A healthy start: A road map to improving CHP+ in Colorado

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Acknowledgments

All Kids Covered is a statewide, non-partisan coalition working to improve the well-being of Colorado's children through health care coverage. Since 2006, All Kids Covered has worked together with elected officials, health care leaders, state and county agency staff, and community-based organizations to fight for comprehensive health coverage for all Colorado kids.

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Key Acronyms

Acronym	Definition
ACC	Accountable Care Collaborative, Colorado's Medicaid delivery system
AKC	All Kids Covered, a non-partisan coalition working to improve the well-being of Colorado's children through health care coverage
ASO	Administrative Service Organization, the contracted entity that runs the State Managed Care Network
CHIP	The federal Children's Health Insurance Program, which provides health coverage to children and pregnant women who earn too much income to qualify for Medicaid, but do not have access to affordable private or employer coverage
CHP+	The Child Health Plan Plus, Colorado's name for its Children's Health Insurance Program
CMS	The Centers for Medicare and Medicaid Services, the federal agency that oversees Medicaid and the Children's Health Insurance Program
eFMAP	Enhanced Federal Medical Assistance Percentage, an enhancement to the federal match rate to states for the Children's Health Insurance Program
EPSDT	Early Periodic Screening Diagnosis and Treatment, a federally-mandated set of health benefits available to all children enrolled in Medicaid; the purpose of EPSDT is to ensure that all Medicaid eligible children receive comprehensive and preventative health care to the maximum extent that Medicaid allows under medically necessary criteria.
FMAP	Federal Medical Assistance Percentage, the federal match rate to states to support the Medicaid program
FPL	Federal Poverty Level, income guidelines used by many government programs to determine eligibility
HCPF	Colorado Department of Health Care Policy and Financing, the state Medicaid agency
HSI	Health Services Initiatives, federal funding through Medicaid and the Children's Health Insurance Program that allows states to design initiatives to improve the health of children
MCO	Managed Care Organization
RAE	Regional Accountable Entity, accountable care organizations responsible for administering both physical and behavioral health services for Health First Colorado enrollees in seven regions across the state
SMCN	State Managed Care Network, the state's third party administrator that oversees CHP+ for all enrolled pregnant women statewide, as well as children in many counties where there are no managed care organizations available
SPA	State Plan Amendment, agreement between a state and the federal government describing how that state administers its Medicaid and Children's Health Insurance Programs and benefits.

I. Recommendations Summary

Introduction

All Kids Covered (AKC) is a coalition of child health advocates including consumer groups, hospitals, and health plans that has been working, since 2006, to improve the wellbeing of children in Colorado through quality, affordable, continuous, and equitable health insurance coverage for all Colorado kids. Providing coverage for children and families who make too much to qualify for Medicaid but not enough to afford private health insurance has been a focus of this work since the beginning. A key program helping to fill this gap is the Children's Health Insurance Program (CHIP).

Colorado launched its CHIP program in 1997, shortly after federal legislation passed creating the program that was designed to help bridge the healthcare gap between Medicaid and commercial insurance for children. The Colorado Children's Basic Health Plan, which goes by the program name Child Health Plan *Plus*, or CHP+, was created to look and feel like commercial insurance, with benefits that resembled typical commercial coverage, cost-sharing through enrollment fees and co-pays, and services delivered through a traditional managed care model using managed care organizations (MCOs). There have been adjustments to the program over time -- those typical of public programs, such as changes in the income eligibility thresholds, adding coverage for pregnant women, a few benefit enhancements, and several other administrative adjustments; however CHP+ continues to run much as it did when it was first implemented. Its primary goal remains to provide healthcare coverage and access for children and pregnant women who make too much to qualify for Medicaid but cannot afford private coverage.

In late 2017 and early 2018, CHIP programs nationally faced a crisis, with the potential that the program would end when Congress failed to reauthorize federal funding as expected by September 2017. When Congress finally did reauthorize funding, for an unprecedented 10-year period, it provided Colorado with a unique opportunity to evaluate CHP+ and identify opportunities both to make program improvements for families and providers, as well as increase coverage and access for Colorado children and pregnant women. The goal of this White Paper is to present an analysis and set of recommendations about options that that could enhance CHP+ in both the short and longer term, within the context of Colorado's larger healthcare landscape.

Health Management Associates (HMA) was contracted by AKC to identify opportunities for improving the CHP+ program for Colorado children and their families. This report provides recommendations for both short and long-term priorities to improve the CHP+ program.

Research conducted for this White Paper included examining the available literature about state CHIP programs, discussions with members of the AKC Coalition, input from staff at the state Medicaid agency, the Department of Health Care Policy and Financing (HCPF), and targeted interviews with key Colorado stakeholders ranging from policy experts and providers to MCO representatives and consumers.

Recommendations for How AKC Can Support Improvements to CHP+

Following are several key steps that policy and program advocates for CHP+ should consider as they contemplate how to most effectively move the CHP+ program forward. They fall into five general categories of focus:

A. Improving operations and systems.
B. Streamlining and enhancing program administration.
C. Augmenting benefits, both for children and for pregnant women.
D. Reducing or mitigating coverage gaps and increasing coverage options for families.

E. Exploring a Combined Health First Colorado and CHP+ Program.

Within each category, recommendations are identified as to whether they are short term and could be accomplished in six to 12 months, medium-term and could be done in one to two years, or long-term and would need three to five years to be fully realized.

A. Improving Operations and Systems

Partner with HCPF to fix foundational CHP+ systems and process issues, including through structures such as the CHP+ MCO working group, targeted meetings with key HCPF staff responsible for these areas, provider organizations, and/or the establishment of a new formal workgroup(s). Areas on which to focus should include:

1. **Short-term -** Ensuring that systems issues related to 12-month continuous coverage for CHP+ and Medicaid are fully identified and resolved.
2. **Short-term -** Documenting enrollment process problems related to passive enrollment and identify feasible solutions to achieve full resolution.
3. **Short-to-medium term -** Make a newborn's CHP+ coverage retroactive up to three months, effective on their birth date.
4. **Medium-term -** Explore eliminating the pre-HMO period and enrolling members in their MCO on the day they are determined eligible.

B. Streamlining and Enhancing Program Administration

1. **Short-term -** Support HCPF in seeking additional resources to focus on improving current CHP+ operations, as well as begin to explore opportunities for longer-term program improvements.
2. **Short- to-medium-term -** Collaborate with HCPF on revising the MCO contracts for the 2020 state fiscal year after a stakeholder engagement process. HCPF and other CHP+ stakeholders need to have comprehensive data about information such as member demographics, enrollment and disenrollment trends, utilization and costs, as well as quality and outcomes to make informed decisions that will make significant program improvements. MCO contracts should prioritize:
    - Improving quality and other performance reporting to better align quality and key performance indicator reporting between CHP+ and Health First Colorado.
    - Formalizing incorporation of screening and tracking information on the social determinants of health (SDoH) for CHP+ enrollees to align with what Health First Colorado's Regional Accountable Entities (RAEs) are doing to track and support SDoH needs among members.
    - Design value-based payment mechanisms for the MCOs and require the MCOs to include such mechanisms for their providers to incentivize desired quality and performance.
3. **Medium- to-long-term –** Explore different Service Delivery Options for CHP+, such as service areas that align with the Health First Colorado RAE regions, administering CHP+ through different MCOs or through the RAEs, or requiring CHP+ MCOs to participate in Colorado's State-based marketplace.

C. Augmenting Benefits for Children and Pregnant Women

While CHP+ provides a generally comprehensive set of benefits, there are areas where augmentation of existing benefits or the addition of new benefits could help to improve the health of children and pregnant women enrolled in CHP+.

1. **Short- to-medium-term -** Explore augmenting benefits for children, such as:
    - Expanding access to behavioral health services and growing the number of pediatric practices with integrated primary and behavioral health care, expanding access to care

coordination for children with dual physical/behavioral health diagnoses, and increasing use of peer support specialists.
- Raising the dental benefit cap to allow for additional preventive and restorative procedures.
- Adding applied behavioral analysis (ABA) therapies for children with autism spectrum disorder, to align with requirements for commercial health plans and with Pediatric Therapy treatments covered in Medicaid through Early Periodic Screening Diagnosis and Treatment (EPSDT).

2. **Short-to-medium-term -** For pregnant women, explore expanding coverage, including:
   - Adding dental benefits for all enrolled pregnant women – this is currently a priority for HCPF and the All Kids Covered Coalition, and new legislation was recently introduced to propose implementing this benefit addition (HB19-1038).
   - Studying options for continuing coverage for women beyond the current 60 days they have once their pregnancy ends. This is particularly important for women who need ongoing treatment for post-partum depression, and for those who fall into the "family glitch" coverage gap. These women are locked out of affordable coverage through the exchange because of access to their spouse's employer-sponsored coverage, but they cannot afford the employer coverage either.[1]

D. Reducing/Mitigating Coverage Gaps and Increasing Coverage Options for Families

Colorado, like all states, has the opportunity to pursue funding through the Health Services Initiative (HSI), a federal program that supports initiatives to provide preventive services to children in Medicaid and CHIP (see additional details on HSI on page 22 of this White Paper).[2] Three opportunities identified through the research and stakeholder conversations for this White Paper would lend themselves particularly well to accessing HSI funding include:

1. **Short- to-medium-term -** Assessing the churn between CHP+ and Medicaid, and between CHP+ and either commercial coverage or no coverage, and identifying ways to help families navigate between programs.
2. **Medium- term -** Study adding all EPSDT benefits or expanding current benefits in CHP+. A key difference between Health First Colorado and CHP+ benefits remains access to the full set of EPSDT services and supports - comprehensive benefits that are federally mandated for all children in Medicaid, but not for CHIP. One way to reduce coverage gaps would be to add full or expanded EPSDT benefits to CHP+, primarily through eliminating benefit limitations by adopting all the current EPSDT benefits and the same medical necessity criteria as in Medicaid.
3. **Medium- to long-term -** Investigate the option of offering parent/family supports as "value-added benefits" through CHP+, such as transportation vouchers or memberships to local recreation centers.

E. Exploring a Combined Health First Colorado and CHP+ Program

The above recommendations and priorities encompass actions and activities for CHP+ program improvements that could occur over the next six months to three years. There is an additional key recommendation identified by stakeholders that would require a longer time period for a more thorough exploration - the feasibility of combining Health First Colorado and CHP+ under the Accountable Care Collaborative (ACC) umbrella – the overall service delivery structure for Colorado's Medicaid program. The state has a prime opportunity to study this now, given the recent 10-year

[1] https://www.verywellhealth.com/aca-family-glitch-1738950

[2] www.medicaid.gov/federal-policy-guidance/downloads/faq11217.pdf; www.cms.gov/newsroom/fact-sheets/michigan-health-services-initiative

funding re-authorization for CHIP. AKC will be an important resource and support for HCPF in that process. As part of this effort AKC should consider the following activities.

