REPORT OF

THE

STATE AUDITOR

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

Performance Audit
July 2000

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July 14, 2000

Members of the Legislative Audit Committee:

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

This report presents our findings, conclusions, and recommendations, and the responses of the CBHP Policy Board and the Department of Health Care Policy and Financing.

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STATE OF COLORADO
OFFICE OF THE STATE AUDITOR **REPORT SUMMARY**

J. DAVID BARBA, CPA
State Auditor

Children's Basic Health Plan
Department of Health Care Policy and Financing
Performance Audit
July 2000

Authority, Purpose, and Scope

This audit of the Children's Basic Health Plan (CBHP) was conducted under the authority of Section 2-3-102, C.R.S., which authorizes the Office of the State Auditor to conduct performance audits of all departments, institutions, and agencies of state government. The audit was conducted in accordance with generally accepted auditing standards. We gathered information through interviews, reviews of documents and financial information, and analysis of data. Audit work was performed between February and June 2000. Our audit included a claims audit conducted by Buck Consultants on the CBHP Network, which is a network of independent providers for children in the program not served by Health Maintenance Organizations (HMOs). Results from the claims audit are summarized in this report. The complete claims audit report is available from the Office of the State Auditor under separate cover (*Children's Basic Health Plan Claims Audit*, Report No. 1225B).

We would like to express our appreciation for the assistance and cooperation extended by management and staff at the Department of Health Care Policy and Financing, Child Health Advocates, and Anthem (formerly Blue Cross Blue Shield of Colorado), and by the CBHP Policy Board.

Overview

The Children's Basic Health Plan, created in 1997 by House Bill 97-1304, provides subsidized health insurance for children in low-income families not eligible for Medicaid. In 1998, House Bill 98-1325 aligned CBHP with Title XXI passed by Congress in August 1997. Title XXI created the Children's Health Insurance Program (CHIP), which made almost $40 billion available to states with approved CHIP plans. CBHP serves as the State's CHIP program. For Colorado the federal match for qualifying expenditures is about 65 percent, or almost two federal dollars to each state dollar. CBHP began operations in April 1998. Federal law allows states three options for structuring their CHIP programs: develop a separate health insurance program that meets certain requirements, expand the state's existing Medicaid program, or use a combination of these two approaches. Colorado is 1 of 15 states that designed a separate, stand-alone program.

Statutes establish the CBHP Policy Board (Board). The Board sets policy and adopts rules for CBHP. The Department of Health Care Policy and Financing (HCPF) administers the program and, as required by statute, contracts for the marketing, outreach, eligibility determination, and enrollment functions of CBHP.

As of April 30, 2000, there were 24,410 children enrolled in the Children's Basic Health Plan, out of an estimated 69,100 eligible in the State. CBHP is available to children in families at or below 185 percent of the federal poverty level who do not qualify for Medicaid. Children must be under 19 years of age. Unlike Medicaid or the State's Colorado Indigent Care Program, there is no asset test for CBHP. CBHP is marketed under the name "Child Health Plan Plus," or "CHP+."

Children receive services through six HMOs in areas where HMO coverage is available. Outside of these areas, children receive services through the CBHP Network (Network), which primarily serves rural areas. The Network consists of independent providers. Primary care physicians (PCPs) act as gatekeepers for referrals to specialized services to other Network providers. Referrals are paid on a fee-for-service basis. As of the end of April 2000, 16,640 children, or over 68 percent of the total 24,410 enrolled, were served through HMOs; 7,770 children, or about 32 percent, were served through the CBHP Network. Families with incomes above 100 percent of the federal poverty level share the cost of CBHP through payment of monthly premiums and copayments.

During Fiscal Year 1999, the first full year of operations, expenditures for the program were about $15.6 million. As of April 30, 2000, CBHP expenditures were about $18.5 million for the first ten months of Fiscal Year 2000, or about 61 percent of the total $30.5 million appropriated to the program for the fiscal year. The Department estimates that it will not spend about $19.1 million of its initial federal award of about $41.8 million by the federal fiscal year end (September 30, 2000). This means that Colorado will revert almost 46 percent of its first federal award. Under CBHP, each state dollar is matched by about two federal dollars. Therefore, in order to use the $19.1 million that is slated for reversion, the State would need to spend approximately $10.1 million more in general funds prior to September 30, 2000, than the Department anticipates. Overall, enrollments have not risen as quickly as originally anticipated. This has resulted in lower expenditures than expected and underutilization of federal funds.

Administration of the Children's Basic Health Plan

The organizational structure for the Children's Basic Health Plan involves numerous entities and contractual relationships. We found that the complexity of the administrative structure, combined with the relatively small number of children served and the costs of starting an entirely new program, has contributed to significant administrative costs. For Fiscal Year 2000, administrative costs for CBHP are expected to run almost 37 percent of the cost of health care services provided to children, or almost 27 percent of total program costs (health care services plus administrative costs). In other words, out of each dollar spent on CBHP, about 27 cents is spent on administration.

On the basis of reports provided by the Department to the federal Health Care Financing Administration (HCFA), since the start of operations in April 1998 through March 2000 CBHP administrative costs have averaged about 23 percent of total program costs (i.e., health care services plus administrative costs). The program's administrative costs exceed the limit established by the

federal government for the purposes of receiving federal reimbursement for program administration. The limit for allowable administrative costs is based on these costs not exceeding 10 percent of total program costs. To help with start up costs, HCFA temporarily allowed states to draw federal funds for administration in excess of the limit, with the understanding that ultimately any excess draws would need to be repaid. The Department reports that as of March 31, 2000, the State owes about $2.9 million to HCFA due to draws above the federal limit for administrative costs.

The Department needs to continue to explore options for reducing administrative costs. The Department identified several options in its Fiscal Year 2001 budget request including changing CBHP to a Medicaid-expansion program, changing CBHP to a combined stand-alone and Medicaid-expansion program, privatizing more CBHP functions, or performing more administrative functions within the Department to reduce redundancy. Another alternative would be to create a stand-alone program that uses the Medicaid administrative structure to the greatest degree possible. This option could allow the State to take advantage of the existing Medicaid infrastructure without creating another entitlement program.

In addition to issues regarding basic program design, we raise concerns regarding other administrative issues. Specifically:

- The contract administrator, Child Health Advocates, has not met requirements in its contract with the Department in areas such as marketing, premium administration, and provider network administration. To date, there has been limited enforcement of contract provisions.

- The Board and the Department have not developed a comprehensive strategic plan for the Children's Basic Health Plan. A strategic plan is critical for positioning the program to meets its goals of providing health care for uninsured children in low-income families.

- Implications of the Board's new cost sharing rule have not been fully addressed. The rule establishes policies for disenrollment from the program if monthly premium payments are not made in a timely manner. As of April 30, 2000, on the basis of information from Child Health Advocates close to 4,800 families, or 37 percent of the almost 13,000 families enrolled in CBHP, were more than 30 days past due (problems with premium records are noted later in the report). These 4,800 families represent almost 53 percent of all families required to pay premiums in the program. If delinquency rates continue to be high after the new rule goes into effect, it will be difficult to maintain present enrollments or to increase them. In addition to its impact on enrollment, we are concerned that the rule will increase already high administrative costs. Finally, the program has a history of problems with tracking premiums accurately and these problems have yet to be resolved.

Marketing and Eligibility

CBHP has increased enrollments from 5,528 children in April 1998 to 24,410 children in April 2000, or by about 342 percent in two years. Nonetheless, enrollments have lagged expectations and fall significantly short of covering the estimated 69,100 eligible children. Since CBHP began operations in April 1998, a wide range of marketing and outreach techniques have been used. However, it is not clear how effective different efforts have been. Until recently there has not been a systematic marketing strategy focused on identifying specific tactics, tracking and analyzing their effects on enrollment, and using these results to refine marketing activities. Our review of monthly marketing reports showed that prior to January 2000, reports did not include the results of particular marketing efforts in terms of impact on enrollments. In March 2000, reports included the results of several specific initiatives and began to suggest ways to use knowledge gained from these results to improve marketing strategies.

Financial Operations

Our audit reviewed financial operations of the Children's Basic Health Plan. We found the following:

- CHA reported that it provided the Department with an estimate of about $80,300 in possible overpayments to HMOs during a three-month period early in Fiscal Year 2000. However, the Department did not investigate and resolve the overpayments. Overall, the Department does not have procedures in place to identify retroactive adjustments that should affect future HMO capitation payments. In addition, we found that in a recent two-month period, CHA staff made 61 retroactive disenrollment adjustments that should have reduced payments to HMO and Network providers by almost $14,000. The disenrollment information was not provided to staff responsible for calculating provider payments, and consequently, providers likely were overpaid. As a result, we concluded that reconciliation procedures for provider payments were not sufficient to ensure that provider payments are accurate.

- Out of 15,691 children enrolled in CBHP during part or all of the period between May 1999 and April 2000, there were 1,830 children (11.7 percent) simultaneously enrolled in Medicaid. We estimate that approximately $242,000 in excess CBHP capitation payments were made for these dual-enrolled children. Simultaneous enrollments varied from 1 month to as long as 12 months. Under federal regulations, children cannot be enrolled in CHIP programs such as CBHP if they are eligible for Medicaid.

- Due to a history of problems with tracking families' premiums, subsequent efforts to correct inaccuracies, and lack of adequate controls over the premium administration process, we have concerns about the accuracy of the premiums reported as being owed to the program. In a sample of 67 families' premium accounts, we identified problems in 14 (about 21 percent).

CBHP and Other Children's Health Services Programs

The creation of the Children's Basic Health Plan has introduced a new dynamic among programs funding children's health services to low-income children in the State. Similar to other states, Colorado is experiencing the need to reevaluate relationships between its CHIP program and other established programs. In particular, the State needs to assess the relationships among CBHP, the Medicaid program, and the Colorado Indigent Care Program (CICP). Medicaid has several programs that serve children up to 133 percent of the federal poverty level, depending on the age of the child and the family's income. CICP serves both adults and children in families up to 185 percent of the federal poverty level. Medicaid has two asset tests, among the major programs serving children, that limit the resources a family may possess (e.g., car, savings account) and still qualify. CICP has a different, higher asset limitation. All three programs have different eligibility and enrollment systems, benefits, cost sharing arrangements, and requirements.

The Department of Health Care Policy and Financing oversees all three programs. Under Senate Bill 00-223, the Department is charged with identifying and recommending ways to facilitate moving children from CICP to CBHP. Shifting children from CICP to CBHP will increase the State's ability to leverage general fund dollars through the federal CHIP program. In addition to performing this study, HCPF can take a broader approach and further work toward the goals of coordination and consolidation among programs required under CBHP statutes. The Department can identify ways to align the programs, streamline processes, and generally move to create a seamless eligibility and enrollment system. The implementation of the Colorado Benefits Management System should significantly assist these efforts.

Problems we identified with coordination among programs include:

- Lack of adequate communication between CBHP and Medicaid eligibility systems can cause processing delays for applicants referred to the other program. From mid-February to mid-March 2000, CHA sent the counties applications for 536 children who appeared Medicaid-eligible. By late April, CHA had received dispositions from the counties for only 144 of the children, or about 27 percent. If families are determined ineligible for Medicaid, CBHP staff need to follow up and ensure that families are enrolled in CBHP if appropriate.

- The Medicaid program does not have processes in place to ensure that families receive information about CBHP if they are determined ineligible for Medicaid or disenrolled from Medicaid programs due to lack of continued eligibility.

CBHP Network Claims Audit

The claims audit performed by Buck Consultants on the CBHP Network noted the following:

- Currently there is no monthly reconciliation between the eligibility information maintained by CHA and by Anthem. As a result of the lack of reconciliation procedures, discrepancies in eligibility information (e.g., start dates, end dates) were found between Anthem's and CHA's records for nine children. This represents 4 families out of the total sample of 20 families tested at CHA, or 20 percent.

- The audit found that Anthem's error rates related to claims processing were higher than industry standards. A random sample of 150 claims was selected from CBHP Network claims paid by Anthem between March 1, 1999, and February 29, 2000 (total of 34,310 claims for over $2.6 million). The financial error rate for the sample was 1.4 percent; this rate exceeds the industry standard of 1 percent. The financial error rate represents the absolute value of incorrect dollars paid divided by the total dollars paid in the sample. This error rate is the most substantive measure of claims administration because it directly impacts plan dollars.

  The payment incidence error rate was 21.3 percent; this rate exceeds the industry standard of 3 percent. The payment incident error rate represents the number of incorrect sample payments divided by the total number of sample payments. The financial and payment incident error rates both exceeded Anthem's internal standards as well.

- Claims were not processed in a timely manner. Anthem processed 64.7 percent of claims within 14 calendar days and 82.7 percent of claims within 45 days. This falls considerably short of the industry standard of processing 85 to 90 percent of claims within 14 calendar days. Anthem also failed to meet its internal standard for timely processing.

