with design of projects that evaluate the role and efficiency of satellite eligibility determination sites in outreach and eligibility determination, as well as the impact of the new cost-sharing structure. This is a group focused on providing information to the CBHP Policy Board and the Department that will support program policy decision making and development.

THE COSTS OF COVERING CHILDREN: BUDGET AND RISK POOL

To adequately provide for the families served by CBHP, the General Assembly appropriated $25,165,356 to the program for SFY 2000. Appropriated funding splits for the overall CBHP program were as follows: $8,780,193 cash funds exempt and $16,385,163 federal funds. General Funds in the amount of $8,603,720 were transferred to the CBHP Trust Fund to cover these spending appropriations. Below is an accounting of how those monies were used to fund benefits, the HMO risk pool and administrative costs.



Benefit Costs

For SFY 2000, the Department received an initial appropriation of $24.1 million to fund the cost and delivery of benefits covered under the CBHP. This appropriation reflected a projected, per child per month cost of $68.76, and an average monthly enrollment of 31,725 children. This appropriation was reduced to $20,029,014 million, due to a lower mid-year caseload estimate of 24,448. Appropriated funding splits for covered CBHP benefits were as follows: $6,988,123 cash funds exempt and $13,040,891 federal funds.

There are three key variables that may cause expenditures to differ from the projections on which appropriations are based:

- Variation in the total level of program enrollment;
- Distribution of enrollments between managed care organizations and the non-managed-care delivery system, and within the nine age and income rating categories established for the program; and
- Utilization of benefits covered directly by the state on a fee-for-service basis.

However, benefit expenditures did not deviate significantly from budgetary projections during SFY 2000. Total benefit expenditures for SFY 2000 are projected to be approximately $19,323,398, which is $705,643 less than the final appropriation for the year. Final total benefit expenditures cannot be reported for SFY 2000 at this time, as all claims incurred for services provided during the fiscal year have not yet been received, processed and paid.

HMO Risk Pool

In SFY 2000, the Department also received an initial appropriation of $2.4 million to fund a temporary HMO risk pool arrangement. The risk pool is designed to provide a limited source of funds, which may be used to mitigate managed care organization losses due to unexpected financial risk during the initial years of the program. As enrollment grows and credible utilization data is compiled, the need for the HMO risk pool will diminish, until it is eliminated altogether. This appropriation was also reduced to reflect the revised caseload projection noted above and to correct a technical error in the original appropriation regarding the distribution of managed care and non-managed-care enrollment. The final HMO risk pool appropriation for SFY 2000 was $1,265,612. Appropriated funding splits for the HMO risk pool were as follows: $441,572 cash funds exempt and $824,040 federal funds.

Disbursements (if any) from the risk pool to participating HMOs will be based upon audited reports of HMO benefit expenditures for SFY 2000. If appropriate, they will be made on May 1, 2001, to allow a full run-out of claims and adequate time for financial analysis. Any funds remaining in the HMO risk pool will revert to the CBHP Trust Fund per program statute.