1. **Medium-to-long-term -** Essential steps to exploring options for combining CHP+ with Medicaid should include working with HCPF providers and other stakeholders to establish a workgroup with the specific task of evaluating the impacts of merging CHP+ into the Health First Colorado ACC structure. Underlying all of these aspects should be consideration of the longstanding bipartisan support that CHP+ has enjoyed and how merging it with Medicaid could change that support dynamic. This workgroup should, at minimum, investigate and evaluate the following areas:
    - Administrative changes that would be required at HCPF and any potential cost savings these might generate.
    - Costs and benefits of expanding Medicaid benefits to all children and pregnant women currently on CHP+.
    - Effect on providers and clients.
    - Effects on various member cohorts, such as families in rural Colorado, those with relatively healthy children vs. children who may have chronic health needs, families who are higher income and more susceptible to churning off of CHP+ because of income increases, families who use the Medicaid Buy-In program for Children with Disabilities, etc.
    - Federal mechanisms (e.g., State Plan Amendments - or SPAs - and waivers) that would be required to accomplish this.
    - Challenges and concerns for both the current ACC RAEs and the CHP+ MCOs to gather their input and ideas, as well as what they see as challenges and opportunities.
    - Effects on counties, including the administrative, operational, and financial costs and benefits to them.
    - How changes to CHP+ fit into the larger context of health care reforms in Colorado and help the state to create a continuum of quality and affordable health care coverage that is accessible for all Colorado families.

F. Additional Recommendations and Considerations

Applying an Equity Lens to CHP+ Improvements

Stakeholders also identified that it is critical to apply an equity lens in all advocacy efforts. Systems, including economies, neighborhoods, and government programs like CHP+, determine how resources are distributed. Often those systems have developed in the context of discriminatory policymaking and biased attitudes and beliefs. As a result, it can be especially hard for certain groups, including people of color, immigrants and their families, and people with nonconforming gender identities to access the basic things everyone needs to be healthy, including quality affordable health care. Applying an equity lens to advocacy involves recognizing the ways in which systems disadvantage certain groups and targeting efforts to address those systemic defects.

As systems and process improvements are studied and implemented, they must include identifying ways to ensure access to enrollment and services for qualified individuals and families who face particular barriers such as limited English proficiency (LEP) and attitudes and policies about immigrant access to public benefits. For example, many of the CHP+ systems issues such as confusion about eligibility and enrollment are exacerbated for children and families whose first language is not English, or immigrant families who have some members who are U.S. citizens and some who lack proper documentation. Addressing all of these recommendations must include improving the experiences of those with language or cultural barriers.

It also is important to incorporate equity information into the data that is collected, analyzed, and distributed about CHP+. More robust information about factors such as demographics, language preference, immigrant status, etc., should be available regarding applicants and members. This would allow both advocates and HCPF to target initiatives and efforts to better support specific groups who may be experiencing unnecessary challenges and barriers to coverage and care.

Engaging Providers and Consumers

Given the general consensus that CHP+ enjoys considerable support from a very broad community of stakeholders, it will be important for AKC to consider how to incorporate the voices of these many stakeholders - especially providers and consumers - into the process of implementing these recommendations as much as possible. This may be accomplished through a variety of mechanisms, including participation in various workgroups, interviews, focus groups, and surveys.

Legislative Authority and Appropriations

Finally, it is important to note for all of the recommendations included in this report, specific actions or activities that need resources or include significant changes in policy or program operations also may require HCPF to have legislative authority and/or appropriations before they are able to move forward. In some cases, changes also may require federal authority through state plan amendments or waivers. These types of authority are discussed in more detail later in the paper.

The full White Paper below provides some brief contextual background information about the state's CHP+ program and Health First Colorado. It also offers additional details for each of the above recommendations for strengthening and enhancing CHP+ for children, their families, and providers, and optimizing program effectiveness and efficiency.

II. Contextual Overview of CHP+ and Health First Colorado (Medicaid)

Child Health Plan Plus (CHP+)

The Children's Health Insurance Program (CHIP) was created in 1997 to fill a gap in insurance coverage for children in families with incomes over the Medicaid limit, but who were unable to afford private coverage. Colorado's CHIP built upon an existing program for children called the Colorado Child Health Plan and took the name Child Health Plan *Plus* (CHP+), managed by HCPF.

CHP+ offers a comprehensive set of benefits to children up to age 19 with incomes between 143 percent and 260 percent of the federal poverty level (FPL)[3] and includes benefits that are structured based on commercial benchmark coverage. CHP+ is a full-risk managed care model run through contracts with private health insurers, as well as a State Managed Care Network (SMCN) that is run by a contracted Administrative Services Organization (ASO). In 2002, Colorado added the Prenatal Care Program (Program) to CHP+, which extends coverage to pregnant women ages 19 and older with incomes between 196 and 260 percent FPL.[4] The Program provides coverage for enrolled women through the CHP+ SMCN up to the end of the month in which the 60th day after the end of the pregnancy occurs and covers most of the same benefits as children enrolled in CHP+ receive, with the primary exception of dental benefits.[5] CHP+ average monthly enrollments numbers for calendar year 2018 were 82,313 for children and 861 for pregnant women.[6]

Because CHP+ is structured as a stand-alone program separate from Health First Colorado, it has its own administrative structure within HCPF. The CHP+ full-risk managed care model requires oversight of the contracts for each of the organizations providing care, its own accounting and budgeting processes, as well as its own data and reporting for the Centers for Medicare and Medicaid Services (CMS). However, HCPF has integrated many of the up-front aspects of CHP+ with Medicaid, such as using a single eligibility application, a common eligibility determination process for both programs, and payment of the CHP+ enrollment fees for individuals and families through the PEAK online system.

On January 22, 2018, Congress passed a six-year extension of CHIP funding, providing stable funding for states through Federal FY2023.[7] A second bill, passed on February 8, 2018, extended funding through FFY2027, although the CHIP allotment to states will change starting in FFY2024.[8] This 10-year funding extension is the longest Congress has passed since CHIP's creation. The extension also continues the 23-percentage point enhanced federal medical assistance percentage (eFMAP) rate for CHIP that was established by the Patient Protection and Affordable Care Act (ACA), although this enhanced rate gradually reduces over time and eventually will revert to the original rate of 65 percent by FY2021.[9] Colorado currently receives the eFMAP of 88 percent for CHP+.

Health First Colorado

Colorado authorized its Medicaid program in 1969, and it was re-branded as "Health First Colorado" in 2016 to reflect a more modernized program. Under 2010 ACA, and through state legislation passed in

[3] For pregnant women, coverage lasts 60 days after the pregnancy ends
[4] https://www.colorado.gov/pacific/sites/default/files/April%202018%20CHP%2BIncome%20Chart%20Final.pdf
[5] https://www.coaccess.com/members/chp/new/
[6]https://www.colorado.gov/pacific/sites/default/files/2019%20January%2C%20Joint%20Budget%20Committee%20Monthly%20Report.pdf
[7] https://www.kff.org/medicaid/fact-sheet/summary-of-the-2018-chip-funding-extension/
[8] Ibid.
[9] Ibid.

2013, Colorado opted to fully expand Medicaid with coverage starting in January 2014 to all citizens and qualified immigrants living in the state under the law's new eligibility guidelines; this now also includes eligibility for children and pregnant women who are lawfully present immigrants, regardless of their date of entry into the U.S. The average Health First Colorado enrollments number for calendar year 2018 was 1,286,661, which equates to approximately 23 percent of the state's population.[10] Of those 1.2 million, just over 500,000 are children.

Most Health First Colorado members are enrolled into ACC, currently in Phase II (initiated in 2018). In this second phase of this evolving delivery system model, the state combined the administration of both the behavioral health and physical health benefits under a single organization called a Regional Accountable Entity (RAE). A smaller portion of Health First Colorado members (approximately 114,000[11]) are enrolled in two previously existing limited capitation initiatives within the ACC.

Federal payments to a state depend on each state's FMAP, which ranges from the minimum of 50 percent to a high of a 74 percent for states with the lowest per capita income.[12] The FMAP is adjusted annually. In Colorado, the current FMAP for non-expansion Medicaid enrollees for FY2019 is set at the minimum of 50 percent. However, under the ACA, states that expanded Medicaid received an enhanced FMAP for expansion enrollees, which started at 100 percent and will decrease to 90 percent by 2020.

Differences Between CHP+ and Health First Colorado

Both Medicaid and CHIP are public insurance programs that provide coverage for certain populations, including children and pregnant women. Both are jointly funded with federal and state dollars. In Colorado, both Health First Colorado and CHP+ are administered by HCPF. However, there are foundational differences between the programs in Colorado, in terms of benefits and services, covered populations, and administrative structure and financing. A summary of these differences can be found in Figure 1 below.

Figure 1. Key Differences between Health First Colorado and CHP+ at the State level

	Health First Colorado (Medicaid)	Child Health Plan *Plus* (CHIP) - Children	Child Health Plan *Plus* (CHIP) – Pregnant Women
Eligibility	For ages 0-18: household incomes up to 142% of the FPL For pregnant women: household incomes up to 195% of the FPL	For uninsured children ages 0-18, with household incomes between 143% and 260% FPL	For uninsured pregnant women ages 19 and older, with household incomes between 143% and 260% FPL
Federal Match Rate	FMAP – 50% (currently 93% for CY 2019 for Medicaid expansion group – tapering to 90% in 2020)	eFMAP – 88% (ratcheting down to original FMAP of 65% by 2021)	Same as for children

[10]https://www.colorado.gov/pacific/sites/default/files/2019%20January%2C%20Joint%20Budget%20Committee%20Monthly%20Report.pdf
[11]https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/Managing%20Medicaid%20in%20Colorado.pdf
[12]https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8352.pdf

Federal Funding	Guaranteed – no cap (entitlement)	Not guaranteed – capped federal funding (quasi-entitlement)	Same as for children
Waiting Lists	Not permitted	Permitted (although not adopted by Colorado)	Same as for children
Dual Private & Public Coverage Allowed?	Yes	No	No
Benefits	Full Medicaid benefits including Early Periodic Screening Diagnosis and Treatment (EPSDT) mandate	Receive benchmark* coverage, no mandate for EPSDT	Receive benchmark* coverage, not including dental benefits, from start of pregnancy and up to 60 days after pregnancy ends
Premiums and Co-Payments Allowed?	Colorado does have for some of the waiver and buy-in programs for individuals with household incomes >150% FPL	Colorado has both enrollment fees and co-payments based on a household's income	Pregnant women do not have to pay an enrollment fee or co-pays

*Each state sets a **benchmark plan** as the baseline of benefits and coverage for other plans, which must provide at minimum those same levels of benefits and coverage. In Colorado, the benchmark plan is the State of Colorado Kaiser HMO Plan.[13]

Covered Populations

Health First Colorado and CHP+ differ in the populations that each program covers based on eligibility levels linked to an individual's income. Enrollment between Health First Colorado and CHP+ can change as a family's income changes, with children sometimes moving back and forth between the two; or children can gain access to employer coverage or private plans through the exchange. This movement between programs, or movement from coverage to being uninsured, is a process known as "churn." Eligibility levels and enrollment numbers are listed below in Figure 2.