Buck's recommendations include ensuring that consistent and accurate eligibility data for CBHP are maintained by Anthem and CHA, and requiring that Anthem improve the poor financial and payment incidence error rates and timeliness of claims payments.

Out of 26 recommendations directed to the Department, HCPF agreed with 24 and partially agreed with 2 recommendations. The Board agreed with all 5 recommendations addressed to it. A summary of our recommendations and the Department's and the Board's responses can be found in the Recommendation Locator.

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
1	29	Identify options for reducing administrative layers and costs for the Children's Basic Health Plan, including options for alternative structures and delivery systems. Recommended statutory changes should be submitted to the General Assembly as needed.	CBHP Policy Board	Agree	January 1, 2001
			Department of Health Care Policy and Financing	Agree	January 1, 2001
2	33	Implement substantive monitoring procedures to ensure that contractual provisions for the Children's Basic Health Plan administrative contract are met.	Department of Health Care Policy and Financing	Agree	Implemented
3	37	Develop a strategic plan for the Children's Basic Health Plan that includes necessary elements such as a mission statement, strategic goals, objectives, and performance measures.	CBHP Policy Board	Agree	October 15, 2000
			Department of Health Care Policy and Financing	Agree	October 5, 2000
4	44	Ensure that implementation and impact of the cost sharing rule for the Children's Basic Health Plan is addressed by (a and b) identifying and tracking the rule's impact on enrollments and administration costs, (c) assessing the impacts of the cost sharing rule and using the results as the basis of future program policies, and (d) proposing legislative changes as needed.	CBHP Policy Board	Agree	September 30, 2000
			Department of Health Care Policy and Financing	Agree	Parts a and b - August 1, 2000 Parts c and d - contingent upon Parts a and b.
5	53	Ensure that results-oriented marketing is implemented.	Department of Health Care Policy and Financing	Agree	Implemented

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
6	57	Evaluate satellite eligibility determination sites to determine the cost of resources used to support the sites and how to improve their performance.	Department of Health Care Policy and Financing	Agree	June 30, 2001
7	59	Revise the eligibility rule to (a) reflect federal guidance stating that Social Security Numbers are not to be required as a condition of eligibility and (b) require verification of income for the same time period used to calculate gross family income for eligibility determination.	CBHP Policy Board	Agree	September 30, 2000
8	59	Ensure enforcement of state and federal requirements to provide documentation of alien registration numbers.	Department of Health Care Policy and Financing	Partially Agree	Contingent upon clarification from federal Health Care Financing Administration.
9	61	Ensure all eligibility-related errors are reported in monthly eligibility error rate calculations.	Department of Health Care Policy and Financing	Agree	September 15, 2000
10	65	Ensure capitation payments for the Children's Basic Health Plan are accurate by (a) performing monthly reconciliations for provider payments to identify retroactive enrollment changes and making necessary adjustments to payments and (b) requiring appropriate communication among staff regarding all adjustments to enrollment records.	Department of Health Care Policy and Financing	Agree	Part a: August 15, 2000 Part b: August 1, 2000
11	69	Work with the Department of Human Services to identify on a monthly basis instances in which children are simultaneously enrolled in the Children's Basic Health Plan and in the Medicaid program, and make necessary adjustments.	Department of Health Care Policy and Financing	Agree	September 15, 2000

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
12	74	Ensure adequate controls over premium administration.	Department of Health Care Policy and Financing	Agree	August 1, 2000 and ongoing
13	75	Ensure that the new information system premium administration is adequate to meet program requirements and addresses problems with the present system.	Department of Health Care Policy and Financing	Agree	August 1, 2000
14	77	Develop and implement collection requirements that are reasonable for the program and consistent with state requirements.	CBHP Policy Board Department of Health Care Policy and Financing	Agree Agree	September 1, 2000 August 1, 2000
15	79	Ensure that program staff provide to accounting staff all required information regarding premium administration.	Department of Health Care Policy and Financing	Agree	June 2000
16	80	Develop and implement a mechanism to ensure the administrative contractor complies with federal requirements.	Department of Health Care Policy and Financing	Agree	Implemented
17	82	Ensure that the administrative contractor develops and maintains a comprehensive and current program policy and procedures manual for the program that addresses all areas of operation, as required by contract.	Department of Health Care Policy and Financing	Agree	June 30, 2000

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
18	91	Promote program coordination and consolidation among the Children's Basic Health Plan, the Colorado Indigent Care Program, and the Medicaid program by identifying ways in which to streamline and standardize eligibility and enrollment processes and requirements, benefits, cost sharing requirements, and other aspects of these programs. Recommendations should be forwarded to the Joint Budget Committee and the House and Senate Health, Environment, Welfare, and Institutions Committees under the same timeline established by the Department in its response to Recommendation No. 1 of this report.	Department of Health Care Policy and Financing	Agree	January 1, 2001
19	94	Ensure applications referred between the Children's Basic Health Plan and Medicaid program are processed timely.	Department of Health Care Policy and Financing	Agree	September 30, 2000
20	96	Ensure that families determined to be ineligible for the Medicaid program receive information on how to apply for the Children's Basic Health Plan by including information about CBHP in denial letters sent to these families.	Department of Health Care Policy and Financing	Agree	August 2000
21	99	Ensure consistent and accurate eligibility data are reflected on-line at Anthem and Child Health Advocates.	Department of Health Care Policy and Financing	Agree	October 1, 2000
22	102	Require that Anthem execute a utility report to quantify the error amount caused by the installation of the incorrect benefit package for the Children's Basic Health Plan and determine the cost-benefit of correcting erroneous payments.	Department of Health Care Policy and Financing	Agree	August 1, 2000

RECOMMENDATION LOCATOR

Rec. No.	Page No.	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
23	102	Require that Anthem improve the poor financial and payment incidence error rate results for the Children's Basic Health Plan by including performance guarantees and remedies for nonperformance in future contracts.	Department of Health Care Policy and Financing	Agree	October 1, 2000
24	103	Require that Anthem improve timeliness of claims payments for the Children's Basic Health Plan by including performance guarantees and remedies for nonperformance in future contracts.	Department of Health Care Policy and Financing	Agree	October 1, 2000
25	104	Require that Anthem restructure its internal audit program to specifically target the Children's Basic Health Plan and ensure all plan components receive adequate review.	Department of Health Care Policy and Financing	Partially Agree	October 15, 2000
26	105	Require that Anthem develop an action plan to address the internal issues identified by the claims audit on the Children's Basic Health Plan.	Department of Health Care Policy and Financing	Agree	October 1, 2000
27	105	Perform a follow-up audit to test the effectiveness of Anthem's action plan with regard to the Children's Basic Health Plan claims audit.	Department of Health Care Policy and Financing	Agree	April 1, 2001

Description

Chapter 1

Introduction

The Children's Basic Health Plan (CBHP), created in 1997 by House Bill 97-1304, provides subsidized health insurance for children in low-income families not eligible for Medicaid. In 1998, House Bill 98-1325 aligned the program with federal Title XXI, which was enacted by Congress in August 1997. Title XXI created the Children's Health Insurance Program (CHIP) to "initiate and expand child health assistance to uninsured, low-income children." Accordingly, CBHP serves as Colorado's CHIP program. The Department of Health Care Policy and Financing (HCPF) oversees CBHP.

Under Title XXI, approximately $39.7 billion in federal funds over a ten-year period was made available to states with approved CHIP plans. Federal awards are allotted to states according to a formula based on each state's share of the total number of uninsured children at less than 200 percent of the federal poverty level, multiplied by a geographic cost factor. Funding under each award is available for a three-year period, after which any funds not used by the state are reverted and redistributed to states that have fully spent their allotments.

Colorado has received three awards under the CHIP program to date:

- $41.8 million, available until September 2000.
- $41.6 million, available until September 2001.
- $46.9 million, available until September 2002.

Under the CHIP program, Colorado receives matching funds of about two federal dollars for each state dollar expended. As of March 31, 2000, the State had spent approximately $16.7 million of the initial award, leaving a balance of $25.1 million of this award available until September 2000. The Department reports that it expects to drawing down about $6 million in additional federal funds prior to September 2000. This will result in Colorado reverting about $19.1 million (almost 46 percent) of the initial award. In order to use this $19.1 million, the State would be required to spend approximately $10.1 million more in general funds by September 2000 than HCPF anticipates. No funds have yet been expended from the second or third awards.

Federal law allows states several options for structuring their CHIP programs: develop a separate health insurance program that meets certain requirements; expand the state's existing Medicaid program; or use a combination of these two approaches. Colorado is 1 of 15 states that designed a separate, stand-alone health insurance program; 17 states expanded their Medicaid programs; and 18 others developed a combined program.

Colorado statutes provide that CBHP make health insurance affordable and support employers in efforts to provide employees and their dependents with health insurance coverage. Additionally, statutes establish that it is not the intent of the General Assembly to create an entitlement for health insurance coverage.

Statutes define the following principles to be used in implementing CBHP:

- Interprogram communication in order to maximize existing state appropriations.
- Efficient program utilization through interprogram coordination and program consolidation.
- Emphasis on strong managed care direction.
- Private sector involvement to the greatest possible degree.
- Strong emphasis on coordination with local and state public health programs and initiatives for children.

History and Relation to Other Programs

The Children's Basic Health Plan evolved out of the Colorado Child Health Plan, which was created in 1992. This earlier program subsidized outpatient services to uninsured children in low-income families not eligible for Medicaid. The Colorado Child Health Plan was administered by the University of Colorado Health Sciences Center. Services to children were furnished through a network of fee-for-service providers, and the program was available primarily in rural areas. The intent of the program was to give some access to health care services to uninsured, low-income children in regions without providers under the Colorado Indigent Care Program. The Colorado Child Health Plan initially was financed entirely through donations; in Fiscal Year 1997, general funds were appropriated for the program.

The creation of the present Children's Basic Health Plan established a statewide program of health services for children in low-income families not qualifying for Medicaid. CBHP began operations in April 1998, and families with children in the Colorado Child Health Plan were given the opportunity to transfer into the new Children's Basic Health Plan. By the end of Fiscal Year 1999 the Colorado Child Health Plan was completely superseded by the Children's Basic Health Plan.

CBHP is one of a number of programs in the State that seek to provide health care services to children. Two other programs, in particular, that fund health services for low-income children are the Colorado Indigent Care Program, funded by state general funds (some federal funds under Medicaid supplement this program), and the Medicaid program, funded by both state general funds and federal funds. The Department of Health Care Policy and Financing also administers these two programs.

Program Structure and Administration

The Children's Basic Health Plan is available to children in families at or below 185 percent of the Federal Poverty Level. Currently this means a family of four with an annual income of about $31,500 could qualify for CBHP. Federal laws prohibit CHIP programs from serving children eligible for Medicaid. Therefore, CBHP is targeted at families that do not meet the more restrictive eligibility requirements of Medicaid. For example, unlike the State's Medicaid program, CBHP does not restrict the amount of assets a family may have in order to qualify for the program. (See Chapter 5 for additional information on how CBHP compares with Medicaid and the Colorado Indigent Care Program.) CBHP is marketed under the name "Child Health Plan Plus," or "CHP+."

Benefits. Children under 19 years of age may receive benefits under CBHP. Benefits include inpatient, outpatient, and emergency hospital services; laboratory services; physician and clinical services; prescription drugs; preventive services and screenings; limited vision and hearing services; limited mental health and substance abuse services; and others. The benefits package is based on that required under state law for use in the State's small-employer market. For Fiscal Year 2000 the average cost per child was appropriated at slightly over $814 for the year to serve an estimated average enrollment of 31,628 children.

Under Senate Bill 00-71, $10 million annually will be deposited into the Children's Basic Health Plan Trust from the State's share of federal tobacco settlement monies beginning in Fiscal Year 2001. The Act authorizes the CBHP Policy Board to add dental service to the schedule of benefits for CBHP, provided the Board determines that there are an adequate number of dentists to serve the children in CBHP and that there are sufficient resources to fund the services.

Service Providers. HCPF contracts with six HMOs. As of April 30, 2000, these HMOs provided services to all children enrolled in 21 of the State's 63 counties. Children in 26 rural counties receive care through a network of independent providers administered by CBHP, referred to as the CBHP Network (Network). In the remaining 16 counties children may be covered by either an HMO or by the Network. The Network consists of primary care physicians (PCPs) that act as gatekeepers for

referrals to other Network providers for specialized services. Referrals are paid on a fee-for-service basis. As of the end of April 2000, 16,640 children, or over 68 percent of the total 24,410 enrolled, were served through HMOs; 7,770 children, or about 32 percent, were served through the CBHP Network. The Department hopes to have HMO coverage available statewide by the end of December 2000.