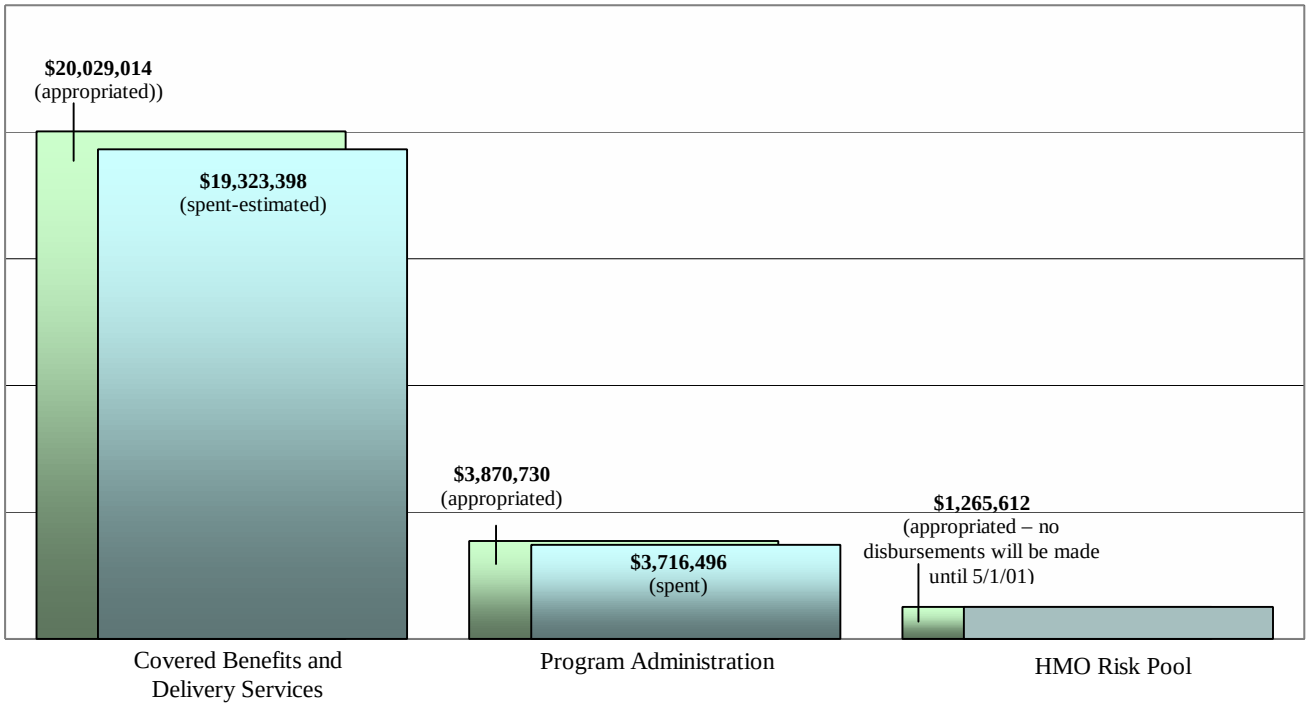
Administrative Costs

The Department received a SFY 2000 appropriation of $3,870,730 to fund core administrative functions for CBHP. These included marketing, eligibility, enrollment, family premium administration, community outreach and coordination. This appropriation also included funds for necessary professional services staffing and agreements maintained by the Department for

conduct of program administration, accountability, evaluation and oversight. Finally, this appropriation reflected investments made by the Department in the development of information systems and program infrastructure, which will improve the efficiency of operations and capture program data essential to informed, state policy making. Appropriated funding splits for CBHP administration were as follows: $1,350,498 cash funds exempt and $2,520,232 federal funds.

Total SFY 2000 administrative expenditures for the CBHP functions noted above were $3,716,496. Approximately $154,233 of the total administrative appropriation was unspent, and will revert to the CBHP Trust Fund.

SFY 1999-2000 CBHP
Expenditures to Appropriations



DMG-Maximus Study

As mentioned above, the federal government requires CBHP to screen applicants for Medicaid eligibility. This is important to assure that all children are enrolled in the appropriate program. However, due to the Medicaid screen, the asset test in particular, there is significant cost to CBHP. A June 30, 1999, study by DMG-Maximus estimated that the administrative cost of screening for Medicaid eligibility is 73% of the costs associated with enrolling a CBHP eligible child. Approximately 20% of children screened are Medicaid eligible.

As this program matures, the CBHP Policy Board and the Department are working to maximize federal dollars in the most cost-effective manner.

Administrative Structure

The State Auditor identified the current CBHP structure as one issue that needed to be addressed. Specifically, the State Auditor raised the concern regarding the multi-tiered approach to program development and implementation. The CBHP Policy Board is reviewing the current structure and will be making recommendations to the General Assembly to resolve the issues identified by the State Auditor.

Federal Allocation

The State of Colorado is returning $19 million allocated by the federal government to CBHP primarily for the payment of enrolled children's health benefits. This funding was set aside for Colorado's use in SFY 1999 when the program was just getting underway. Utilizing these funds is contingent on enrolled children using benefits. In the program's first year, CBHP was not in a position to use all of the funding because efforts were focused on establishing an effective administrative structure and reaching out to the community.

Congress allowed states three years to use this allocation because it recognized that programs nationwide were in a start-up phase. As of this report, it appears that the federal government may continue to make this funding available for payment of CBHP benefits for an extended period of time as more children enroll.

Federal 10% Administrative Limit

The federal law that established all Title XXI programs specifies that federal funding is not available for state administrative expenditures in excess of 10% of total program expenditures. Over the course of SFY 2000, total program enrollment increased by 80% from an average monthly enrollment of 12,825 to approximately 23,015. However, SFY 2000 administrative expenditures exceeded the federal funds matching limitation by $3,447,681, of which $1,872,501 were for core administrative functions and $1,575,180 were for network administration.

The costs inherent in the development and maintenance of CBHP's administrative structure are largely fixed rather than variable. The program's fixed costs are decreasing as a proportion of the total CBHP budget due to the fact that they will remain relatively constant as total enrollment grows.

The Department has implemented numerous financial and managerial strategies in its efforts to obtain federal matching funds for all program expenditures (benefits and administration) and reduce administrative costs. These strategies are:

- Holding the total administration budget relatively constant as enrollment grows;
- Allocating appropriate costs to Medicaid;
- Reducing the cost of premium administration; and
- Restructuring financing arrangements for CBHP provider network administration.

THE YEAR IN REVIEW

There have been numerous successes and challenges throughout SFY 2000. CBHP continues to evolve administratively with each partner from the CBHP Policy Board to community partners finding and refining their role. The program has matured and learned through its experiences with rules and regulations that there can be unintended barriers and consequences, such as the issues identified through the eligibility rule process, that can be addressed to meet the needs of families.

CBHP marketing and outreach strategies have broadened to include a wide variety of techniques to meet the needs of disparate family concerns. The program will continue to pilot new initiatives and track on-going efforts to assure the strategies employed are the most successful and cost effective.

Finally, CBHP will continue to refine the unique public/private partnership that Colorado has employed to assure maximum community involvement and take advantage of the most appropriate administrative efficiencies that meet the Program's goals.

GLOSSARY

Appropriation

A legislative spending authority for a specific purpose, as contained in the Long Bill and special bills.

Cash Funds Exempt

Revenues that are exempt from the 'Taxpayers' Bill of Rights (TABOR) limitation such as: donations, collections from a previous year or revenues transferred from another agency.

Federal Funds

Matching revenues from the federal government based on a percentage of state expenditures.

General Fund

State revenues collected through taxation that are legislatively appropriated to various financial priorities statewide.

Supplemental

A requested revision to the revenues appropriated for the current state fiscal year. Revisions may be positive, negative or simply change the spending authority as recorded in the Long Bill.