Figure 2. Eligibility Levels by Population Group for Health First Colorado and CHP+, 2019[14]

Health First Colorado			Child Health Plan Plus		
Population Group	*Eligibility Level*	*Enrollment (CY2018)*	*Population Group*	*Eligibility Level*	*Enrollment (CY2018)*
Children (ages 0-18)	142% FPL	510,240	Children (ages 0-18)	260% FPL	82,313
Pregnant Women (age 19 and over)	195% FPL	13,441	Pregnant Women (ages 19 and over)	260% FPL	861

Member Benefits, Provider Reimbursement

Medicaid requires states to provide all children with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits, which are designed to ensure that children receive all medically necessary preventive, dental, mental health, developmental, and specialty services.[15] Separate CHIP programs do

[13] https://www.colorado.gov/pacific/dora/aca-benchmark-health-insurance-plan-selection

[14] https://www.colorado.gov/pacific/sites/default/files/2019%20January%2C%20Joint%20Budget%20Committee%20Monthly%20Report.pdf

[15] https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

not have this mandate. This allows states greater flexibility on what benefits they can offer through CHIP but can result in substantial differences in benefits between Medicaid and CHIP, which is the case in Colorado.

Colorado CHP+ members are covered under a capitated full-risk managed care model with a commercial-like benefit package, compared to Health First Colorado's ACC model that incorporates a mix of payment structures from fee-for-service (FFS) to capitated full-risk and includes a more comprehensive set of benefits. CHP+ provides some level of coverage for many benefits covered by Health First Colorado, but with specific limitations either in service units or dollar value. These differences can have an impact on the quality and efficiency of children's healthcare services if they churn back and forth between the two programs because of changes in family income or other circumstances.

Also, Health First Colorado and CHP+ each maintain different provider reimbursement rates. There is a general consensus among physicians that CHP+ reimburses at a higher rate than Health First Colorado, but a more intensive analysis of rates would be needed to determine the true difference. However, even small variances may make a difference to providers and thus are an important factor to consider when comparing the two programs.

III. Priorities for Improving CHP+

The priorities detailed below reflect the combined information and ideas gathered from the research and stakeholder input conducted for this White Paper and can be broadly categorized under five categories:

A. Improving operations and systems.
B. Streamlining and enhancing program administration at HCPF.
C. Augmenting benefits, both for children and for pregnant women.
D. Reducing/mitigating coverage gaps and increasing coverage options for families.
E. Exploring a Combined Health First Colorado and CHP+ Program

These categories have been further divided between actions that could be completed in the short- (6 - 12 months), medium- (1-2 years), and longer-term (3- 5 years) due to operational complexities and policy issues that would have to be addressed first. The sections below outline these priorities and steps that could be taken to improve the program in each of these areas.

In some cases, priorities may require additional resources or include significant changes in policy or program operations. HCPF generally must have legislative authority and/or appropriations before they are able to move forward on such actions. In some cases, changes also may require federal authority through state plan amendments or waivers. These types of authority are discussed in more detail later in the paper.

A. Improving Program Operations and Systems

As noted above, HCPF needs adequate resources to be able to dedicate attention on fixing policy, program, and systems problems that are impacting CHP+ eligibility and enrollment today, as well as exploring and implementing operations and systems improvements over time. Having sufficient and expert support focused on CHP+ issues would help identify solutions and prioritize problem fixes that might otherwise have to wait. These recommendations center around the primary areas where many of the key interviewees and other stakeholders agree there are problems, even as the program operates with relatively few issues. Again, it is important to remember that some of these changes could require that HCPF seek legislative support not only for appropriations, but also for potential statutory authority updates.

1. **Short-term:** Verify that systems rules and processes that impact eligibility are functioning correctly and consistently over time; for example, 12-month continuous coverage for both Health First Colorado and CHP+.

   Some families and providers have reported that there are occasional issues with 12-month continuous eligibility that occur for children enrolled in CHP+. This can cause problems of unnecessary churn between Health First Colorado and CHP+, which has potentially adverse impacts on families' access to both providers and certain benefits. While it may not impact a significant proportion of children, it is an issue that has compounded ripple effects that can be critical to families and to providers. Thus, it should be a priority to monitor this issue to ensure that all systems and processes are functioning and continue to function correctly to maintain accurate 12-month continuous coverage.

2. **Short-term:** Review the passive enrollment process into MCOs and identify opportunities for improvement.

   Based on stakeholder feedback, it appears that many of the earlier issues related to the PEAK online application and account system have been greatly improved and members experience fewer

problems there. However, some of the stakeholders identified a few remaining glitches with communications around enrollment, most notably related to occasional delayed notification from the state and/or county on which CHP+ MCO a client is enrolled in for services. The communications received sometimes can be confusing and unclear to families, which leaves them questioning their child's enrollment, and it is not always clear to them who they should contact with questions – the state, their local county social services office, or the MCO. This can lead to frustrations of having to take time to try to sort through the various layers (county, state, MCO) to validate eligibility, dates of enrollment, and MCO enrollment.

3. **Short-term:** Make a newborn's CHP+ coverage retroactive up to three months, effective on their birth date.

   The goal for this would be to ensure that as long as an application was received for the child within at least 90 days of their birth, coverage would be effective retroactive to their birth date. Health First Colorado already is structured this way, because retroactive eligibility can pay for a newborn's health care during the three months prior to their enrollment. Retroactive coverage usually is not available in separate CHIP programs, including Colorado's. However, states may elect, through a State Plan amendment (SPA), to pre-date a newborn CHIP enrollee's coverage eligibility to their birth date during their first three months. For example, New York and Kansas allow backdating newborn coverage to the date of birth if the parents file an application within a specified time period[16,17]; Pennsylvania covers newborns under the mother's CHIP for the first 31 days[18]; and West Virginia automatically enrolls newborns on the first day of the month of their birth.[19]

   Options should be explored for how to facilitate enrollment of eligible newborns as soon after their birth date as possible, including signing babies up before they leave the hospital as part of their discharge paperwork, as well as applying their coverage retroactively to the day they were born. This would help both providers and families by ensuring coverage of services during a critical time for newborns and mothers, and one in which it can be easy for administrative application requirements to be overlooked.

4. **Medium-term:** Explore eliminating the pre-HMO period and enrolling members in their MCO or a state-administered SMCN on the day they are determined eligible.

   Several interviewees mentioned that it would be helpful to explore eliminating the pre-HMO period and have enrollment into MCOs begin on the day the member's eligibility starts rather than waiting until the first of the next month. This would have to be investigated to understand the financial, systems, policy, and MCO impact. For example, the state's new Medicaid Management Information System (MMIS), *interChange*, which gives HCPF more flexibility for designing and implementing different types of provider reimbursement mechanisms, may make the pre-MCO period unnecessary. Other questions that would need to be explored in conjunction with this are how this would work with the 30 days applicants have to pay an enrollment fee before their application is cancelled, the current passive enrollment methodology, and how CHP+ might handle presumptive eligibility through the MCOs. HCPF is evaluating the feasibility of bringing the SMCN in-house, which could potentially eliminate the pre-HMO period and these other issues.

[16] https://info.nystateofhealth.ny.gov/sites/default/files/CHPlus%20Newborns%20Presentation.pdf
[17] https://khap2.kdhe.state.ks.us/kfmam/policydocs/PD%20Medicaid%20Newborn%20Eligibility%2009-16.pdf
[18] https://www.chipcoverspakids.com/Eligibility/Documents/CHIP%20Eligibility%20and%20Benefits%20Handbook%202017.pdf
[19] http://www.wvdhhr.org/bcf/policy/imm/New_Manual/IMManual/Manual_PDF_Files/Chapter_07/ch7_14.pdf

B. Streamlining and Improving Program Administration

As a stand-alone program within HCPF, CHP+ requires its own staff and administrative infrastructure within HCPF. Staff oversee and manage contracts for the five MCOs that serve CHP+ members, plus the ASO that operates the SMCN. They also provide the full complement of management reports and program documentation to the Colorado State Legislature and CMS, including the separate financing structure, managed care requirements, and other federal/state statutory and regulatory requirements.

Stakeholders noted that when CHP+ was first launched, there were a lot more federal and state resources put toward supporting the program. For example, because such a significant focus was on enrolling eligible children, the program included significant marketing and outreach funding. Given significant outreach efforts over the years, and the implementation of the ACA, there are many fewer eligible but not enrolled children. These changes have led to CHP+ having fewer dedicated staff than it had at one time. While there are many staff who support aspects of CHP+ (e.g., budget, rates, accounting, IT, etc.) there currently are only three full-time CHP+ staff.

Still as one stakeholder noted, "CHP+ works pretty darn well." CHP+ has had a largely problem-free history - outside of the recent federal crisis regarding program authorization and funding, and the co-occurring stakeholder process to identify options for winding down the CHP+ program if funding had not come through. This is in part due to CHP+ serving populations with fewer needs and lower costs than many Medicaid members (CHP+ covers primarily healthy, slightly higher income children and pregnant women, while Medicaid covers many children with greater health issues, as well as those with complex special needs through waiver programs). Because Health First Colorado is so much bigger, both in terms of members and budget, and because it is more complex, it simply overshadows CHP+. Especially with the implementation of ACC Phase II - which brought significant operational changes for the state, providers, and members – as well as the various Medicaid waiver programs, the majority of HCPF's resources are logically focused on administration of this larger and more comprehensive program.

However, this more focused emphasis on Medicaid over the last few years has resulted in less of an impetus toward exploring opportunities to improve or "update" CHP+. As such, research and interviews conducted for this White Paper identified several recommendations for consideration to streamline and enhance CHP+ program policies and operations, including examining the option to eliminate the stand-alone program and combine it with Health First Colorado. These recommendations are presented in a general order of priority and timing.

1. **Short-term:** Support HCPF in any potential future efforts to seek additional resources to focus on improving current CHP+ operations, as well as begin to explore opportunities for longer-term program improvements.

   To really explore how the program could/should be improved and implement any changes, HCPF needs to augment its small team of current CHP+ staff with resources that can provide additional, policy, operations, and financing expertise focused specifically on improving the CHP+ program. This is important for two reasons: 1) to address immediate program policy and operational needs, and 2) to identify the best ways to improve the program over the next several years and to facilitate implementation of those improvements. This includes whether, and how, HCPF could effectively merge CHP+ into Health First Colorado.

   For example, whether employed staff or external experts, these additional staff should have enough expertise and knowledge, specifically of federal CHIP policies and program operations, to be able to provide overall guidance and direction to the current CHP+ MCOs and SMCN ASO. They further should have enough line of sight into operations to make high-level program recommendations,

have the ability to prioritize systems problems that should be fixed, and have the ability to design and help implement operational improvements. Although dedicated to CHP+, it is imperative that this team also closely collaborate and coordinate with Health First Colorado HCPF leadership and ACC staff, to identify ways in which both Health First Colorado and CHP+ can continuously work toward better alignment. HCPF is at a critical juncture with CHP+ and needs to ensure it has adequate dedicated resources to guide current operations, as well as support careful study of next steps for the program.

2. **Medium-term:** Provide input to HCPF on revising the MCO contracts for the 2020 state fiscal year (SFY) after a stakeholder engagement process.

   In the 20+ years since CHP+ was launched, there have been relatively few changes to the current contract structure for MCOs that provide CHP+ coverage - Colorado Access, Friday Health Plans (previously known as Colorado Choice Plans), Denver Health, Kaiser Permanente Colorado, and Rocky Mountain Health Plans. Virtually all stakeholders interviewed commented that there is a lack of comprehensive data about CHP+, in part because the MCOs do not currently provide it to the state.[20] It is critical for HCPF and stakeholders to have robust data about utilization and costs, as well as timely data about quality and outcomes to make informed decisions that can have significant impacts on program improvements.