Cost Sharing. Families share the cost of CBHP through payments of monthly premiums and by copayments made at the time services are received. Both premiums and copayments are based on a sliding fee scale, as required by statutes. In Fiscal Year 1999, premium revenues were $541,490; this represents about 3 percent of total program expenditures of $15.6 million. Through the first ten months of Fiscal Year 2000, premium revenues were about $1.3 million, which represents about 7 percent of year-to-date expenditures of $18.5 million. The current premium and copayment structure is shown in Table 1 below.

Table 1: Children's Basic Health Plan Premium and Copayment Schedule Fiscal Year 2000

Family Income by Federal Poverty Level	Monthly Premium		Copayment
	One Child	2 or More Children	
Below 101%	$0	$0	$0
101%-150%	$9 per family	$15 per family	$2 per visit
151%-170%	$15 per family	$25 per family	$5 per visit
171%-185%	$20 per family	$30 per family	$5 per visit

Source: Department of Health Care Policy and Financing.

Premiums and copayments were not designed to provide a significant source of funds for the program. The legislative intent is that requiring financial participation will help families learn to value the services received and be more prepared for the cost-sharing requirements of private insurance.

Program administration. As required under Section 26-19-111(2), C.R.S., the Department contracts for the marketing, outreach, eligibility determination, and enrollment functions of CBHP. The Department has contracted with three different entities for these services since assuming responsibility for CBHP. However, there has been a core of personnel that has moved with the program through these entities since CBHP began operations in April 1998. Therefore, there has been administrative continuity for CBHP, despite changes in contractors.

Child Health Advocates (CHA) has been the Department's contractor since March 1, 1999. In addition to the duties HCPF is required by statutes to obtain through contract, CHA performs premium administration, manages the information systems for CBHP, and administers the CBHP Network. For Fiscal Year 2000 the amount of the Department's contract with CHA is just under $6.6 million. After deducting provider payments of $1.8 million to be made through CHA, the administrative costs reflected in the contract are almost $4.8 million.

History of Expenditures and FTE

The Children's Basic Health Plan began operations in late Fiscal Year 1998 and expended approximately $2.6 million in that year. The Colorado Child Health Plan was still in operation during Fiscal Year 1998. Fiscal Year 1999 was the first full year of operations for CBHP, during which about $15.6 million was expended for the program; the Colorado Child Health Plan ceased operations during that same year.

For Fiscal Year 2000, as of April 30, 2000, expenditures for CBHP were about $18.5 million. This represents about 61 percent of the total $30.5 million appropriated to the program for the year. As mentioned earlier, the State has not fully utilized federal funds available for the program. Table 2 below summarizes expenditures and appropriated full-time equivalent employees (FTE) for the Children's Basic Health Plan from Fiscal Years 1998 through 2000.

Table 2: History of Expenditures and FTE for the Children's Basic Health Plan
Fiscal Years 1998 through 2000
(Dollars in Millions)

	Fiscal Year 1998	Fiscal Year 1999	Fiscal Year 2000 (10 mos.)
Total Expenditures	$2.6[1]	$15.6[2]	$18.5[3]
Appropriated FTE[4,5]	–	–	6.5

Source: Office of the State Auditor analysis of agency data.
Notes:
1. The Children's Basic Health Plan (CBHP) began operations in the last quarter of Fiscal Year 1998.
2. Fiscal Year 1999 expenditures include $15.4 million from the CBHP Trust, which is net of $0.7 million in Fiscal Year 1999 expenditures subsequently reversed in Fiscal Year 2000, and $0.2 million in expenditures from the State's General Fund.
3. Fiscal Year 2000 expenditures include $18.1 million from CBHP Trust, and $0.4 million in expenditures from the State's General Fund.
4. During Fiscal Years 1998 and 1999 there were no FTE appropriated for the program; FTE were funded by a private grant that provided approximately 5 staff. For Fiscal Year 2000, in addition to 6.5 appropriated FTE there were two positions funded by private grants.
5. CBHP is administered by an independent contractor. During Fiscal Year 2000 the contractor employed approximately 70 staff dedicated to administering CBHP.

Expenditures for the program are significantly lower than appropriations largely due to enrollments not increasing as quickly as anticipated. The Department reports that as of April 30, 2000, there were 24,410 children enrolled in the Children's Basic Health Plan; HCPF estimates roughly 69,100 children in the State are eligible for CBHP. Therefore, approximately 35 percent of total eligible children are currently enrolled. The Department does not expect to meet its original goal of 31,000 children enrolled by June 30, 2000.

As mentioned earlier, under Senate Bill 00-71 the Children's Basic Health Plan Trust will receive $10 million annually from the State's share of tobacco settlement monies. These monies will be available beginning in Fiscal Year 2001.

Organizational Structure

State law establishes the CBHP Policy Board (Board), which is authorized to adopt rules for the operation and financial management of the program. Other Board responsibilities include reporting on certain matters to the Joint Budget Committee, approving the benefit schedule for the program, and performing other policy-related functions. The Board consists of 11 members, 7 of whom are appointed by the Governor from designated businesses or health care-related fields. The other four

members are the executive directors of the Departments of Health Care Policy and Financing, Human Services, and Public Health and Environment, and the commissioner of the Department of Education. All 11 members may vote on matters before the Board.

As mentioned above, the Department of Health Care Policy and Financing oversees the Children's Basic Health Plan and expenditure of funds. Statutes outline the following responsibilities for the Department:

- Establishing the schedule of benefits under the program and submitting it to the Board for approval.
- Designing and implementing the cost-sharing structure for the program, which includes premium payments and copayments for families based on a sliding scale.
- Proposing various rules for the financial management of the program and submitting them to the Board for approval.
- Establishing and maintaining contractual relationships with providers for the program, utilizing a managed care model as much as possible.
- Overseeing the administration of the program, certain aspects of which are performed by an independent contractor. As noted above, statutes require the Department to contract for marketing and outreach and eligibility determination and enrollment.

The Department performs additional administrative functions for CBHP such as procurement and contract management. As the state agency receiving federal CHIP funds, the Department is responsible for compliance with all related federal laws and regulations.

Audit Methodology

We reviewed documentation and interviewed personnel for the Children's Basic Health Plan at the Department of Health Care Policy and Financing in areas related to program operations, financial management, and oversight. We also interviewed staff and examined documentation related to the Colorado Indigent Care Program, the Medicaid program, and several other health-related programs. We conducted audit work at the Department's administrative contractor for CBHP in areas including marketing and outreach, eligibility and enrollment, and financial management related to premiums paid by families and capitation payments to providers.

Chapter 2 of the report discusses the administrative and oversight roles of the Department and the CBHP Policy Board for the program; Chapter 3 reviews CBHP marketing activities and enrollments; Chapter 4 considers the financial operations of CBHP; and Chapter 5 addresses issues among CBHP, the Medicaid program, and the Colorado Indigent Care Program.

As part of our audit we contracted with Buck Consultants to conduct a claims audit on the CBHP Network. A summary prepared by Buck Consultants of the claims audit is included here as Chapter 6. The full report is available under separate cover from the Office of the State Auditor (*Children's Basic Health Plan Claims Audit*, Report No. 1225B).

Administration of CBHP

Chapter 2

Introduction

The Children's Basic Health Plan (CBHP) is the State's program under the federal Children's Health Insurance Program (CHIP). This federal program enables states to receive a federal match for approved plans to expand health care to low-income children. For Colorado, the federal match for qualifying expenditures is about 65 percent, or almost two federal dollars to each state dollar.

The infusion of federal funds has allowed the State to offer a much more comprehensive benefit package to more children than was possible under CBHP's predecessor, the Colorado Child Health Plan. Under the Colorado Child Health Plan, children received only outpatient benefits; CBHP offers outpatient and inpatient benefits, prescription drugs, and a variety of other services. In terms of enrollment, the Colorado Child Health Plan had 14,086 children enrolled as of April 1998, when CBHP first began operations. CBHP had 5,528 children enrolled in April 1998; these were children in families that elected to transfer into CBHP from the Colorado Child Health Plan. As of April 2000, CBHP has 24,410 children enrolled.

Some of the major accomplishments of CBHP include:

- **First federally approved stand-alone plan.** CBHP was approved by the federal Health Care Financing Administration in February 1998. Colorado was the first state to gain approval for a non-Medicaid expansion CHIP plan. Colorado's program uses CHIP funds to create a subsidized health insurance program that, unlike Medicaid, is not an entitlement.

- **Statewide coverage.** Since the start of operations, CBHP has offered coverage to children in all areas of the State. This has been accomplished through a combination of HMO coverage and a managed care network of independent providers.

- **Community-based outreach.** CBHP has an Internet-based application system that is accessible to 67 sites across 25 counties in the State. These sites assist with outreach and with eligibility determination and enrollment. By providing outreach and enrollment services outside of Denver, the sites

increase families' access to information about CBHP and the application process.

- **Provisions for community input.** The CBHP Policy Board and the Department have established many relationships with community providers and other health programs in an effort to obtain input about CBHP and promote communication.

The Department of Health Care Policy and Financing (HCPF) has direct responsibility for the Children's Basic Health Plan (CBHP). Under state law, HCPF is required to contract for the marketing, outreach, eligibility determination, and enrollment functions of CBHP. The Department contracts for these functions with Child Health Advocates (CHA), which also performs premium administration and oversees the CBHP Network (Network). The Network is an association of independent providers that furnish care under a managed-care format.

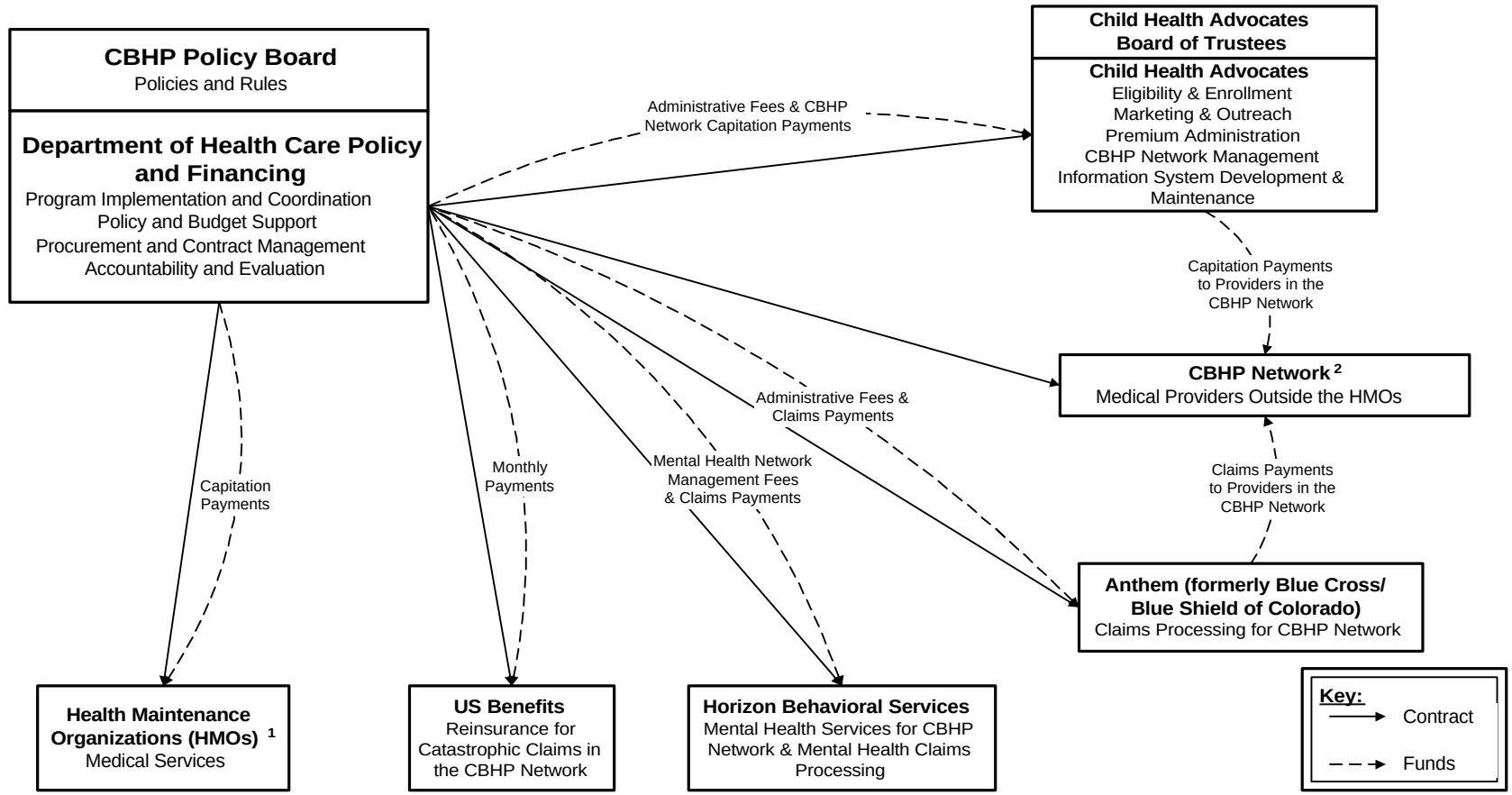
The CBHP Policy Board (Board) establishes rules and overall policies for the Children's Basic Health Plan. As required by law, Board meetings are open to the public. The Board has also created several committees to gain more input into the program from interested parties. These committees target program areas such as finance, operations, benefits, and proposed legislation; these meetings are also open to the public and are attended by representatives from HCPF, CHA, program providers, and other stakeholders. Each committee has at least one Board member among its membership. In turn, some committees have established subcommittees to focus more specifically on areas such as network administration and eligibility and enrollment.