   For example, it will be important for HCPF to identify ways to incorporate into the next round of CHP+ contracts quality, outcome, and performance indicators that more explicitly align to those required of the new Medicaid RAEs. This would help to bring the two programs closer together in terms of performance standards and encourage MCOs to incentivize their providers who are participating in both CHP+ and Medicaid to manage both sets of patients more similarly. Additionally, the CHP+ MCOs are audited annually on several Healthcare Effectiveness Data and Information Set (HEDIS) measures[21] – standardized measures used by the National Center for Quality Assurance (NCQA), which accredits managed care organizations who meet specific quality metrics and other criteria. While there is some overlap with the Health First Colorado Key Performance Indicators that RAEs[22] must meet, providers have noted that the metrics between Health First Colorado and CHP+ are different enough that they create additional administrative burdens for practices that serve children and pregnant women in both programs.

   Stakeholders should encourage the incorporation of screenings and supports for social determinants of health (SDoH) and create expectations for CHP+ MCOs to assist families in navigating to providers and services they need outside of the health care system. For example, if members meet certain criteria based on their SDoH screens, they could receive additional supports through "value-added benefits," services and supports above and beyond mandatory benefits for things such as transportation to medical appointments, food prescriptions, or help with housing quality issues (e.g., mold, lead paint). MCOs also could offer enhancement of pediatric patient-centered medical home criteria and payments to providers, enhanced models of care coordination, or other

[20] Per HCPF staff, today MCOs provide encounter data to the state's actuary; however, they are in the process of finalizing the submission of encounter data to the state's interchange system.

[21] *2016–2017 External Quality Review Technical Report for Child Health Plan Plus*, Health Services Advisory Group, Inc., for the Colorado Department of Health Care Policy and Financing, December 2017; https://www.colorado.gov/pacific/sites/default/files/CO2016-17_CHP%2B_TechRpt_F1.pdf

[22] *Colorado Department of Health Care Policy and Financing Accountable Care Collaborative (ACC) Key Performance Indicators (KPI) Methodology State Fiscal Year 2018-19, VERSION: V4,* Truven Health Analytics, July 2018 https://www.colorado.gov/pacific/sites/default/files/Key%20Performance%20Indicator%20Methodology%20FY%202018-2019.pdf

partnerships with providers and consumers. This would build new supports for families that are higher income, but still need access to safety net services that can help them maintain and achieve economic stability. It also would create greater alignment between CHP+ around the levels of care coordination between the programs. These may be things that could be funded in part by the Health Services Initiatives (HSI) mechanism, which is described in more detail on page 22 of this report.

Finally, new performance measures should be accompanied by new payment models. The payment models would be designed to create incentives for the CHP+ MCOs to help the state meet specific health outcome and cost containment goals for CHP+, as well as to more closely align with those of Medicaid. This also can serve to reduce administrative burdens on providers who are serving children and pregnant women in both Health First Colorado and CHP+. These recommendations will require a thorough and thoughtful rate review to ensure the state is able to maintain adequate rates to keep both the MCOs and providers engaged.

There are multiple models from other states that have fully-capitated Medicaid programs that HCPF could use as examples for strengthening performance, quality, data, and reporting requirements for CHP+ without creating an unnecessary burden for the participating MCOs. For example, Kaiser Family Foundation provides data on Medicaid managed care quality initiatives and payment models such as pay-for-performance bonuses, capitation withholds, and publicly available MCO quality comparison data, all related to quality initiatives specified in states' SFY 2018 MCO contracts.[23] However, one caveat is that making such significant changes to current contracts also could require a SPA, and potentially a re-procurement.

3. **Medium-term:** Explore different service delivery options for CHP+.

   There are many ways HCPF could potentially structure the CHP+ program's delivery model and service areas, while continuing to maintain the essential full-risk capitated delivery model mandated in current state legislation. For example, it could look at aligning CHP+ MCOs service areas with the RAE regions; having a single, statewide service area; using the RAEs as the MCOs to administer CHP+; requiring MCOs that administer CHP+ to participate, and offer mirrored plans, in Connect for Health Colorado; or a myriad of other such options. The point being that it is worth the time and effort to study what service delivery model(s) could most effectively serve CHP+ members and providers, while also supporting efficient operations for HCPF.

B. Augmenting Benefits

Benefits for Children

As discussed above, children in Health First Colorado have access to a wide-ranging set of benefits under EPSDT, whereby Medicaid is required to cover all "medically necessary" preventive, dental, mental health, developmental, and specialty services. CHIP programs such as Colorado's are not required to provide EPSDT benefits. Thus, while CHP+ does offer robust and child-focused benefits, they are not as expansive as those in Health First Colorado under EPSDT. For example, CHP+ includes many of the same EPSDT benefits as Medicaid, but not all of them; and those that are included have limitations such as a certain number of visits or maximum dollar amounts. Thus, there are several benefit enhancements that could be explored to further align CHP+ and Health First Colorado. This would help to ensure fewer continuity of care effects on children who move between Health First Colorado and CHP+, reduce the

[23] https://www.kff.org/medicaid/state-indicator/medicaid-managed-care-quality-initiatives/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

burden for providers who serve children in both programs, and give CHP+ children and families access to additional services and supports.

1. **Short-to-medium term:** Improve behavioral health services and access.

   In Colorado, like many states, youth have significant behavioral health needs.[24] Colorado's high rates of youth suicide is cause for significant concern across the state. According to the 2015 Healthy Kids Colorado Survey (HKCS)[25] nearly a third of Colorado high school students feel so sad or hopeless for two weeks in a row that they stop doing their usual activities; up from less than 25 percent in 2013. In the 2017 HKCS, 17 percent of all participating middle and high school students reported considering suicide and 7 percent reported making one or more suicide attempts in the previous 12 months.[26]

   While CHP+ provides behavioral health benefits, interviewees noted that the state should be looking for every opportunity to build on efforts such as those of the State Innovation Model (SIM) grant to expand integrated physical and behavioral health to include more pediatric practices. Given the managed care structure of CHP+, HCPF could work with MCOs to incentivize providers to move toward integrated care, as well as build network capacity to improve general access to behavioral health services. This could include building into MCO contracts performance metrics related to behavioral health access and opportunities for value-based payments related to efforts to increase access to behavioral health services, increasing care coordination for families with children with behavioral health needs, building behavioral health workforce capacity through recruitment, as well as programs such as telehealth and peer support specialists.

2. **Short-to-medium term:** Raise the dental benefit cap.

   Colorado Medicaid uses the dental periodicity schedule recommended by the American Academy of Pediatric Dentistry (AAPD).[27] While CHP+ provides coverage for diagnostic, preventive, basic restorative, root canals, and some extractions, there is an annual maximum benefit cap for dental services of $1,000.[28] Beginning in state fiscal year 2019-2020 (which starts July 1, 2019), DentaQuest will become the new CHP+ dental benefits provider. As the new dental vendor, DentaQuest is offering an additional $1,000 in benefits subject to additional Prior Authorization Request (PAR) criteria for CHP+ children, as a value-added benefit above the current $1,000 cap. While it does not change the state's $1,000 benefit cap, this will be valuable for many CHP+ children. As interviewees noted, investing in helping children maintain healthy teeth and gums can prevent much costlier health issues longer-term. Poor oral health care has been linked to issues such as cardiovascular disease, endocarditis, premature birth, and low birth weights[29] and the cost of treating tooth-decay related cases in emergency rooms cost more than $110 million for states in 2006.[30]

   Overall, in Colorado, from 2016-17, 31.3 percent of kindergarten students and 15.2 percent of third graders had untreated tooth decay, showing that dental care remains a significant issue in the

[24] *Breakdown: Mental Health in Colorado*, Jennifer Brown, The Denver Post, 2014, http://extras.denverpost.com/mentalillness/index.html
[25] https://www.colorado.gov/pacific/cdphe/hkcs
[26] Healthy Kids Colorado Survey 2017, Colorado Department of Public Health and Environment (Denver, CO, 2018).
[27] http://www.aapd.org/assets/1/7/AAPD_Periodicity_Schedule.pdf
[28] https://www.colorado.gov/pacific/hcpf/child-health-plan-plus-dental-care
[29] https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475?pg=2
[30] http://www.ncsl.org/research/health/improving-access-to-medicaid-dental-benefits.aspx

state.[31] The same report also showed that students at the lowest socioeconomic status (SES) schools were more likely to have tooth decay and less likely to have preventive sealants than students at the highest SES schools.[32] Studies have also shown that children with poor oral health are three-times more likely to miss school due to oral health problems[33], making access to oral health care important for a child's education. Thus, it would be worth exploring the option of formally increasing current coverage limits with a focus on additional procedures that can improve health outcomes and reduce overall health care costs long term for children by increasing their access to oral health services.

3. **Short-to-medium term:** Add Applied Behavioral Analysis (ABA) therapies for children.

   Several treatments for a diagnosis of Autism Spectrum Disorder (ASD) are covered under CHP+ if they are determined to be medically necessary, appropriate, effective, or efficient; however, ABA therapy is not a CHP+ covered benefit. For example, CHP+ does pay for evaluation and assessment, habilitative or rehabilitative care such as occupational therapy, physical therapy, and speech therapy for fine and gross motor delays, and psychiatric/psychological services; but it currently will not pay for ABA therapy. Under Medicaid, the services that previously had been provided through the Autism Waiver (Waiver, which was discontinue in June 2018) now have been incorporated into the State Plan services under EPSDT, as a broader suite of services called Pediatric Behavioral Therapies. Now instead of serving a very small number of children via the Waiver, any child eligible for Medicaid has access to these services based on a validated screening and care plan submitted through HCPF prior approval process. Families with children with ASD who are over the income threshold but still under 300 percent FPL (after disregards) can "buy-in" to Medicaid, at a cost of approximately $1,200 per year.[34]

   In 2010, Colorado began requiring commercial health plans to provide ABA benefits for children with Autism Spectrum Disorder. Plans must provide at least $34,000 of coverage per year for ABA for children ages from birth to nine years.[35] Plans also must provide at least $12,000 of coverage per year for ABA for a child nine years of age or older until the child is 19.[36] One option would be to explore how CHP+ could include similar requirements for ABA therapy to match those of commercial plans. This would need to include an analysis of both costs, as well as access to qualified providers, which initially presented problems for many of the commercial plans.

Benefits for Pregnant Women

A significant difference between Health First Colorado and CHP+ is that pregnant women in CHP+ do not have access to many of the more robust health services available to pregnant women enrolled in Health First Colorado. Here, too, is an area where additional data about pregnant women covered by CHP+ is needed. For example, tracking when prenatal care starts, whether members get the recommended number of visits during their pregnancies, what types of screenings pregnant women receive pre- and post-partum (e.g., depression screening), and what types of post-partum care and services they receive. However, one complicating factor for collecting and reporting this type of data is the way providers bill

[31] https://www.colorado.gov/pacific/sites/default/files/PW_OH_BSSReport.pdf
[32] Ibid.
[33] Jackson, S., Vann, W., Kotch, J., Patel, B., & Lee, J. (2011). Impact of Poor Oral Health on Children's School Attendance and Performance. American Journal of PublicHealth,1900–1906
[34] https://www.colorado.gov/pacific/hcpf/medicaid-buy-program-children-disabilities
[35]http://advocacy.autismspeaks.org/atf/cf/%7B2A179B73-96E2-44C3-8816-1B1C0BE5334B%7D/Colorada_FAQ.pdf
[36] Ibid.

for prenatal services – through global billing. This limits the level of detailed information that is accessible through claims data.