This chapter discusses the administrative structure and costs for CBHP, and the oversight roles of the Department and the CBHP Policy Board.

Administrative Structure for CBHP

The organizational structure for the Children's Basic Health Plan involves numerous entities and contractual relationships. In addition to Child Health Advocates, the Department contracts with Health Maintenance Organizations, or HMOs (6); independent providers participating in the CBHP Network (368 contracts representing about 2,300 providers); a third-party administrator for claims under the CBHP Network; reinsurance for catastrophic claims under the CBHP Network; and a provider for mental health services under the program. These contractual relationships are depicted in Table 3 below.

Table 3: Children's Basic Health Plan (CBHP) Organization Chart
April 2000



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

Notes:

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

The complexity of the administrative structure, as discussed later in this section, combined with the relatively small number of children served and the costs of starting an entirely new program, has contributed to significant administrative costs for CBHP. Projected Fiscal Year 2000 administrative costs for CBHP are shown below in Table 4.

Table 4: Analysis of Administrative Costs for the Children's Basic Health Plan Fiscal Year 2000
(Based on 10 Months of Actual Expenditures Projected to Fiscal Year-End)

Entity		Costs
Department of Health Care Policy and Financing		$ 563,500[1]
Child Health Advocates		
General Administration (includes marketing, outreach, eligibility, and enrollment)	$3,468,400	
Provider Network Administration (net of $1.8 million for capitation payments)	914,000	
Premium Administration	405,700	
Total, Child Health Advocates		4,788,100[2]
Anthem Claims Administration		602,500[3]
Total Administrative Costs		**$ 5,954,100**
Total Health Care Services Costs		**$16,231,300[1]**
Administration Costs as a Percentage of Health Care Services Costs		**36.7%**
Administration Costs as a Percentage of Total Costs (Health Care Services and Administrative)		**26.8%**

Source: Office of the State Auditor analysis of agency data.
Notes:
1. Based on actual expenditures for the first ten months and projected amounts for the final two months of Fiscal Year 2000.
2. Based on Fiscal Year 2000 contract with Child Health Advocates. Contract amount is $6.6 million, which includes $1.8 million for capitation payments to providers not included here.
3. Based on the average number of children enrolled per month in the CBHP Network during the first ten months multiplied by the contractual per member per month rate and projected to the final two months of Fiscal Year 2000.

The table shows that administrative costs for Fiscal Year 2000, the second full year of program operations, are expected to run almost 37 percent of the cost of health care services provided to children served in the program, or almost 27 percent of total program costs (health care services plus administrative costs). In other words, out of each dollar spent on CBHP almost 27 cents is spent on administration.

The federal Health Care Financing Administration (HCFA), which oversees the federal CHIP program, indicates that some of the other 15 states with stand-alone CHIP programs have experienced high start-up costs. In Colorado some of the sources of high administrative costs appear to be:

- Duplicate oversight and administrative layers for the program. First, the CBHP Policy Board establishes policies and rules for CBHP. Second, the Department of Health Care Policy and Financing oversees and is accountable for CBHP; additionally, it administers some aspects of the program. The Department is required by statutes to contract for significant portions of CBHP administration. This brings in a third layer, the administrative contractor, which is currently Child Health Advocates (CHA). CHA does not administer any programs other than CBHP at this time, and the Department is its sole client. CHA also has its own board to which it is responsible.

  This administrative structure is overly cumbersome for a program with fewer than 25,000 participants.

- Creation and maintenance of a separate administrative structure and systems for CBHP for functions such as marketing and outreach and eligibility and enrollment. States that have chosen to use CHIP funds for a Medicaid expansion have been able to take advantage of the existing infrastructure of their state Medicaid programs. Again, because CBHP is a relatively small program, there is limited opportunity for spreading administrative costs, unlike in the Medicaid program. The average enrollment in Medicaid across all programs in Fiscal Year 1999 was 259,540 individuals.

Another contributing factor to relatively high administrative costs for CBHP is that enrollments have not increased as rapidly as originally anticipated. Further, there is concern that some families eligible for CBHP continue to use the Colorado Indigent Care Program (CICP) for their children's health care. CICP is supported by some federal funds under the Medicaid program, which receives matching funds of about one federal dollar to each state dollar. However, CICP itself does not receive federal matching funds. Therefore, state dollars in CICP cannot be leveraged in the manner possible under CBHP. The continued availability of CICP for families qualifying for

CBHP may be one factor influencing CBHP's rate of growth (the relationship between CBHP, CICP, and Medicaid is discussed in Chapter 5).

Departmental Proposals Regarding Administrative Costs

The Department is well aware of the high administrative costs of CBHP. In its Fiscal Year 2001 budget request the Department listed management of administrative costs as one of the problem areas encountered during the implementation of CBHP. It identified several alternatives for reducing these costs, including:

Change CBHP to a Medicaid-expansion CHIP program. This would allow the State to take advantage of economies of scale by operating CBHP through the existing state and county administrative structure and the Medicaid Management Information System used for claims processing. This option would also expand the health services available to children, since Medicaid provides a higher level of benefits than CBHP.

While not noted in the budget request, this option could allow the State to simplify some of the differences in eligibility requirements between CBHP and the Medicaid program that contribute to administrative complexity and costs for the counties and the State. These complexities also create confusion for families seeking health care services for their children (see Chapter 5).

A Medicaid expansion would require the State adopt a different model for CBHP other than the current commercial model that emphasizes maximizing privitization. In addition, an expansion would create an entitlement for CBHP, which is contrary to the expressed intent of the General Assembly. While this option would likely decrease administrative costs, creating another entitlement program would not allow the State to control the overall costs of the program. This could have serious implications for the State's budget, especially in view of constitutional and statutory growth limits.

Change CBHP to a combined stand-alone and Medicaid-expansion CHIP program. Under this scenario, children at the lower income levels would be included in a Medicaid expansion, and children at higher income levels would be served through the stand-alone portion of CBHP, as in the present model.

We found that currently 18 states use a combined option for their CHIP programs. These states have designed a variety of structures for their programs. For example, one state serves all children in families with income up to 100 percent of the federal poverty level in a Medicaid-expansion program, and it serves children in families with

incomes between 100 percent and 200 percent of the federal poverty level through a stand-alone program. Another approach would be to serve all children under a certain age, such as 6 years, up to 185 percent of the federal poverty level in a Medicaid-expansion program and serve older children up to 185 percent in a stand-alone program. The "combined" CHIP option allows a state to limit the impact of an additional entitlement program; however, the ability to decrease administrative costs is less clear than under the Medicaid-expansion option.

Privatize more CBHP functions, or administer more CBHP functions within the Department. HCPF noted that no additional statutory authority would be needed to contract more functions; on the other hand, some administrative functions might be less costly to perform within the State, due to possible economies of scale.

The Department did not detail specific costs and benefits associated with these options or recommend any of these approaches for immediate consideration. It stated that it would, together with the CBHP Policy Board, continue to examine ways to enhance the efficiency and effectiveness of the program and increase enrollments. For Fiscal Year 2001, administrative costs are budgeted at 10 percent of estimated enrollment for CBHP. However, if enrollment targets are not met, administrative costs could still exceed 10 percent of health care costs and be within budgeted amounts.

Alternatives for Decreasing Administrative Costs

Another option not discussed by the Department in its budget request would be to develop a stand-alone program using the Medicaid administrative structure to the greatest degree possible. We surveyed five states with stand-alone CHIP programs. We requested that they provide us with information regarding administrative and health care costs since their programs' inception. Two of the states (Arizona and Montana) reported that their administrative costs were about 30 percent of total program costs; two other states (Kansas and Utah) reported that they were able to contain these costs at around 10 percent. Oregon reported that by operating its CHIP program entirely out of the state Medicaid office, it was able to hold administrative costs to 2.9 percent of health care costs. The Oregon program may offer some ideas for using the existing Medicaid infrastructure without creating an entitlement program.

Federal Limits on Reimbursement for Administrative Costs

In addition to the general concern about high administrative costs, federal law limits the amount of reimbursement a state may receive for program administration. The limit for allowable administrative costs is based on these costs not exceeding 10 percent of total program costs. Administrative costs over this limit must be funded

entirely from state funds or other non-federal sources such as donations. To help defray start-up costs, HCFA temporarily permitted states to draw federal matching funds for administrative costs in excess of the limit. However, ultimately, states must repay any excess federal matching funds received.

On the basis of reports provided by the Department to HCFA, since the start of operations in April 1998 through March 2000, CBHP administrative costs have averaged about 23 percent of total program costs (i.e., health care services plus administrative costs). As of March 31, 2000, the Department reported that the State owes HCFA about $2.9 million, due to excess federal draws received for administrative costs over the limit.

The issue of excess federal draws for CBHP administrative costs was discussed in the Colorado *Statewide Single Audit Report, Fiscal Year 1999*, performed by the Office of the State Auditor and released in March 2000. The Department agreed with the recommendation to identify a strategy to reduce administrative costs, and HCPF proposed that it would (1) increase enrollments, thereby spreading fixed costs over more enrollees; (2) use performance-based contracting with an emphasis on payment for attainment of measurable products and outcomes; and (3) spread start-up costs over multiple years.

In terms of the Department's strategy to contain administrative costs, during our audit of CBHP we found:

- Enrollments have not risen as quickly as anticipated (see Chapter 3).
- The Department has not received full performance on the administrative contract, and it needs to ensure performance requirements are met (discussed in the next section of this chapter).
- The Department has limited ability under current federal requirements to spread costs over multiple years.

Addressing Decision-Making Responsibilities and Administrative Costs

It is critical to the success of CBHP that the CBHP Policy Board and the Department address these two fundamental issues: identifying ways to decrease the duplicate oversight and administrative layers of the Children's Basic Health Plan and reducing administrative costs. If the overall goal is to maximize the use of available funds to provide health care to uninsured, low-income children, such efforts will enable the program to have a clearer direction, create more specific lines of authority and responsibility, and result in more dollars going to health care as opposed to administrative functions.

Recommendation No. 1:

The CBHP Policy Board and the Department of Health Care Policy and Financing should identify options for reducing administrative layers and costs for the Children's Basic Health Plan, including options for alternative structures and delivery systems. The Board and the Department should establish a timeline for completing this review and submitting recommended statutory changes to the General Assembly on ways to achieve these goals.

CBHP Policy Board Response:

Agree. The Board agrees that administrative costs are a concern. The Board will review the report and respond to the Legislative Audit Committee by no later than January 1, 2001.

Department of Health Care Policy and Financing Response:

Agree. The Department has continued to identify options for reducing administrative costs. The non-HMO network has been maintained by the Department due to its overall cost-effectiveness to date (in comparison to other options). However, given the advent of new factors that will affect the volume of enrollment in the non-HMO network (HMO service area expansions), and recent federal statements of policy regarding the availability of matching funds, the Department may need to implement another solution for statewide benefit delivery. A major effort has been underway to identify alternatives to the non-HMO network and proposals will be made to the Legislature this Fiscal Year 2001 in this area. The Department will also evaluate the administrative structure prior to the legislative session and prepare recommended statutory changes by January 1, 2001.

Departmental Oversight of CBHP

One of the key elements in the Children's Basic Health Plan is the relationship between the Department of Health Care Policy and Financing and the program's administrative contractor. The program has had three administrative contractors since HCPF assumed responsibility for CBHP in April 1998: University of Colorado Health Sciences Center (April 1998 - June 1998); Colorado Foundation for Families and

Children (July 1998 - February 1999); and Child Health Advocates (CHA), from March 1, 1999, to the present. Despite this change in contractors, there has been a small core of personnel that has moved with the program and administered CBHP since its inception. The current contractor, Child Health Advocates, is a private nonprofit entity created in December 1998. At this time CHA administers no other programs in addition to CBHP.

CBHP is often described as a public-private partnership, and the relationship between HCPF and CHA has been viewed as an important manifestation of this partnership. To that end, the Department has exercised its oversight of the contractor on a "performance-based" contract approach. HCPF ensures contract requirements are met by obtaining and reviewing monthly reports from CHA and by conducting monthly contract management review meetings with CHA. The Department's Fiscal Year 2000 contract with CHA provides for almost $4.8 million to be paid to CHA for administrative functions; the Fiscal Year 2001 contract amount for administrative duties is set at about $6.1 million.

We found that the Department needs to strengthen its enforcement of contractual requirements for CBHP.

Contractual Performance Requirements

The Department's Fiscal Year 2000 contract with CHA is not to exceed $6,588,093 and consists of the following line items:

General CBHP Administrative Services (includes $218,441 to be provided through donations)	$3,468,441
Provider Network Administration (includes $1.8 million in capitation payments to CBHP Network primary care physicians)	2,713,922
Premium Administration	405,730
Total Contract	$6,588,093
Less: Capitation payments to CBHP Network	*(1,800,000)*
CHA administrative costs per contract	$4,788,093

The contract outlines CHA's areas of responsibility, requirements and in some instances establishes specific performance measures to be met. We found that CHA has failed to meet contractual requirements in several areas, a number of which are discussed in more detail later in this report. The Department has taken limited action in response to these performance issues. The following is a summary of some of the problems identified and the related contractual requirements:

- For the first six months of Fiscal Year 2000, CHA submitted marketing reports that were insufficient to determine the impact of strategies and efforts on program enrollment. The contract states that CHA is to "conduct and provide ongoing review and analysis of marketing effectiveness in relation to enrollment growth and the marketing plan and make changes to the outreach and marketing plan as needed to effectively enroll more children in [CBHP]" (Contract 2000-0119, Sec. 1.02(b)(xiii)). The contractor has only recently begun to provide this kind of information (see Chapter 3).

- CHA did not perform monthly reconciliations of premium receivable accounts to ensure that families' premium accounts were accurate and all appropriate charges and payments were entered (see Chapter 4). The contract requires CHA to establish and maintain "fiscal and programmatic accountability systems including accounts and controls that meet or exceed federal, state, and generally accepted accounting standards"(Contract 2000-0119, Sec. 1.07(a)(v)(2)). Another section of the contract states that CHA shall "maintain, *reconcile*, and transfer on a timely basis eligibility, premium and enrollment information to the State . . ." (Contract 2000-0119, Sec. 1.03 (b)(xix), emphasis added).

- CHA did not ensure retroactive changes to enrollment records were forwarded to network administration personnel in charge of provider payments (see Chapter 4). These changes should be reflected in amounts paid to providers. Such communication of vital information is also part of "generally accepted accounting standards" as required in Section 1.07(a)(v)(2) of the contract referenced above.

- CHA did not compile and maintain a "comprehensive program policy and procedure manual, consistent with policies and procedures defined by the CBHP Board and federal and state entities, that delineates eligibility, enrollment, marketing, outreach and all other policies and procedures . . ." (see Chapter 4) (Contract 2000-0119, Sec. 1.07(a)(xiii)).

- CHA did not complete a disaster recovery plan for the CBHP eligibility and enrollment system database. This plan was to be incorporated into the policy and procedures manual (Contract 2000-0119, Sec. 1.04(b)(vi)(3)).

- In terms of specific performance guidelines established in the contract, we found that CHA's performance has been somewhat mixed, generally showing some improvement over the period reviewed. The performance guidelines were for various aspects involving the timely processing of applications and responsiveness to phone calls and other inquiries. On the basis of six months

of reports provided to HCPF between November 1999 and April 2000, we found that for 8 processing guidelines:

- ✓ 3 guidelines were reported for all 6 months.
  - ✓ 2 guidelines were met for all 6 months.
  - ✓ 1 guideline was met for 3 out of the 6 months.

- ✓ 5 guidelines were reported for 5 out of the 6 months.
  - ✓ 2 guidelines were met for all 5 months.
  - ✓ 1 guideline was met for 4 out of the 5 months.
  - ✓ 2 guidelines were met for 3 out of the 5 months.

During the Department's review of the monthly reports, it noted ongoing problems such as mathematical errors, omissions, and inconsistencies in data reported between months, as well as occasionally within the same monthly report. We found similar occurrences during our review.

Sanctions Have Been Limited

Despite these problems, the Department has invoked penalties in only two instances during Fiscal Year 2000 for a total of $31,000, or less than one half of 1 percent of the total contract price. The Department also delayed partial payments to CHA for two months early in the fiscal year until some performance issues were corrected. These tactics may have had some success, but they did not resolve ongoing performance issues.

HCPF staff indicate they have made limited use of financial penalties because they did not want to withhold the funds needed to correct problems. Instead, the Department has preferred to use corrective action plans with the contractor as a way of addressing performance problems. Further, the contractor was new and CBHP was still in the start-up phase. However, as noted above, while CHA as an entity is new, there has been a core of personnel that has moved with CBHP through the various administrative contractors since the program began operations in April 1998.

In any case, Department staff believed it was of primary importance to establish the program and to create a working relationship with CHA within which problems could be addressed. Additionally, the contract did not provide specific financial remedies for noncompliance. Overall, the Department believes that performance has improved during the year. In developing the Fiscal Year 2001 contract with CHA, the Department included specific penalties for nonperformance in the areas of eligibility determination, customer service, and marketing. The Department also emphasizes it

has the option of withholding contract payments for noncompliance, regardless of whether or not specific financial remedies are spelled out in the contract.

While our audit found some improvements in contractual performance have occurred, in other areas problems persist. The Department identified performance-based contracting as one of its primary tools for controlling administrative costs. It is unclear how this strategy can be successful unless sanctions are used in instances of continuing nonperformance to ensure administrative dollars are being spent for value received. Now that CBHP is emerging from the start-up phase with the establishment of formal rules and more adequate systems, the Department should increase efforts to ensure contractual obligations and program goals are being met. It is the Department's responsibility to ensure that the State receives appropriate performance and services for the expenditure of taxpayer dollars.

Recommendation No. 2:

The Department of Health Care Policy and Financing should implement substantive monitoring procedures to ensure that contractual provisions for the Children's Basic Health Plan administrative contract are met. The Department should use corrective actions and penalties as appropriate to address instances of noncompliance.

Department of Health Care Policy and Financing Response:

Agree. Substantive contract monitoring procedures are in place, but can and will be improved. Corrective actions including withholding of contract payments are in use and will be used more aggressively in the current contract year (Fiscal Year 2001) if warranted. The current contract has strengthened the specification of deliverables and specified liquidated damages. Payment will be made only for performance to specifications.

Fiscal Year 2000 contract closeout procedures are being employed in July-August 2000, to assure that all outstanding performance issues (including those identified in the monthly reports/performance tracking, and those identified by the audits) are resolved prior to final payment (partial or full) for the Fiscal Year 2000 contract year. The contractor will be required to respond to every outstanding performance issue with a clear plan for bringing performance to specification, including timelines and staffing/financial resource allocations. Final payment will be made contingent upon satisfactory completion of these corrective actions, and payments can and will be recovered in the event of any failure by the contractor to complete the corrections.

Role of the CBHP Policy Board

The CBHP Policy Board (Board) is charged under statutes with establishing rules for the Children's Basic Health Plan. As such, it sets policies for how the program operates and provides overall direction. The Board is composed of seven members appointed by the Governor and approved by the Senate, as well as the executive directors of the Departments of Health Care Policy and Financing, Human Services, Public Health and Environment, and the commissioner of Education. Appointed members serve four-year terms. The Board has no staff of its own; it relies on staff from the Department for support functions. The Board meets monthly.

Strategic Planning for CBHP

The first rule passed by the Board for CBHP was the benefit package rule, which became effective December 1, 1998. There has been some criticism of the Board because it has not established additional rules for the program more quickly. However, over the last six months the Board has moved ahead by passing an eligibility rule (effective December 1, 1999) and a cost sharing rule (effective August 1, 2000). A revised eligibility rule and enrollment rule are currently in various stages of the public rule-making process.

While the Board has been successful in setting some program rules, it has not developed a strategic plan for the Children's Basic Health Plan. Ideally, a strategic plan would have been one of the initial actions of the Board. However, the Board was not created in statutes until April 1998 and did not have its first meeting until July 1998. At that point CBHP had already begun operations. Board membership has also undergone significant alteration during the Board's short existence. With elections in the fall of 1998 resulting in a new state administration, many members of the Board changed in January 1999, both among the governmental and non-governmental representatives.

In July 1999 the Board had preliminary discussions regarding strategic planning. This resulted in a draft mission statement, goals, and strategies for CBHP. However, it has not converted this beginning effort into a comprehensive plan describing specific objectives and performance measures to gauge the program's progress. Recently the Board directed the Department to present an annual report and a strategic plan to the Board at its October 2000 meeting.

Departmental Planning Efforts

The Department has undertaken some strategic planning efforts. Specifically, HCPF developed strategic objectives and performance measures as part of creating the original State Plan for CBHP submitted to the federal Health Care Financing Administration (HCFA) in the fall of 1997. In March 2000 the Department submitted an evaluation to HCFA reporting on these objectives and measures, some of which are now outdated. The Department also develops objectives and measures as part of the State's budgeting process. However, other than target dates for specific events or accomplishments, these measures are limited to number of children enrolled and percentage of children covered by HMOs. The Department reports that in large part the limited measures are due to the fact that the program has been in place a relatively short time. As a result, there has not been a sufficient time frame to measure aspects of performance related to health services received by children in the program. The Department expects to start reporting performance data on services beginning in Fiscal Year 2001.

Given the Department's responsibilities for reporting to HCFA and preparing budget requests, as well as the Board's lack of staff, it is not surprising that HCPF, rather than the Board, has embarked on setting objectives and performance measures. However, statutes give the Board responsibility for establishing policy.

Importance of Strategic Planning

The strategic planning process is one of the fundamental ways in which an organization creates its unique sense of identity and purpose. Through defining its mission, goals, and how it will measure success, an organization develops the foundation for making policy decisions. The exercise of strategic planning is particularly important for the Board because the membership of the Board includes a combination of state and private-sector personnel who have substantial expertise and differing perspectives. The process of developing the consensus necessary to establish a plan would give Board members an opportunity to create a common vision and direction for CBHP. The Department's involvement in the process of strategic planning is also vital because it is involved with CBHP on a day-to-day basis. HCPF staff have an in-depth knowledge of how the program functions, operational barriers and opportunities, and the various state and federal requirements within which CBHP must operate.

In the course of defining CBHP's mission, goals, and performance measures, the Board and the Department also need to address specific issues that have arisen over the two years of operation. One issue, the need to simplify the administrative structure of the program, was discussed earlier in this chapter. Others include:

- Defining the roles and responsibilities of committees created by the Board. As mentioned earlier in this chapter, the Board has created committees that focus on areas such as finance, operations, benefits, and proposed legislation affecting CBHP. Membership of these committees and subcommittees bring in viewpoints not only from the Board, the Department, and CHA, but also from other stakeholders such as providers for CBHP. While the program has benefitted from this wide participation, there has been confusion about the role of the committees and subcommittees and how the Board and the Department can effectively use this input for policy-making and other decisions.

- Clarifying what the use of a "commercial model" for CBHP means, and additionally, how the model is appropriate for the program and how it is not. The term "commercial model" does not appear in CBHP statutes. However, the Department and the Board report they have received clear indications from the General Assembly since the early days of the program that this is the type of model the program should emulate. The experience of the last two years may have helped clarify some of the opportunities for using such a model, as well as some of the limitations. In specific cases, the Board and the Department may need to request guidance from the General Assembly as to the proper model for the program. The next section of this chapter discusses cost sharing for CBHP and addresses some of the questions that have arisen over application of the commercial model.

- Considering results of the proposed independent study on "options, benefits, and merits of changing the administrative structure of the Children's Basic Health Plan, including creating a separate instrumentality of the State to administer" the program (Sec. 26-19-104.6(2.5), C.R.S.). This report is due to the Joint Budget Committee and the House and Senate Health, Environment, Welfare, and Institution Committees by October 15, 2000. While any decision about changing the program's structure would be that of the General Assembly, the Board and the Department need to make their own assessment of the options. As part of this the Board and the Department should ensure that state and federal requirements are adequately addressed.

  For example, there has been continued concern expressed by program staff and Board members that the state procurement process has been a significant barrier to operating CBHP under a commercial model. There has been some hope that this independent study could identify an administrative structure that would result in CBHP's being exempt from the state procurement process, similar to the Colorado Uninsurable Health Insurance Plan. However, under federal regulations, CHIP programs are required to follow state procurement procedures. Therefore, setting up an entity exempt from the state

procurement process will not result in CBHP's being exempt from this process.

Joint Efforts on Strategic Planning

Since the Board lacks a staff of its own, it is understandable it would request the Department develop a strategic plan for CBHP to be presented at the Board's October meeting. This proposal should present a useful starting point for the Board and the Department to mutually create a strategic plan that can be used to shape policy decisions. The plan should also reflect consensus on the program's basic goals and objectives, as well as an understanding of program operations and requirements.

Recommendation No. 3:

The CBHP Policy Board and the Department of Health Care Policy and Financing should develop a strategic plan for the Children's Basic Health Plan that includes necessary elements such as a mission statement, strategic goals, objectives, and performance measures. The plan should be reviewed and updated on a regular basis.