1. **Short-to-medium term:** Add dental benefits for pregnant women.

   Pregnant women in CHP+ have no dental benefits at all, yet they are especially vulnerable to developing oral health problems due to hormone fluctuation, oral lesions, morning sickness, and sugary dietary cravings.[37] These issues can lead to serious complications for fetal development and although the mechanism is not fully understood, poor maternal oral health has been linked to preterm births, low birth weight, and early childhood caries.[38] This is an area that already is a priority focus for HCPF, which is supporting new legislation proposed under HB19-1038 to include dental services to all eligible enrollees, which would cover pregnant women, as well as children.[39]

2. **Medium-term:** Study extending coverage for pregnant women who fall into the "family glitch."

   Pregnant women in CHP+ lose their coverage at 60 days after the last day of the month in which their pregnancy ended. Though, in general, women use few health services in the postpartum period, many need ongoing behavioral health supports and some need ongoing physical therapy. Some women are able purchase subsidized coverage through the exchange, which generally provides comparable health benefits. However, there are women who fall into the "family glitch" and are not able to purchase affordable coverage through the exchange or an employer.[40] This "glitch" means that some low-to-moderate-income families are locked out of receiving financial assistance to purchase health coverage through the health insurance exchange because of the way their spouse's employer-provided coverage is offered. The exchange defines "affordable" employer insurance based on the cost of *individual-only* coverage; it does not take into consideration the often significantly higher cost of a family plan. This creates a situation where some families essentially have no access to affordable coverage. For these women, the state should study options for keeping them enrolled in CHP+ for up to a year post-partum.

   This could be especially important for pregnant women who are diagnosed with a behavioral health need while enrolled in CHP+. CHP+ does include limited coverage for behavioral health services such as outpatient treatment, medication management, day treatment, emergency services, and inpatient services and residential treatment. Women who fall into the family glitch coverage gap, would potentially lose access to important behavioral health services. Allowing them to remain enrolled in CHP+ for a full 12 months post-partum could provide them access to critical services. Women who lose Medicaid coverage when their pregnancy ends (those over age 19 with incomes between 133% FPL and 195% FPL) and who would otherwise fall into the "family glitch" would benefit from being able to join this CHP+ program in the post-partum period.

[37] https://www.aafp.org/afp/2008/0415/p1139.html
[38] Adam Allston, Improving Women's Health And Perinatal Outcomes: The Impact Of Oral Diseases (2002)
[39] http://leg.colorado.gov/bills/hb19-1038
[40] https://www.verywellhealth.com/aca-family-glitch-1738950

C. Reducing/Mitigating Coverage Gaps and Increasing Coverage Options

An important consideration in health coverage is the "churn" that can occur between Health First Colorado and CHP+, as well as between these programs and private coverage via employer insurance plans or the Exchange. As children churn between programs, based on changes in family incomes and access to insurance, it can have a big impact on their ability to maintain a consistent medical home - if their providers are not part of all networks - on the services they receive, and the benefits they can access. However, there are consequences for states, providers, and health insurance plans as well from costs associated with enrolling and disenrolling beneficiaries, reconciling billing issues, and expenses associated with delivering "new member" services multiple times.[41] If smoother transitions could be created and if there were an easier transition between public programs or between public and private programs (or vice versa), including more aligned benefits, it could help to decrease the burden on members, MCOs, providers, and the state.

One notable vehicle for potentially funding some of these activities is the Health Services Initiative (HSI - see the call-out box, "What is a Health Service Initiative?"[42]). Colorado could submit an HSI State Plan Amendment to CMS that focuses on improving the health of children enrolled in CHP+ through projects that incorporate the provision of preventive services and interventions.[43] Oklahoma, for example, used HSI funds to organize focus groups to identify ways to improve treatment guidelines and medication monitoring of psychotropics for foster care youth enrolled in Medicaid.[44] Similarly, Colorado could leverage HSI funds to support a project such as those noted here, which were raised as important issues by stakeholders, including: studying the "churning" between CHP+ and other coverages or no coverage; exploring expanding full EPSDT benefits to CHP+; and providing additional supports to CHP+ families. Again, because it requires a state match, it is important to remember that HCPF would need to first seek legislative approval to pursue HSI funds for any initiatives.

What is a Health Services Initiative (HSI)?

- Under Title XXI, states have the option to develop a state-designed HSI to improve the health of children with low-incomes who are younger than 19 years old and are eligible for CHIP and/or Medicaid.
- To date, states have used HSIs to provide preventive services and interventions such as:
  - School health programs
  - Youth violence prevention programs
  - Lead testing and abatement
  - Training of staff to administer naloxone
  - HCBS services to foster care youth
- States must finance the non-federal portion of HSI expenditures, and the federal portion is funded from the 10% CHIP allotment directed towards administration. All CHIP administration expenses must be funded first; any funds left over may be used for an HSI up to the 10% cap.

1. **Short- to-Medium-term:** Study the "churning" that occurs between CHP+ and other insurance programs (Medicaid, employer sponsored insurance, Qualified Health Plans) and ways to support families in navigating the various coverages.

   This could help to identify where the most churn is occurring and where adjustments may be needed to stabilize coverage for kids. Once the main issues are identified, steps could be taken to

[41] Instability of Public Health Insurance Coverage for Children and their Families: Causes, Consequences and Remedies. Laura Summer and Cindy Mann. The Commonwealth Fund. 2006.
[42] www.medicaid.gov/federal-policy-guidance/downloads/faq11217.pdf; www.cms.gov/newsroom/fact-sheets/michigan-health-services-initiative
[43] https://www.medicaid.gov/federal-policy-guidance/downloads/faq11217.pdf
[44] https://nashp.org/oklahoma-uses-focus-groups-to-identify-strategies-to-better-serve-foster-care-youth/

create processes to ease transitions. HSI could provide dollars to the state of Colorado to take a deeper look into the churn issue and, with a better understanding of the problem, could design a program to help children and families moving between CHP+ and Health First Colorado or the Exchange/private coverage to navigate changes in providers, health plans, benefits, and services to ensure that they are able to continue established prevention and treatment plans. This research could also play a role in considering another aspect of what it would look like to merge together Health First Colorado and CHP+ into one program.

2. **Medium-term:** Study adding all or expanding EPSDT benefits into CHP+.

   While several benefit enhancements have been described above, a key difference between Health First Colorado and CHP+ benefits remains access to the full set of EPSDT services and supports only for children in Health First Colorado. One way to improve access to health services for CHP+ clients care would be to add full or expanded EPSDT benefits to CHP +, primarily through eliminating benefit limitations by adopting all the current EPSDT benefits and the same medical necessity criteria as in Medicaid. This could significantly benefit children who move between the programs, ensuring they have improved access to services and supports that are part of any individualized care plans they may have in either program.

   EPSDT provides coverage that is recommended by the American Academy of Pediatrics' Bright Futures standards and helps to promote the early discovery and treatment of health problems that may impede a child's development.[45] Staff at HCPF did note that the CHP+ MCO contracts include language that MCOs meet "recommended screenings in accordance with the American Academy of Pediatrics (AAP) accepted Bright Futures schedule." However, interviewees for this White Paper generally agreed that the state should be making more investments in children's health to help reduce greater long-term costs and making full EPSDT benefits available to CHP+ children would help to do that.

   However, adding this "gold standard" level of benefits to CHP+ is not without controversy, especially related to administrative burden and associated costs.[46] For example, stakeholders have indicated that because of issues such as lack of access to providers, lack of information, lack of transportation, and other barriers, many children in Health First Colorado do not actually receive the required screenings and treatments under EPSDT. This is particularly true in rural areas, where there can be a struggle to access specialty care and dental care services[47], and transportation problems can be compounded significantly. Also, in 2017, 17.2 percent of individuals with public insurance in Colorado reported issues finding a provider who accepted their insurance.[48] Further, problems with providers not always coding visits correctly or under-reporting also have been noted. Studying these potential barriers and how to effectively address them should will be a critical component of understanding the feasibility of expanding EPSDT benefits for CHP+.[49,50]

[45] https://ccf.georgetown.edu/wp-content/uploads/2014/08/MCDCoverage_Children0to5.pdf
[46] EPSDT: Medicaid's Critical but Controversial Benefits Program for Children. Christie Provost Peters. National Policy Health Forum. Issue Brief No. 819. 2006.
[47] https://www.packard.org/wp-content/uploads/2016/02/Children-Health-Care-Coverage-and-Access-Cross-State-Issue-Brief.pdf
[48] https://www.coloradohealthinstitute.org/research/2017-access-care-index
[49] Ibid
[50] The Colorado Health Institute plans to release a Medicaid Access to Care Index sometime in the near future that may help to further data available to better understand these issues.

3. **Medium-term:** Opportunities to provide additional support for families.

   One unique idea that arose from the interviews and research was looking at ways CHP+ could potentially create partnerships with other providers, organizations, and agencies that would create value-adds to benefit both children enrolled in CHP+ and their parents. For example, developing discount programs for recreation centers to promote healthy activities for the whole family, discounts on items such as glasses and over-the-counter medications, or transportation vouchers or discounted bus passes. Many families in CHP+, especially those right at the edges of eligibility based on their slightly higher incomes, are still working hard to make ends meet. Leveraging CHP+ as a mechanism to help them access needed services and assistance for the whole family would help to strengthen the safety net of supports that can help them achieve and sustain economic stability. As noted by one stakeholder, families who do not qualify for Medicaid also typically do not qualify for other programs or services that are subsidized specifically for individuals and families living at or below the poverty level. This is an area where CHP+ MCOs may be able to offer incentives or "value-added benefits" to members that would support overall health of children and families, for instance, tying supports to needs identified through screening for SDoH. It also is an area where HCPF could potentially use HSI funding to create innovative prevention programs or services for CHP+ children.

D. Exploring a Combined Health First Colorado and CHP+ Program

The above steps and priorities encompass actions and activities for CHP+ program improvements that could occur over the next six months to three years. However, one key priority that would require a longer time period is exploration of the feasibility of combining Health First Colorado and CHP+ under the ACC umbrella, which would affect CHP+ across all four of the operational categories noted above: streamlining program administration, improving operation systems, augmenting benefits, and reducing coverage gaps. AKC should provide support to HCPF in exploring the option of merging CHP+ into the Health First Colorado program; moving all children into the ACC care delivery model to create a combined program. The timing is optimal now, given the 10-year funding authorization, which allows HCPF some time to study and make long-term changes to the program without the threat that funding might end halfway through the process, or that CHIP could disappear entirely.