CBHP Policy Board Response:

Agree. The development of a strategic plan for the program needs to be a joint activity between the Board and the Department. The development of a "strategic plan" for CBHP is within the purview of the Board. The Board has had three planning retreats (September 1998, July 1999, and May of 2000). The purpose of these meetings was as outlined in the audit. The result of the July 1999 meeting was a written list of goals and objectives. This work was updated in the May 2000 retreat. This material included a mission statement, a list of values, and specific strategies. Without a dedicated staff, it is difficult for the Board to provide detailed planning documents. The Board will work jointly with the Department on this recommendation. Key strategic issues that need to be resolved, and may require action by the General Assembly are:

1. The definition, and the intent, of the term "commercial model" should be clarified. The desire to ensure that the program operates as would a "commercial health plan" has shaped various decisions that the Board has made. Some of these decisions (e.g. the disenrollment of children for failure to pay premiums) have created a stir within the media and the public.

2. A separate but related question is the stated desire to have CBHP operate as a "public-private partnership" through the use of private entities, such as CHA, working as contractors to the Department. The implications of this goal are significant, and should be reviewed as the program moves forward.

The Board will review the recommendations in the report and respond to the Legislative Audit Committee by no later than October 15, 2000.

Department of Health Care Policy and Financing Response:

Agree. The Department of Health Care Policy and Financing has been working with the CBHP Policy Board on aspects of a strategic plan for the last year. A mission statement and program goals are in place. Department staff have participated in planning sessions to identify program structure and key administrative issues and have participated with the Board in its initial efforts toward this end. However, a programmatic strategic plan needs to be completed collaboratively between the Department and the Board for it to be a meaningful reflection of program goals. The Department is committed to this process. Implementation date: October 5, 2000.

Implications of the Cost Sharing Rule

As mentioned above, the Board recently passed a cost sharing rule for CBHP. This rule formalizes premiums and copayments for families and establishes policies for disenrollment from the program if monthly premium payments are not made in a timely manner. Under the rule, if premiums are not paid by the second month, or about 60 days after they are due, the family will be disenrolled as of the third month and the account will be sent to Central Collections. Once disenrolled, families will be "locked out" of the program for three months. The rule will go into effect on August 1, 2000. Up to this time families have never been disenrolled for nonpayment, because there was no rule establishing when disenrollment should occur.

Two questions have raised a great deal of discussion for the Board, the Department, and various stakeholders for CBHP: (1) what is the appropriate level of premiums to charge for CBHP, or at what point does the amount of premium charged have a significant negative effect on enrollments? and (2) what impact will enforcement of premium payments (i.e., disenrollment for nonpayment) have on families' participation, the number of children in the program, and overall program goals of

increasing access to health care? In addition to these two questions, there are other factors that need to be considered in light of the new rule.

Appropriate Levels for Premiums

Several studies have attempted to address the issue of how levels of premiums affect enrollment. At this point there is no simple answer to the question of the appropriate amount to charge. The decision of how much to charge for premiums becomes more complex if it is driven by goals other than maximizing enrollments to expand health care services to low-income children. For example, in Colorado part of the intent of charging premiums is to teach participants to value the services of the program. If the goal to teach value requires that premiums for families be set higher than at a nominal rate, achieving this goal is likely to be in direct conflict with the goal of maximizing health services to low-income children.

From a financial perspective, CBHP may be spending more to collect premiums than it receives in revenue, and the new rule is likely to increase collection costs. This is discussed more below. Additionally, HCPF staff express concern that by making it more difficult for families to maintain enrollment in CBHP through the new cost sharing rule, it is possible that some "adverse selection" could take place. This could result in higher average health care costs per child. In other words, families that have greater need for health care services for their children may be more likely to attempt to maintain monthly payments in order to continue to use program services. Families with healthy children may be less motivated to participate, especially if they believe their accounts will be turned over to Central Collections if two months' worth of payments are missed.

Comparisons With Other States

Currently states have a wide variety of premium structures for their CHIP programs. Out of all 50 states, Colorado is 1 of 8 states that charge a premium or an enrollment fee for families below 150 percent of the federal poverty level. In terms of the 15 states with stand-alone programs, only four states (Colorado, Montana, Delaware, and Georgia) charge premiums or enrollment fees to families in this income level. Therefore, Colorado appears to have relatively high premiums for families at the lower income levels. Additionally, among states with stand-alone programs, only three states (Colorado, Montana, and Delaware) do not include dental services in their benefit packages.

On the basis of the limited information we were able to gather, Colorado also appears to be somewhat less successful in marketing its CHIP program than several of the other stand-alone programs. We contacted five states with stand-alone CHIP

programs and requested that they provide us with their estimated market penetration rates (percentage of enrolled vs. estimated eligible children). These penetration rates must be viewed with caution; they are self-reported, and estimates of eligibles are based on 1990 census data adjusted for intervening years. We found that three of the states (Montana, Utah, and Oregon) have lower premiums and reported higher estimated penetration rates than Colorado. The other two states (Arizona and Kansas) also had generally lower premiums, but they were unable to provide estimates on penetration rates. This information is reported in Table 5 below.

Table 5: Summary of Premium Structures and Market Penetration Rates for Selected Stand-Alone CHIP Programs Reported as of June 2000

State	FPL[1] Served	Premium Structure				Estimated Penetration Rate[2]
CO	Up to 185%	Below 101% FPL	101% - 150% FPL	151% - 170% FPL	171% - 185% FPL	35%
		None	$9 monthly for 1 child $15 monthly for 2 or more children	$15 monthly for 1 child $25 monthly for 2 or more children	$20 monthly for 1 child $30 monthly for 2 or more children	
MT	Up to 150%	Up to 100% FPL		101% - 150% FPL		45%
		None		$15 annual enrollment fee per family		
OR	100%-170%[3]	None				67%
UT	Up to 200%	None				59%
AZ	Up to 200%	Below 150% FPL	150% - 174% FPL	175% - 200% FPL		N/A[4]
		None	$10 monthly for 1 child $15 monthly for 2 or more children	$15 monthly for 1 child $20 monthly for 2 or more children		
KS	Up to 200%	Below 151% FPL	151% - 175% FPL	176% - 200% FPL		N/A[4]
		None	$10 monthly per family	$15 monthly per family		

Source: Office of the State Auditor analysis of data reported by states.

Notes:

1. Federal Poverty Level. Currently a family of four with an annual income of about $31,500 would be at 185% FPL.
2. State estimates of market penetration rates, which are calculated by dividing the number of enrolled children by the total estimated number of CHIP-eligible children.
3. Oregon serves families below 100% FPL in its Medicaid program through a waiver obtained under that program.
4. Not available. These states were unable to provide estimates for market penetration rates for their CHIP programs.

Results from our limited survey suggest states with lower premiums than Colorado may have more success marketing their CHIP programs.

As discussed in Chapter 3, CBHP has experienced its lowest market penetration rates with families at 100 percent of the federal poverty level and below. These families do not have to pay any premiums or copayments. The reasons for low participation from this population are not known. HCPF staff indicate that part of the reason may be the continued availability of the Colorado Indigent Care Program for children in many of these families, combined with the families' familiarity with that program. The five states we surveyed were unable to provide information on their penetration rates for families in this income category; therefore, we cannot compare Colorado's performance in this area.

Impact of Disenrollment Policies on Enrollment

There has been concern that the new cost sharing rule will have a significant impact on enrollments due to the number of families currently behind on premium payments. As of April 30, 2000, on the basis of information from Child Health Advocates close to 4,800 families, or 37 percent of the almost 13,000 families enrolled in CBHP, were more than 30 days past due in their premium payments. These 4,800 families represent almost 53 percent of the approximately 9,100 families required to pay premiums. If delinquency rates continue to be high after the new rule goes into effect, it will be difficult to maintain present enrollments or to increase them. On the other hand, it is difficult to know if part of the reason for the high percentage of delinquencies is that the program has never enforced payment by disenrolling families in arrears.

Whatever the impact of the rule, it is critical that information be appropriately tracked concerning the program's experience, once the new cost sharing rule goes into effect on August 1. The Board should work with the Department to establish in advance data that should be tracked by Child Health Advocates, including the program's experience regarding whether or not disenrolled families re-enroll after the three-month lockout period. The Board and the Department should inform policymakers of any substantial changes in enrollment. If the disenrollment policy significantly impacts CBHP enrollments, the General Assembly may wish to consider other options for cost sharing.

Other Considerations

While questions about the appropriate level of premiums and the impact on enrollments are important, there are several other issues related to the new cost sharing rule that need to be considered.

- *Administrative costs.* These costs could be expected to increase under the new rule because more information must be tracked, specifically the three-month lockout period for families that have been disenrolled. The Department has relied on industry data to estimate the costs of premium collections. However, costs may be higher for CBHP, even before the new rule. Automated payment methods such as payroll deductions or bank account withdrawals are not used, and the high delinquency rates mean more costs for collection efforts.

- *Federal regulations.* The State is implementing a rule that is likely to raise CBHP administrative costs at a time when the State has already exceeded the limit at which it can receive federal matching funds for these costs.

  Further, federal regulations for CHIP do not permit the administrative costs of collecting and enforcing premiums to be offset by the revenue gained.

  ✓ *Premium administrative costs* are part of general administrative costs, which are reimbursable only up to certain limits under federal laws for CHIP.

  ✓ *Premium revenues,* however, are deducted from benefit costs, thereby decreasing the amount of costs against which the administrative limit is calculated. This means premium revenues have the effect of decreasing the amount of dollars allowable for administration for which federal matching funds can be obtained.

- *Implementation of adequate systems and controls.* Finally, there has been a history of problems with tracking premiums accurately since the program's inception, and these problems have yet to be resolved. This is discussed in Chapter 4. Child Health Advocates must develop and implement adequate controls over the premium administration process. Further, CHA is currently developing a new software module for premium administration that is scheduled for implementation on August 1, the same day the cost sharing rule goes into effect. Both the control structure and information systems must be operating effectively on August 1; otherwise, the State will be disenrolling families based on information that could be incorrect.

Regardless of the new cost sharing rule, CBHP should have a premium administration system that is reliable and accurate. By tracking the impact and costs of the rule, the Board will be in a position to make more informed policy decisions in the future than is now possible because of the newness of the program. If enrollments level off and premium administration costs rise, consideration should be given to other ways to structure cost-sharing mechanisms. For example, the program could rely more on

copayments, to the extent permitted under federal laws and regulations, rather than premiums, as a way for families to share in the cost of the program. Alternatively, the cost-sharing structure could be simplified to cut down on administrative costs, e.g., charging annual instead of monthly premiums, or charging a one-time enrollment fee. In any case, information gained should be used to improve the program.

Recommendation No. 4:

The CBHP Policy Board and the Department of Health Care Policy and Financing should ensure that implementation and impact of the cost sharing rule for the Children's Basic Health Plan is addressed by:

a. Identifying and tracking appropriate data under the new cost sharing rule to determine its impact on enrollments.

b. Identifying and tracking premium administration costs for the program.

c. Assessing the impacts of the cost sharing rule and using the results as the basis of future program policies.

d. Proposing legislative changes as needed to change cost-sharing mechanisms to streamline administration and encourage participation.

CBHP Policy Board Response:

Agree. The cost sharing rule is significant to the program. At the present time there is no clear determination regarding the goal of the program; i.e., is the purpose to cover as many children as possible or to conduct a program that operates like a "commercial model." The full Board will meet to discuss the cost sharing rule again in September 2000 and keep the Legislative Audit Committee apprised of its plans. The Board will review the recommendations in the report and respond to the Legislative Audit Committee by no later than September 30, 2000.

Department of Health Care Policy and Financing Response:

Agree. The Department and the Board earlier agreed that the implementation of a cost sharing rule required a strong tracking and evaluation system to identify the impact of the rule on existing and potential members. The

Department is working with the Board on a schedule for the evaluation and recommended legislative changes.

The Department has already developed a new tracking system to be implemented on August 1, 2000, concurrent with the effective date of the new rule including a system of billing, recording payments, issuing delinquency letters, terminating enrollment for non-payment of premiums and enforcing a period of disenrollment for non-payment of premiums. The Department began a parallel track of developing the requirements for the system and proposing cost sharing rules to the Board so that the new system would reflect the requirements of the rule. The system must support the premium administration function and the policy and evaluation needs of the Department and the Board to enforce the underlying cost-sharing policies and track the information necessary to evaluate the impact of those policies. The Department is confident that the new premium administration system will support all of the above recommendations. The Department has process flow and data flow diagrams, report formats and underlying pseudo-code, and testing plans and test results on file if there are any further questions regarding the development of the premium administration system.

In addition, the Department and its contractor have implemented new procedures for cash controls and segregation of duties. In June, enrollees were notified to begin sending premium payments to a bank lockbox. The majority of all cash, checks and money orders are processed directly through the bank. A new cash control system is in place for those rare instances where cash is presented to the contractor. In this instance, the cash, check or money order is accepted, recorded and deposited by an employee other than the accounting manager. The new system enforces strict controls over access, usability, who can make adjustments, and who can review and approve them.

Implementation date, parts “a” and “b”: August 1, 2000. Implementation date, parts “c” and “d”: to be determined based on the results obtained from parts “a” and “b.”

Marketing and Eligibility

Chapter 3

Background

The Children's Basic Health Plan (CBHP) began operations in April 1998 with an enrollment of 5,528 children. These were families that chose to transfer their children into CBHP from the previous state children's health insurance program, the Colorado Child Health Plan. The Department of Health Care Policy and Financing (HCPF), which oversees CBHP, reports that as of April 30, 2000, there were 24,410 children enrolled in the new program. Thus CBHP has increased enrollments by about 342 percent in about two years of operations. CBHP is marketed under the name "Child Health Plan Plus," or "CHP+."

The marketing and outreach function for CBHP is one of the key functions performed by the Department's contractor, Child Health Advocates (CHA). Similar to other states, Colorado is experimenting with a variety of approaches in an attempt to identify the most successful strategy for encouraging families to enroll in the State's version of the federal Children's Health Insurance Program (CHIP).

This chapter discusses marketing activities and enrollments for CBHP, as well as some issues related to eligibility determination for the program.

Marketing Efforts and Enrollment Trends for CBHP

According to HCPF, the 24,410 children enrolled in CBHP as of the end of April 2000 represents about 35 percent of the estimated 69,100 eligible children in the State. The estimated number of eligible children for CBHP is a rough approximation based on 1990 census data adjusted for subsequent years. The ratio of enrolled children to the estimated number of eligible children, or market penetration rate, is one of the key indicators used to gauge the success of CBHP. Although enrollments and penetration rates have increased considerably since inception, levels have not met the Department's expectations.

Specifically, the enrollment goal for June 30, 2000, was about 31,000 enrollees, or a penetration rate of about 45 percent. However, Child Health Advocates reports actual enrollment may be short of the goal by over 5,000 children, or about 16 percent fewer children than anticipated. In addition to this shortfall, three particular concerns have been noted: (1) the relatively low levels of enrollment in urban areas, particularly in the Denver metro area, which has been the target of considerable marketing efforts; (2) the relatively low levels of enrollment among families at or below 100 percent of the federal poverty level; and (3) the leveling off of enrollments overall.

The first concern about urban penetration rates is illustrated in Table 6 below. Market penetration rates for the Denver Metro and South Front Range regions are 28 percent, while rates for rural areas overall are significantly higher at 52 percent. The relative success of CBHP in rural areas has been attributed to the fact that the program's predecessor, the Colorado Child Health Plan, was primarily located in these counties. The Department also indicates that the number of estimated eligible children in rural areas may be understated, which could account for some of the discrepancy between metro and rural marketing results. In any case penetration rates for CBHP in the major urban regions consistently lag behind the state average.

Table 6: Children's Basic Health Plan
Estimated Market Penetration Rates by Region
Based on April 2000 Enrollments[1]

Region	No. of Children Enrolled	Estimated No. of Eligibles	Estimated Penetration Rate[2]
Urban Regions:			
Denver Metro: Adams, Arapahoe, Boulder, Denver, Douglas, Jefferson	10,859	35,532	31%
South Front Range: El Paso, Pueblo	2,347	11,926	20%
All Urban Regions	*13,206*	*47,458*	*28%*
Rural Regions:			
NE Colorado: Logan, Sedgwick, Phillips, Yuma, Washington, Elbert, Kit Carson, Weld, Larimer, Morgan	3,538	8,179	43%
NW Colorado: Moffat, Routt, Eagle, Mesa, Garfield, Rio Blanco, Delta, Pitkin, Lake, Summit, Park, Chaffee, Teller, Clear Creek, Grand, Jackson, Gilpin	3,342	6,807	49%
SE Colorado: Lincoln, Cheyenne, Kiowa, Crowley, Otero, Prowers, Baca, Las Animas, Bent, Huerfano, Costilla	1,378	1,755	79%
SW Colorado: Gunnison, San Miguel, Montrose, Mineral, Rio Grande, Ouray, Dolores, Custer, Montezuma, La Plata, Archuleta, Hinsdale, San Juan, Saguache, Conejos, Alamosa, Fremont	2,946	4,958	59%
All Rural Regions	*11,204*	*21,699*	*52%*
Statewide	***24,410***	***69,157***	***35%***

Source: Office of the State Auditor analysis of agency data.
Notes:
1. Data reported by Child Health Advocates as of May 2000.
2. Penetration rates are calculated by dividing the number of enrolled children in each region by the estimated number of eligible children in the region. Eligible children excludes children eligible for the Medicaid program.

The second concern is the relatively low market penetration rate for families at or below 100 percent of the federal poverty level. This result is unexpected, because families in this income level do not pay either premiums or copayments under CBHP. In other words, for these families the program offers free health care coverage for their children. Although estimates on the number of eligibles may not be entirely reliable, the gaps in relative penetration rates by income levels is striking. These are shown below in Table 7.

Table 7: Children's Basic Health Plan
Estimated Market Penetration Rates by Income Level
Based on March 2000 Enrollments[1]

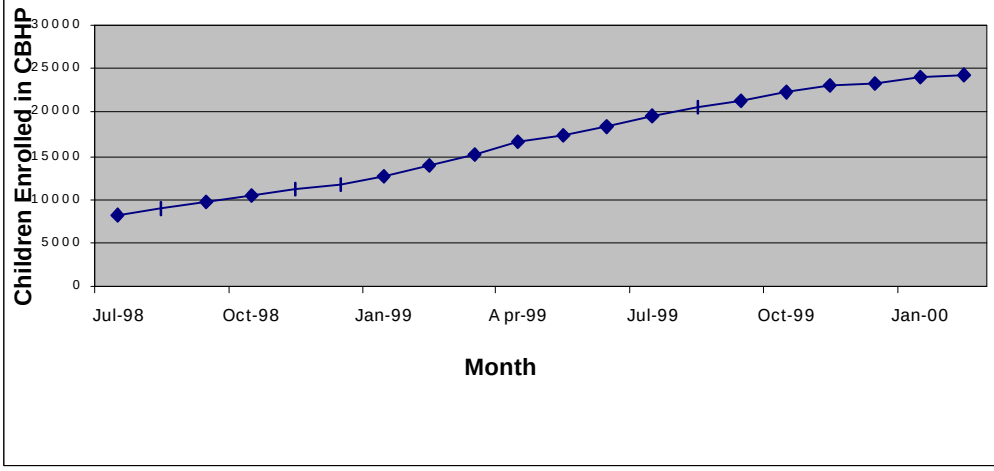
Family Income Based on Percent of Federal Poverty Level (FPL)	Estimated Penetration Rates[2]
100% FPL or less	20%
101 % - 150% FPL	40%
151% - 185% FPL	67%

Source: Office of the State Auditor analysis of agency data.
Notes:
1. Data reported by Child Health Advocates as of May 2000.
2. Penetration rates are calculated by dividing the number of enrolled children in each income level by the estimated number of eligible children in each income level in the State. Eligible children excludes children eligible for the Medicaid program.

Department staff believe many of the families at or below 100 percent of the federal poverty level may be eligible to receive health services for their children under the Colorado Indigent Care Program (CICP). Families may be more comfortable with continuing their participation in that program, since they are already familiar with it.

The third area of concern is that although enrollments continue to climb, the monthly rate of increase has leveled off, despite the fact that overall only 35 percent of the estimated number of eligible children are enrolled in CBHP. This trend is demonstrated in Table 8 on the next page.

Table 8: Children's Basic Health Plan Enrollment
July 1998 - March 2000



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

Taken altogether, these enrollment results for CBHP emphasize the need to continually analyze and reevaluate the marketing strategies used for the program to ensure eligible families are being targeted and resources are used in the most effective manner.

Tracking and Evaluating Marketing Strategies and Efforts

Since CBHP began operations in April 1998, a wide range of marketing and outreach techniques have been used. Some examples include:

- Satellite eligibility determination sites to offer local one-on-one application and enrollment assistance to families.
- Radio, television, and newspaper advertisements.
- Presentations to community-based organizations, such as schools, clinics, and nonprofit organizations.
- School outreach campaigns.
- Program co-promotions with HMOs.
- Newsletters to families and providers.
- Training sessions and site visits at county departments of social services.
- Coordination with other programs and organizations that serve low-income children in Colorado.

However, while many approaches have been used, it is not clear how effective different efforts have been. Although CBHP has been operating for just over two years, until recently there has not been a systematic marketing strategy focused on identifying specific tactics, tracking and analyzing their effects on enrollment, and using these results to refine marketing activities.

Our review of monthly marketing reports from CHA to the Department showed that for the first six months of Fiscal Year 2000 the reports did not critically address the objectives of the approved marketing plan. That is, the reports did not include the results of particular efforts, such as a specific series of newspaper advertisements, an informational booth set up at a back-to-school night, or a meeting with a community service organization. Further, there were no suggestions for ways to use knowledge gained from these results to refine the marketing plan.

Rather, the reports generally focused on numbers such as applications and information kits distributed, calls received by potential applicants, information sessions presented, attendees at CBHP trainings, and applications received by the various satellite eligibility determination sites. This information may have helped the Department monitor the activities of the contractor, but such information could not assist HCPF in determining the most valuable and cost-effective marketing tactics. In addition, although the Fiscal Year 2000 marketing plan submitted to HCPF by CHA included time frames for specific objectives and projects, the monthly reports from CHA indicate that these time frames were frequently missed and projects were not started on time.

With active involvement from the Department, progress has been made since December 1999. In that month, Child Health Advocates hired a new marketing director, who has worked with the Department to make improvements, such as:

- **Revised marketing plan.** A revised Fiscal Year 2000 marketing plan was submitted to the Department in January 2000. The updated plan reflects a more results-oriented marketing approach and includes an evaluation section that addresses how CHA will monitor the results of each marketing tactic. The plan identifies 13 target audiences and the tactics that will be implemented for reaching each group. The evaluation section describes how the results of these tactics will be monitored with the implementation of the database integration project that is described below.

- **Database integration project.** This project links CHA's enrollment and marketing databases and makes it possible to determine the origin of a new enrollee's application through numeric tracking. In turn, this allows CHA to assess the success of specific marketing events and community partners, such as schools, employers, providers, and satellite eligibility determination sites.

These data also include demographic information about families that respond to marketing initiatives. After being delayed for several months, the database integration project was finally implemented in January 2000.

- **Analysis of marketing initiatives.** In January 2000 the monthly marketing reports from CHA began to include some results of particular marketing efforts in terms of impact on enrollments. In March and April 2000, reports began to include critical analysis of several marketing initiatives and address ways in which the marketing plan could be fine-tuned in response. For example, the April 2000 report discusses the outcome of a print advertising campaign that produced disappointing results. The report includes both a description of the advertisements and a discussion of how the results can be used to refine the current marketing strategy regarding paid print media.

These improvements are encouraging. However, they are only the initial steps to the comprehensive and ongoing analysis of marketing data that is needed. Much remains to be done to identify the best approaches for marketing CBHP to unique population groups and geographic areas. As data on marketing activities become increasingly available, the Department must ensure information is analyzed and used to adjust marketing strategies accordingly. Additionally, the Department should establish clear timelines for accomplishing marketing activities and evaluation tactics, such as cost analysis, as proposed in the updated Fiscal Year 2000 marketing plan.

Results-Oriented Strategies

One of the major program goals for CBHP is to increase low-income children's access to health care services in the State. Many factors influence enrollment, such as the ease in applying or a family's willingness to participate in a government program. Additionally, the national CHIP program is still relatively young. Although there are many suggestions, there is little conclusive research on how best to conduct outreach for state CHIP programs. Therefore, in order to ensure that limited marketing funds are spent most effectively to maximize the number of children in CBHP, it is especially important for the Department to develop a comprehensive marketing approach that includes consistent analysis and fine-tuning of strategies for the Children's Basic Health Plan.

Recommendation No. 5:

The Department of Health Care Policy and Financing should continue to work with the contractor to ensure that results-oriented marketing is implemented for the Children's Basic Health Plan by:

a. Tracking, analyzing, and reporting the enrollment impact of both specific and overall marketing strategies on a routine basis.

b. Including time frames and conducting cost analysis for specific marketing activities.

c. Modifying strategies as needed in response to the marketing results.

Department of Health Care Policy and Financing Response:

Agree. As identified in this audit, reporting and analysis of marketing and outreach strategies, activities, and results have improved over the last few months. The Department will continue to work closely with the contractor to establish and operate close connections among marketing and outreach strategies, plans, activities, results measurements, reporting and analysis, and recycling of lessons learned to plan and modify strategy. Specifically addressing the recommendation subparts:

Tracking, analyzing, and reporting on both targeted and overall marketing strategy are being accomplished by a variety of methods employing an integrated database/reporting system that tracks and reports all marketing/outreach information in the same formats as eligibility and enrollment, demographic, and budgetary and quarterly analysis and reporting of enrollment results and trends.