In 2013 with the removal of the "stairstep" of different eligibility requirements based on ages and incomes, many children previously eligible for CHIP became eligible for Medicaid. For example, in CY 2018, there was an average enrollment of 63,393 kids and 2,309 pregnant women in the categories in Medicaid that were created from SB 11-008 and SB 11-250 (the categories that previously would have been eligible for CHP+). Colorado saw a significant transition of children into these populations starting in January 2013, which gives the state some good historical data and lessons learned to help understand the impacts of a major transition of enrollment.

Additionally, while there is little national research on the benefits or outcomes related to stand-alone vs. combined CHIPs, there is a good case study from California (see below), which transitioned from a stand-alone CHIP to a combined program within the last five years, that also offers some important perspective and lessons learned for at least one state's experience. While it is important to recognize that full assessment of the impacts of combining CHP+ with Health First Colorado requires a comprehensive and robust analysis of these kinds of data and information, as well as many other factors and inputs, stakeholders consulted for this White Paper identified some high-level pros and cons that should be considered. Those pros and cons are noted below.

High-Level Pros and Cons of Combining CHP+ and Health First Colorado

Pros

As other states with combined Medicaid and CHIP programs do, Colorado could provide the same package of benefits and services to all enrolled children, including EPSDT services, and the state would still receive the eFMAP for the CHP+ eligible population. This would eliminate benefit differences for both providers and families, simplify provider billing and care management, and make it easier for families to navigate provider changes.

A combined program would create significant administrative simplification for HCPF, and potential cost savings, by eliminating the need to have separate program staffs and structures for program oversight, provider management, rate setting and budgeting, contract management, and reporting. Once initial systems changes were made, it also would potentially streamline day-to-day operations functions and processes for things like eligibility and enrollment, member communications, provider network management, RAE management, etc.

There is potential cost savings for benefits and services, as well, as shown in the table below of HCPF's state fiscal year 2019-20 per capita cost projections for CHP+ and Health First Colorado children and prenatal women. Importantly, CHP+ is more expensive per member (for non-waiver children and pregnant women) than Health First Colorado even though it has a more limited benefit package. However, it also is significant to remember that Colorado receives a higher match rate for CHP+ than Health First Colorado, so that means more of the cost of CHP+ is covered by federal match.

Figure 3. Estimated Per Capita Cost Projections SFY 2019-20 for CHP+ and Health First Colorado Children and Pregnant Women[51]

	CHP+	Health First Colorado (SB 11-008, SB 11-250)
Children	$ 2,424.84	$1,830.80
Pregnant Women	$12,804.09	$9,059.77

Finally, a combined program would effectively eliminate "churn" between Health First Colorado and CHP+ as households' incomes change. Children would have access to the same benefits and the same network of providers, so the issues families face today when they move between the programs would not exist.

Cons

Initial transition from the stand-alone program to a combined program would likely result in some children losing access to providers they had in CHP+ due to the different member attribution process within the Health First Colorado RAEs and because not all CHP+ providers participate in Medicaid. Although potentially disruptive initially, it is expected that the effects of this would abate as families settled into the new processes and structure of the RAEs.

There also might be some providers who would choose not to participate in a combined program if they believed they would have a decrease in reimbursement. HCPF would need to determine if it would continue to pay providers different rates for children and pregnant women who qualify for CHP+, which could impact how willing providers are to either continue seeing those members, or potentially cut back on the number of Medicaid and CHP+ members they would accept in their panels. Loss of participating

[51] FY 2019-20 per capita cost projections from HCPF's most recent forecast, as of February 22, 2019.

providers could erode access to care. For example, reports from Georgetown University show that some 45 percent of Colorado children in 2017 did not receive the recommended six or more well-child visits in their first 15 months.[52] Approximately 40 percent didn't have at least one well-child visit in their third, fourth, fifth, and sixth years.[53] Such low numbers are likely the result of many factors, but this is a critical issue that would require considerable further examination to fully understand the potential impacts of combining CHP+ with Health First Colorado.

In addition to general access issues, inclusion of more benefits does not necessarily equal access to those benefits. For example, some interviewees cited problems for many children enrolled in Health First Colorado not being able to access some of the more specialized EPSDT benefits, such as physical, speech, and occupational therapies, and the new pediatric behavioral therapies. Increasing the number of children eligible to receive these kinds of benefits without addressing the access issues could create other unintended consequences for children, families, and providers.

Other Important Considerations

Stakeholders for this White Paper reflected that it often feels as though Medicaid is in a state of flux, with major changes and/or challenges created by new policies, program changes, new delivery models, payment reforms, new systems and business processes, etc. Their fear is that because of the seemingly constant changes in Medicaid, CHP+ children might not get the same access to care or the same quality of care that they now get in CHP+. For example, one interviewee commented, "I never get complaints from providers about CHP+, they only have problems with Medicaid." Another shared, "CHP+ is easier for families because health plans provide the communications. CHP+ requires more from the plans for making sure the members understand what is happening and how to navigate the system." With ongoing issues such as how members are attributed to primary care providers, what roles the RAEs play, the bi-furcated structure of physical and behavioral health, stakeholders were concerned that by merging CHP+ into Medicaid the state would be trading a program that works well for children and families, for one in which there seem to be many more ongoing challenges for both families and providers.

Since its inception CHP+ has enjoyed particular bipartisan favor and been a program supported by both Republicans and Democrats in the Governor's Cabinet, as well as the State Legislature. This historically has been in part because of the program's design as a "public-private partnership" with MCOs, which did not carry the stigma of Medicaid - something that for many years was thought of more as a "welfare" program than as health care coverage. However, especially in recent years, norms have shifted, and more people have come to recognize the value of Medicaid as health insurance that provides not only health care but important economic stability to millions of children, families, individuals with disabilities, adults without dependent children, and older adults. This has greatly reduced the stigma attached to Medicaid, which could mean the state now is potentially ready for CHP+ to be merged into its larger sister program.

Concurrent with examining the feasibility of merging CHP+ and Health First Colorado, and perhaps as part of that process, AKC also should work with HCPF to study how CHP+ could be most effective as a separate program, if findings suggest that it is not optimal to merge the programs. This should include a review of a variety of options regarding the MCO delivery model, service areas, alignment with both the Health First Colorado ACC and Colorado's Exchange, similar to what is outlined under recommendations 2 and 3 for Streamlining and Enhancing Program Administration.

[52] https://ccf.georgetown.edu/wp-content/uploads/2018/10/Promoting-Healthy-Development-v5-1.pdf
[53] Ibid

The California Case Study

There is virtually no research that has been done to understand differences in health outcomes and overall costs between stand-alone and combined CHIPs. In part this reflects the individual nature of states' programs. However, a case study from California, which recently transitioned from a stand-alone to a combined program, offers some lessons for how Colorado could potentially implement a similar change. California showed that it is possible to successfully combine a separate CHIP program with Medicaid, although they faced many of the same pros and cons noted above. This case study provides a good example of the types of issues that could play out for Colorado, both positive and negative.

Case Study: How California Combined Its Separate CHIP with Medi-Cal

Beginning in 1998, with the creation of CHIP under Title XXI, California administered its health insurance programs for children through three separate programs: (1) Medi-Cal (California's Medicaid program) through the Optional Targeted Low-Income Children (OTLIC) authority; (2) through a separate CHIP program entitled the Healthy Families Program (HFP); and, (3) the Access for Infants and Mothers (AIM) program for pregnant women and their children funded by CHIP dollars.[54] In the 2012-13 California state budget, the Governor proposed a plan to shift all children in HFP and AIM into Medi-Cal to consolidate the three separate programs and improve the continuity of care.[55] The proposal would also help to meet ACA requirements under the Medicaid expansion of including families below 133 percent of the FPL. This proposal also included an expansion of Medi-Cal full-risk managed care into all California counties.

Ultimately, the Department of Health Care Services (DHCS) transitioned more than 750,000 children from HFP into Medi-Cal. The transition occurred over four phases, with completion occurring on November 1, 2013.[56] All CHIP children are now enrolled under specific aid codes within Medi-Cal to facilitate tracking of administrative costs, and claims for FMAP, as well as other reporting.

Phase 1: transitioned children who were in an HFP plan that was also a Medi-Cal plan.

Phase 2: transitioned children who were in an HFP plan that was a Medi-Cal plan subcontractor.

Phase 3: transitioned children who were in an HFP plan that had no contract or subcontract with a Medi-Cal plan.

Phase 4: transitioned children in counties where previously no Medi-Cal plan operated.

The biggest changes that resulted when California combined their programs were related to dental care, mental health, and alcohol and substance use disorder (SUD) treatment.[57] Most children had to transition to the state's FFS dental program, Denti-Cal, requiring many to change dental providers. DHCS helped to ease this transition in part with the creation of a Beneficiary Customer Service line that included warm transfers to new providers. For mental health, all children in CHIP gained coverage to Medi-Cal mental health services, which covers the mental health services that can be provided by a child's PCP; children who need additional services must be referred to their county mental health plan or local FFS provider. Prior to this, mental health was only offered to those with serious emotional disturbances through county mental health plans. Finally, for alcohol and SUD treatment, many children who transferred into Medi-Cal were able to access this benefit through the Drug Medi-Cal program.

[54] https://www.dhcs.ca.gov/dataandstats/statistics/Documents/CHIP_Paper_FINAL-ADA.pdf
[55] https://lao.ca.gov/analysis/2012/health/healthy-families-021712.aspx
[56] https://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/AppendixCHFP.PDF
[57] Ibid.

Pros
▪ Under the transition, most children were able to maintain their primary care provider. However, children in Phases 3 and 4 had higher rates of a provider change occurring.[58] ▪ The state projected savings ($91 million/year after full transition) due to reduced reimbursement rates to managed care plans and the fact that average rates paid to Medi-Cal plans are generally lower than the average HFP rates.[59] California has some of the lowest provider rates in the country for its Medi-Cal program – significantly lower than the rates it paid through the HFP. ▪ Overall, most members were pleased with the transition.
Cons
▪ Children with autism initially lost access to applied behavioral analysis services as they were not covered under the Medi-Cal managed care benefit package. ▪ There was an expected loss of providers because many were unwilling to enroll in Medi-Cal (29% of HFP pediatricians prior to the transition, per a state survey) due to concerns about lower rates, more complicated administrative procedures, and access drug formularies.[60]

F. Further Factors to Consider for Improving CHP+

In conjunction with the above recommendations, stakeholders also noted several additional factors that AKC should consider as it looks to support improvements in the CHP+ programs.

Applying an Equity Lens to CHP+ Improvements

As many stakeholders noted, there are a number of systems and process issues that can make navigating both CHP+ and Health First Colorado difficult and confusing for applicants and members. These kinds of issues are often more challenging for families with limited English proficiency (LEP), with a mix of members who are U.S. citizens and non-citizens, and those with limited access to transportation or Internet access. Across all of the above recommendations, it will be important to apply an equity lens that acknowledges and addresses the ways in which the program excludes or discriminates against people based on English-language proficiency, immigration status, race, gender identify, or economic circumstances.

All systems and process improvements that are studied and implemented should incorporate enhancements designed to ensure equal and straightforward access to enrollment and services for all qualified individuals and families, especially those who are impacted by systemic barriers like language discrimination and policies and attitudes that deter or prohibit program utilization by immigrants and their families. This also includes ensuring that HCPF and others are mindful of collecting the data and information that is needed to understand the impacts of policy and program changes, and to inform all policy and program decisions. This includes working with MCOs and providers to collect more robust data on demographics, language preference, immigrant status, etc., regarding applicants and members. This kind of information can be a powerful tool that both advocates and HCPF could use to better support all Colorado families in accessing the care and coverage for which they are eligible.

Engaging Providers and Consumers

Similarly, as has been briefly noted above, CHP+ is a program that both consumers and provides like and believe works well today. As changes to the program are explored, it is critical for AKC and HCPF to

[58] Ibid.
[59] Ibid.
[60] https://lao.ca.gov/analysis/2012/health/healthy-families-021712.aspx

consider how best to ensure the voices of all constituents and stakeholders inform the process. In particular, providers and consumers need a seat at the table. This may be accomplished through a variety of mechanisms, including participation in various workgroups, interviews, focus groups, and surveys.

Legislative Authority and Appropriations

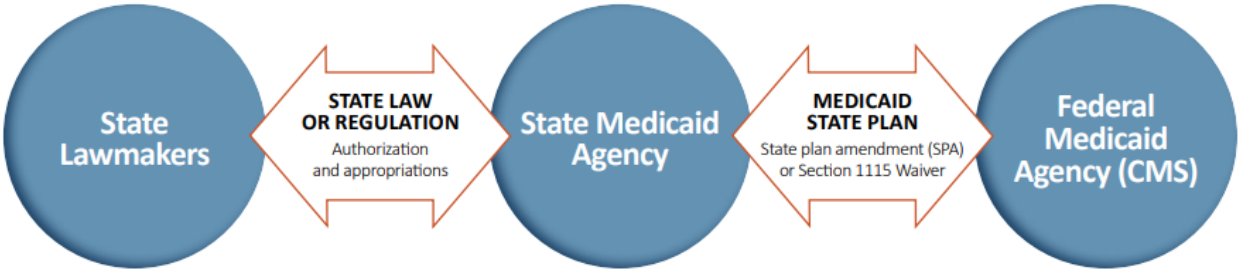
Finally, as has also been noted throughout this paper, it must be remembered that CHP+ is a public program and HCPF requires both legislative authority and appropriations – federal and state – to make significant policy and program changes. In addition to providing a voice of checks and balances to ensure that CHP+ meets the true spirit of serving Colorado families, AKC can be a powerful ally with HCPF for garnering the support of state lawmakers and providing input for necessary federal authorities such as SPAs and waivers that might be needed to help move the program forward to its next phase.

IV. Mechanisms for Changing CHP+ Program and Operations

Many of the CHP+ program improvements noted in this White Paper could be made through mechanisms such as MCO contract amendments and internal systems and process improvements. However, for significant policy and operational changes, both advocates and HCPF must be mindful of the importance of ensuring appropriate legislative authority and/or appropriations - both state and federal. State legislative authority typically requires either a new bill, amending an existing bill, or an approved budget action. Federal authority requires either submitting a state plan amendment (SPA), or a waiver. Some changes could necessitate both state and federal approval.

For example, HCPF could submit a SPA that would incorporate changes, such as quality requirements, adding benefits, changes to existing benefits, changes to cost-sharing, etc. While Colorado does not have state statutes or codes that requires legislative approval for changes to the State Plan, changes to the Medicaid program still require partnering with state lawmakers. Depending on the level and extent of changes, Colorado State Legislators might still need to pass new laws or make new appropriations, regardless of whether or not HCPF must submit a SPA to CMS, as shown in Figure 4. Once approved by CMS, the changes would go into effect indefinitely until/if changed by a subsequent SPA or other federal waiver.

Figure 4. The Process for Making Changes to Medicaid Program Requires State and Federal Partners[61]



The second option is to submit an 1115 demonstration waiver, which would be required for any changes that could not be made via a SPA. An 1115 waiver must show how proposed changes will improve patient care in a way that does not cost CMS more than projected costs would be otherwise – known as "budget neutrality,"- which can be a complicated and time-consuming process for the state.[62] These waivers typically are approved for an initial five-year period, then can be extended. The state also would have to provide an evaluation of whether the changes (e.g., providing EPSDT benefits to children in CHP+ or increasing BH benefits) would increase the services children are able to access, help children live healthier lives, and not increase costs.

For pregnant women, currently the adult prenatal coverage in CHP+ is through an 1115 Demonstration waiver. Colorado's first approval for the demonstration, titled "Colorado Adult Prenatal Coverage and Premium Assistance CHP+", in 2002, and was granted a third extension period in 2015 that extends the demonstration through July 31, 2020.[63] For this specific demonstration, the state's two objectives include:[64]

[61] http://www.ncsl.org/Portals/1/Documents/Health/Medicaid_Waivers_State_31797.pdf
[62] https://familiesusa.org/sites/default/files/product_documents/State-Plan-Amendments-and-Waivers.pdf
[63] https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8179
[64] https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8179

1. Increase the percentage of pregnant women who receive prenatal and postpartum care for those enrolled in the demonstration.
2. Increase the number of healthy babies born to pregnant women enrolled in the demonstration.

Based on how coverage is offered to pregnant women through CHP+, there are two options for how benefits could be expanded. First, when Colorado applies for a fourth extension (which would need to be submitted no later than 12 months prior to the expiration date of July 31, 2020), new/enhanced benefits could be added as a factor that would be expected improve on the objectives of the demonstration.

The second option would be more complicated, and would involve Colorado submitting a SPA, specifically the Pregnant Women State Plan Amendment.[65] This SPA would tie medical coverage for adult pregnant women to benchmark coverage, benchmark-equivalent coverage, or Secretary-approved coverage and would include more comprehensive benefits, including dental coverage.[66] This amendment would have to be approved by CMS, and likely would increase costs to the state by adding more benefits to be covered under the CHP+ program. This could somewhat be offset by the current enhanced match rate, although this is set to end in 2021. However, overall the CHP+ program covers relatively few women compared to Medicaid (approximately 900 in CHP+ vs. 13,000 in Health First Colorado in 2018) so the total costs would reflect the low volume of members. Ultimately, the SPA could provide a more long-term stable benefit to pregnant women than currently allowed under the 1115 demonstration waiver and allow pregnant women greater access to a wider package of benefits and services.

For either SPAs or 1115 waivers, the state will have to make a substantial investment in time and resources. Both will require policy analysis, benefit development, actuarial analysis, rate reviews, and public comment processes.

[65] https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/09/DC_Oral_Health_Care_Pregnant_Women_04-05-12.pdf

[66] See 42 U.S.C. §§ 1397cc(c)(5) (mandating coverage of dental services for youth enrollees, but not explicitly extending such coverage to adult pregnant women); 1397cc(a) (outlining the scope of required CHIP-covered services); CMS, Dear State Health Official Letter (Sept. 3, 2009). Pennsylvania, Florida, and New York also have the option of offering CHIP enrollees with existing comprehensive state-based coverage. 42 U.S.C. § 1397cc(a)(3).

V. Additional Future Program Considerations

In addition to studying the feasibility of combining CHP+ and Health First Colorado, below are several other possible initiatives and actions recommended by stakeholders and through research that could further enhance the CHP+ program. CHP+ should be an important piece of a bold Colorado plan to achieve more comprehensive healthcare reform for all Coloradans, including those children and families currently served by CHP+.

For example, the CHP+ program might fit into the state's exploration of a Medicaid buy-in program or public option, which is also currently being explored by several Colorado health advocacy groups[67], Colorado could consider policies and programs implemented in several other states to address the larger question of how to cover the remaining uninsured and provide more affordable coverage options to people in Colorado. A few of those initiatives are listed here as examples.

- Colorado could require its CHP+ MCOs and ACC RAEs to offer a comparable plan through the Connect for Health Colorado insurance exchange. This would allow individuals and families who transition into a new income bracket to be able to buy a plan that is somewhat similar to what they had under public coverage and ease the transition by creating continuity with providers and health systems, while introducing new cost-sharing measures to members. Nevada is a good example of a state that requires its Medicaid managed care plans to do this.[68]
- Colorado could implement a Basic Health Plan (BHP) option, a state-run health plan allowed under the ACA that would cover individuals and families up to 200 percent FPL. Anyone above 200 percent FPL would still need to buy insurance via the marketplaces. A 2012 *Health Affairs* report estimated that BHPs could reduce churn because people at 200 percent FPL are less likely to be moving back and forth than people at 138 percent.[69] To date, only two states have adopted the BHP as an approach to bridging coverage for families between public and private sectors, New York and Minnesota.[70]
- Colorado could implement a premium assistance program through CHP+, to help individuals pay for private coverage in the individual or employer market.[71] Health First Colorado currently offers a similar opportunity for individuals who qualify for Medicaid but also have access to employer-sponsored insurance (ESI). The Colorado Health Insurance Buy-In Program (HIBI)[72] provides payment for the monthly cost of all or a portion of qualified individuals' commercial health insurance premiums. The state could set up a similar program through CHP+, the primary benefit of which would be to help keep families all covered by one plan, rather than what often happens now with children enrolled in CHP+ and parents enrolled in a separate employer plan.

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[67] https://www.manatt.com/getmedia/21be89cc-b059-4af7-a458-2c6b2801ea21/Manatt-Health_A-Promising-Strategy-for-an-Affordable-Medicaid-Buy-In-Opt

[68] http://www.governing.com/blogs/view/gov-states-work-to-smooth-transition-from-medicaid-to-health-exchanges.html

[69] https://www.documentcloud.org/documents/606772-health-affairs-on-basic-health-plans.html

[70] http://files.kff.org/attachment/Issue-Brief-Improving-the-Affordability-of-Coverage-through-the-Basic-Health-Program-in-Minnesota-and-New-York

[71] http://www.governing.com/blogs/view/gov-states-work-to-smooth-transition-from-medicaid-to-health-exchanges.html

[72] http://www.mycohibi.com/

- Colorado already has child-only health insurance plans; however, they are not marketed very widely or aggressively, so many families are not aware they are an option. These plans are for children 18 years and younger and do not cover any parent or guardian.[73,74] However they have strict enrollment periods, and individuals can only apply for coverage in January and July of any given year. Exceptions are made for "qualifying events" such as a birth, adoption, marriage, or the loss of CHP+, Medicaid, or employer coverage. These plans could be marketed more strongly through the broker and health navigator communities to families who need coverage for their children but perhaps don't want to go on Medicaid or CHP+ or face the possibly of churning between programs. Child-only plans potentially offer more stability for these families.

VI. Conclusion

Clearly what the information gathered for this White Paper shows is that the CHP+ program today works pretty well for children, families, and providers. It is well liked by virtually all parties, and while there have been some typical program updates and changes over the years, generally it has operated smoothly. Yet there also is consensus that it is a good time to evaluate CHP+, to dig deeper into opportunities to fine-tune current operations, as well as explore longer-term improvements and how they could meet the changing needs of members within a healthcare landscape that is much different than when the program was created in 1997. This White Paper offers for consideration a number of recommendations that would help to move the program forward to most effectively and efficiently meet the needs of the Coloradans it serves.

[73] https://www.healthinsurance.org/faqs/are-child-only-policies-available-through-the-exchanges/
[74] https://www.coloradohealthinsurancebrokers.com/colorado-health-insurance-individuals-families/child-only-health-insurance-colorado/

Appendix A: Additional Detail about CHP+ and Health First Colorado

Cost Sharing in CHP+

In Colorado CHP+ has cost sharing requirements in both enrollment fees and co-pays. Families with incomes up to 213 percent FPL pay an annual enrollment fee of $25 for one child or $35 for more than one child, while families with incomes of 214 percent FPL or above pay $75 for one child or $105 for more than one child. Most families also have copays for certain services, ranging from $3 to $50 dollars, depending on family income and the type of service. There is an annual out-of-pocket limit, capped at five percent of a family's annual income, for CHP+ expenses. Co-pays are summarized in Figure A.1.

Figure A.1. Current Copays in Colorado's CHP+ Program[75]

Family Income (% FPL)	ER Visit	Urgent/ After Hour	Ambulance/ ER Transport	Inpatient Hospital	Physician Services at Hospital	Outpatient Hospital	Prescriptions	Lab/ Imaging
0-100%	$3	$1	N/A	N/A	N/A	N/A	N/A	N/A
101-156%	$3	$1	$2	$2	$2	$2	$1	N/A
157-200%	$30	$20	$15	$20	$5	$5	$3-10	$5
201-260%	$50	$30	$25	$50	$10	$10	$5-15	$10

Health First Colorado Model History

Colorado has experimented with a variety of administrative and delivery models for Medicaid, from purely fee-for-service (FFS) to Primary Care Case Management (PCCM), to capitated full-risk managed care. However, since 2011, HCPF has administered the program under an evolving model known as the Accountable Care Collaborative (ACC), currently in Phase 2.0 (initiated in 2018) of its evolution. Initially the ACC started with Regional Care Collaboration Organizations (RCCOs) which received a per member per month (PMPM) rate for providing care coordination services to members, but the state retained payment to providers. Most behavioral health services were "carved out" into regional behavioral health organizations (BHOs) that were fully capitated. In Phase II of the ACC, the state has combined the RCCOs and BHOs into new entities called Regional Accountable Entities (RAEs) that area responsible for both the capitated behavioral health services and a PCCM model for physical care. The goal is to advance coordinated care by supporting a system of multidisciplinary health teams, also incorporating providers of social services.

Eligibility for Health First Colorado

As all other states now do, Colorado uses Modified adjusted gross income (MAGI) to determine eligibility for all non-disabled individuals and older adults (age 65+). Figure A.2 provides an overview of Medicaid levels of eligibility by population group, expressed as a percentage of the FPL for the main population groups.

Figure A.2. Eligibility Levels by Population Group for Health First Colorado

Population Group	Eligibility Level
Children (ages 0-18)	142% FPL
Pregnant Women	195% FPL
Adults (ages 19-6)	133% FPL
Parents & Caretaker Relatives	133% FPL

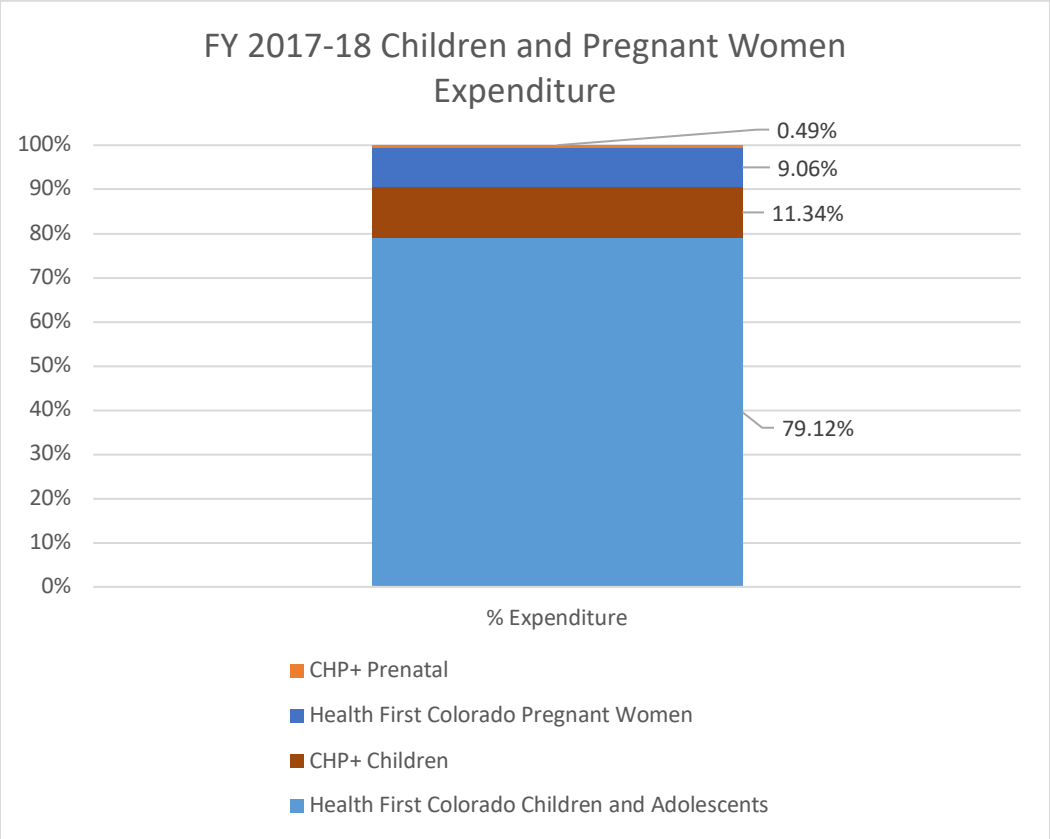
[75] https://www.colorado.gov/pacific/hcpf/child-health-plan-plus

Federal payments to a state depend on each state's FMAP, which ranges from the minimum of 50 percent to a high of a 74 percent for states with the lowest per capita income.[76] In Colorado, the FMAP for non-expansion Medicaid enrollees for FY2019 is set at the minimum of 50 percent. However, under the ACA, states that expanded Medicaid received an enhanced FMAP for expansion enrollees (those who are between 69% and 133% FPL), which started at 100 percent and will decrease to 90 percent by 2020.

Health First Colorado and CHP+ Expenditures and Enrollment Figures

Figures A.3, A.4, and A.5 below give an overview of the enrollment and expenditures associated with both Health First Colorado and CHP+ to try and show the difference in scale between the two programs. Figure A.3, shows the overall expenditures for Health First Colorado and CHP+ for children and pregnant women – nearly 80 percent of which are for Health First Colorado. In Figure A.4 it can be seen that Health First Colorado enrolls a large number of children, roughly 500,000, and that the state expends over $1 billion to serve those children. On the other hand, CHP+ has a much smaller enrollment, closer to 85,000 and spends approximately $225 million. Figure A.5 provides a picture of the total CHP+ caseload and expenditures between children and pregnant women.

Figure A.3. CHP+ and Medicaid Expenditures for Children and Pregnant Women, 2017-18[77]



[76]https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8352.pdf
[77] Figure from HCPF, February 2019

Figure A.4. Medicaid Expenditures and Enrollment between FY2005-06 and FY2019-20[78]

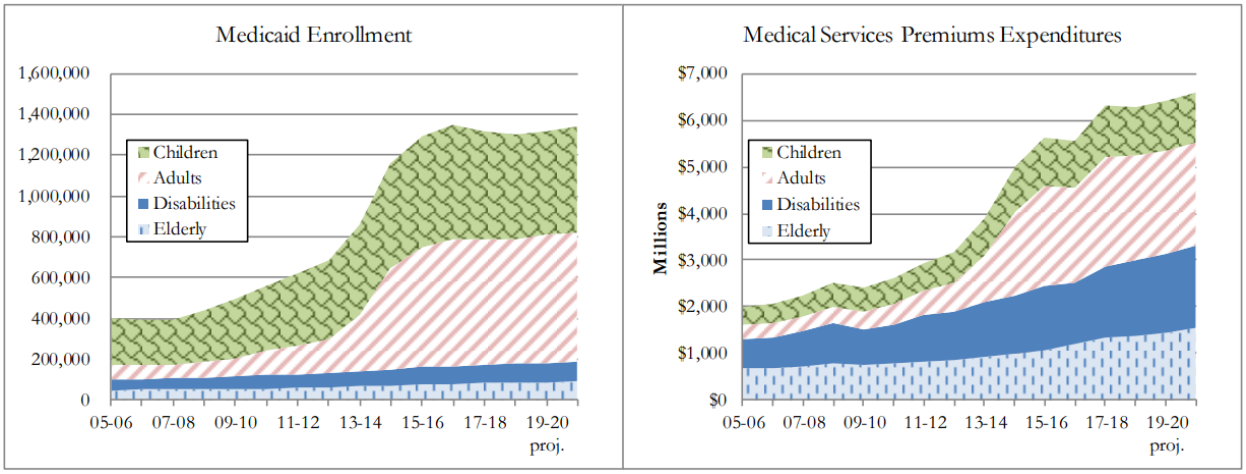
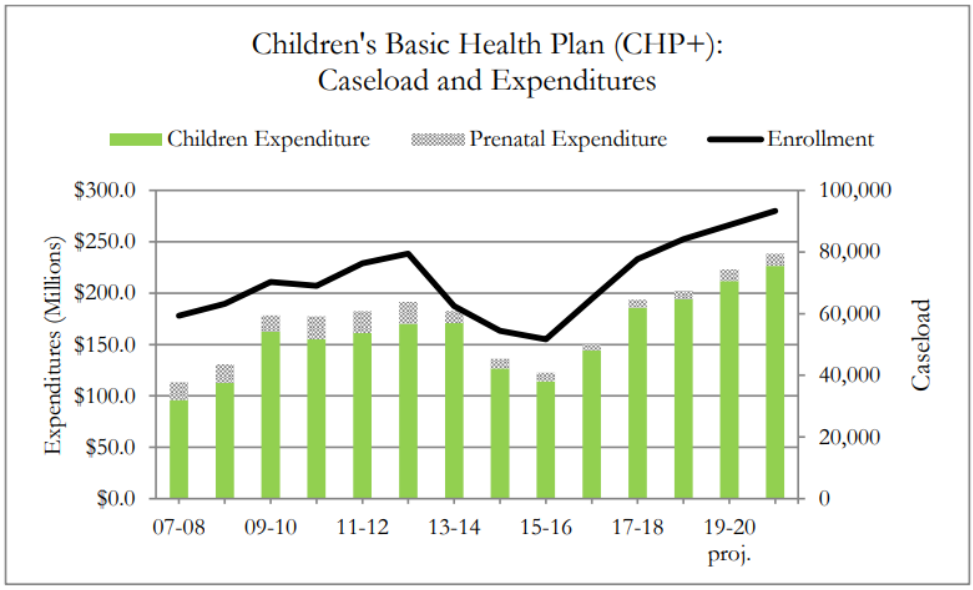


Figure A.5. CHP+ Expenditures and Enrollment between FY2007-08 and FY2019-20[79]



[78] http://leg.colorado.gov/sites/default/files/fy2019-20_hcpbrf1.pdf
[79] Ibid.