Cost/benefit analysis of specific marketing efforts/strategies is already required as a specific contractual obligation during Fiscal Year 2001.

Marketing plans and strategies are reviewed quarterly in the context of the quarterly reports and analyses; modifications to respond to lessons learned are recommended by the contractor and reviewed/approved by the Department, as part of the ongoing planning process.

It should be noted, however, that for some families, the marketing needs to include information on the availability of the program and the dual concepts of the value of health insurance and preventive health care. These are complex messages and will need multiple marketing strategies and evaluation efforts that will have to be stratified for different populations and maintained over time. Experience in other states indicates that multiple marketing

strategies are required and will have different outcomes, due to differences in geography and community characteristics.

Analysis of Satellite Eligibility Determination Sites

An important component of CBHP's outreach and enrollment strategy is the network of 67 satellite eligibility determination (SED) sites that forward applications for CBHP to Child Health Advocates. The SED sites offer a specific example of how the program's current outreach tactics need further evaluation and refinement. During the first ten months of Fiscal Year 2000, the number of applicants coming into CBHP through SED sites declined from 1,128 children in July 1999 (38 percent of total July applicants) to 641 children in April 2000 (20 percent of total April applicants).

The SED sites are located in 25 counties throughout the State and include community health centers, county nursing services, school-based health centers, and other health care providers. The CBHP level of activities performed at sites varies based on resources, but basic responsibilities include conducting CBHP outreach, screening families for eligibility in CBHP and Medicaid, assisting families with the CBHP application process, and forwarding to CHA completed applications for eligible children. CHA pays the sites for complete and accurately screened applications, depending on whether the application was transmitted electronically ($15.00 each) or in hard copy only ($12.00 each). For Fiscal Year 2000, CHA reports that it paid $42,883 to SED sites as of the end of April 2000. This amount appears low, because at the beginning of the fiscal year reimbursement rates were significantly less and the accuracy rates for applications processed by the sites were low. In addition to the application processing costs, there are additional costs incurred by CHA to train and otherwise support the sites. However, these costs are not tracked separately.

The SED sites are important because they provide families with a convenient resource for CBHP information and one-on-one assistance in completing the application. Available studies indicate these two factors are important to enrolling children into CHIP programs. However, in addition to the decline in applicants entering CBHP through SED sites, the sites themselves have had mixed success. Some sites are responsible for a high percentage of the completed applications in their county, while others consistently show a very low level of participation. Table 9 illustrates the average number of applications submitted over a recent three-month period for the 67 sites. Thirty-two of the sites, or a little under half, submitted on average less than five applications per month; seven averaged less than one per month.

Table 9: Children's Basic Health Plan
Average Number of Applications Submitted by SED Sites[1] Monthly
February Through April 2000

Average Number of Applications Submitted per Month	Number of SED Sites
Less than 1 application	7 sites
1 to less than 5 applications	25 sites
5 to less than 10 applications	16 sites
10 to less than 15 applications	16 sites
15 or more applications	3 sites

Source: Office of the State Auditor analysis of agency data.
Note:
1. Satellite Eligibility Determination sites.

Additionally, the accuracy rates of both individual SED sites and the sites in general vary widely from month to month and site to site. Low accuracy rates mean CHA must do more follow-up and the family's enrollment in CBHP is delayed.

Role of SED Sites and Critical Factors for Success

A number of reasons have been suggested for the varying success of SED sites. Some of these are lack of adequate personnel at sites to handle CBHP questions and applications, low reimbursement rates for CBHP applications, and turnover in SED site staff. Further, some SED sites are located in rural areas, which could explain the low number of applicant submissions. CHA has begun to implement pilot programs in an attempt to increase the number of enrollments from the SED sites. Nonetheless, neither the Department nor CHA has performed a systematic evaluation of SED sites and their performance to determine factors, such as staffing levels and bilingual capabilities, that contribute to the success or failure of individual sites and/or counties or the training costs of maintaining the sites. As part of this evaluation the Department also needs to consider how best to maintain rural SED sites to provide outreach in these areas.

A related question concerns the appropriate role of SED sites in the program. Each SED site designated to enroll families and process applications represents an investment in time and resources that must be provided by CHA staff in order to ensure SED site personnel are adequately trained to perform these duties. The Department is currently considering other options for the role of SED sites, such as

limiting activities for some sites to marketing and outreach, rather than having all participating sites assist with applications.

The SED sites have served a useful function in outreach and enrollment efforts for CBHP. However, without further analysis and refinement of the current SED structure, the Department may not be utilizing this resource in the most cost-effective manner.

Recommendation No. 6:

The Department of Health Care Policy and Financing should evaluate satellite eligibility determination sites for the Children's Basic Health Plan to determine the cost of resources used to support the sites, including training; the appropriate role of the sites; and how to improve their performance. The Department should consider eliminating sites with poor performance.

Department of Health Care Policy and Financing Response:

Agree. The Department has communicated with the Office of the State Auditor that this is a priority for Fiscal Year 2001. A comprehensive evaluation of the SED site structure shall be completed by the Department no later than June 30, 2001. That evaluation will include an assessment of the impact of the SED sites in providing access to "difficult to reach" populations, including rural sites or those assisting minority or underserved communities. The Department will consider eliminating sites with poor performance.

CBHP and Eligibility Determination

The eligibility determination process maintained by Child Health Advocates was tested as part of the separately issued claims audit performed by Buck Consultants (see *Children's Basic Health Plan Claims Audit*, Report No. 1225B). Findings and recommendations from that audit are summarized in Chapter 6 of this report.

Our audit identified some changes that need to be made to the current eligibility rule for CBHP and to the methodology for calculating error rates for eligibility determination.

CBHP Eligibility Rule and Documentation

We found that the eligibility rule for CBHP needs to be changed to ensure that documentation requirements for eligibility determination are consistent and appropriate.

- **Social Security Numbers.** Under the CBHP eligibility rule, a child's Social Security Number is required in order for the child to be eligible for and enrolled in the program. However, federal guidance for CHIP states that Social Security Numbers should not be required as a condition of eligibility for state programs. The concern on the part of the federal Health Care Financing Administration (HCFA) has been that immigrant parents may be discouraged from applying for CHIP programs.

  Department staff state this requirement was made because federal law requires CHIP programs to screen for Medicaid, which does require a Social Security Number, and because federal guidelines also emphasize the need to streamline information requirements among programs. However, the CBHP rule is in conflict with federal guidance, which explicitly prohibits the requirement of a Social Security Number for CHIP enrollment. Federal guidelines contain recommended wording that can be used on applications to make families aware that provision of a Social Security Number for participation in a CHIP program is not required.

- **Alien Resident Identification Number.** If the child is not a U.S. citizen, the CBHP eligibility rule requires that an alien resident identification number be provided. This is consistent with federal guidelines requiring documentation of immigration status. However, according to CHA staff, self-declarations are accepted for alien registration numbers and date of entry into the country. CHA's procedures are not consistent with federal guidance or with the CBHP rule requiring documentation of immigration status.

- **Conflicting requirements for income.** The eligibility rule for CBHP states that income has to be verified for income earned "within 30 days of the date of application" (HCPF-CBHP Sec. 130.1.B, C.C.R.). However, in the section regarding the calculation of gross family income for determining eligibility, the rule states that all income received by the family "in the calendar month prior to the date of application" shall be counted (HCPF-CBHP Sec. 150.3, C.C.R.).

  These two time periods may not be the same. As the rule currently stands, in some cases income could be verified for one period (within 30 days of

application) while the income used to determine eligibility could be different because it is based on a different period (the calendar month prior to application). Not only is this administratively complex, but it is counter to the main purpose of verifying income: to ensure eligibility determination is based on information that has been substantiated.

HCPF staff state that this discrepancy was put into the CBHP rule because a similar discrepancy exists in the Medicaid eligibility rule. Despite this, it would be appropriate, as well as administratively simpler, for the CBHP rule to require income be documented for the same period used to calculate gross family income for determining eligibility. A decision should be made on which time period for income is most useful, and it should be reflected uniformly throughout the eligibility rule.

These issues should be addressed to ensure that CBHP is in compliance with all documentation requirements and that requirements are consistent.

Recommendation No. 7:

The CBHP Policy Board should revise the CBHP eligibility rule to:

a. Reflect federal guidance stating that Social Security Numbers are not to be required as a condition of eligibility for child that apply for the program.

b. Require verification of income for the same time period used to calculate gross family income for the purpose of eligibility determination.

CBHP Policy Board Response:

Agree. The Board will review the recommendations in the report and respond to the Legislative Audit committee by no later than September 30, 2000.

Recommendation No. 8:

The Department of Health Care Policy and Financing should ensure enforcement of state and federal requirements that applicants for CBHP provide documentation of alien registration numbers.

Department of Health Care Policy and Financing Response:

Partially agree. The Department believes that federal guidance surrounding verification of citizenship or national status and of immigration status is conflicting. The Personal Responsibility and Work Opportunity Act of 1996 requires that separate CHIP programs verify citizenship or national status and immigration status. However, a letter received by HCFA regarding new guidance relating to the Immigration and Naturalization Service (INS) states that "Section 1902(a)(7) of the Social Security Act requires States to safeguard information regarding applicants for and recipients of Medicaid benefits and prohibits disclosure of that information to an outside entity unless it is directly connected to the administration of the State plan. We have determined that the INS and State Department public charge determinations would not be connected to the administration of the State plan, unless such determinations will directly assist the State in recovering outstanding debts from an alien (most commonly involving overpayments or fraud). States are encouraged to adopt similar restrictions under separate CHIP programs." While this letter directly relates to the issue of "public charge" it does specify that disclosure of information to the INS or Department of State is prohibited. It is the Department's understanding that, under the Systematic Alien Verification of Entitlement system (SAVE) used by Medicaid to obtain verification without requiring personal documentation, information is sent to a clearinghouse for verification of alien status. If the information is verifiable, a positive indication is returned to the program requesting the information. If it is not verifiable, the information is turned over to the INS for investigation. If the letter is correct, the existing use of the SAVE system is prohibited by HCFA. However, the Department shall continue to investigate other alternatives of verification. Implementation date: Contingent upon clarification from HCFA.

Calculations for Eligibility Determination Error Rates

CHA reports error rates for CBHP eligibility determination to the Department monthly. According to the contract, the contractor is to "monitor and assure accuracy of eligibility determination within a 90% accuracy rate determined on a random sampling basis" (Section 1.03(b)(viii), Contract 2000-0119).

CHA calculates and reports the error rate only on the basis of whether or not an error was made that resulted in a child's being incorrectly determined eligible for CBHP. However, there are other types of errors that may occur during the eligibility determination process that have an impact on the program. For example, we found that over a five-month period CHA's quality assurance process noted 14 to 34 errors monthly. The errors included mistakes in calculating a family's income or in determining a child's effective date of enrollment in CBHP. These types of errors are also important to identify and track because the family's income level affects the premiums charged, and family income and the child's enrollment date both affect the monthly capitation payments made to providers.

Other programs, such as Medicaid and Food Stamps, include all errors made during the eligibility determination process in the error rate calculation. This broader calculation presents a more comprehensive picture of how effectively the eligibility process is functioning. By not including all eligibility-related errors in this calculation, CHA is not providing adequate information to the Department on the accuracy of eligibility determination and on contractual compliance and performance.

Recommendation No. 9:

The Department of Health Care Policy and Financing should ensure all eligibility-related errors for the Children's Basic Health Plan are reported in monthly eligibility error rate calculations.

Department of Health Care Policy and Financing Response:

Agree. The Department shall require the contractor to submit reports of eligibility-related errors by September 15, 2000.

Financial Operations

Chapter 4

Introduction

The Department of Health Care Policy and Financing (HCPF) contracts with Child Health Advocates (CHA) to perform a number of financial management functions for the Children's Basic Health Plan (CBHP). CHA maintains all enrollment records for families with children in the program, and it uses these records to calculate the monthly capitation payments due to providers. HCPF and CHA share responsibilities for ensuring retroactive adjustments to enrollment records are reflected in subsequent payments to providers. CHA is also responsible for premium administration, which includes various aspects of maintaining records on families' premium accounts and following up on past due amounts.

Ensure Accurate Payments to Providers

Background

Child Health Advocates determines the amount of monthly payments to HMOs and to primary care physicians (PCPs) serving as gatekeepers to the CBHP Network. HMOs are paid solely on a "capitated" or per head basis for services to children enrolled in CBHP under their specific plans. For children under the CBHP Network, PCPs are paid a smaller capitation fee on a per head basis, and referrals from PCPs for other specialized services are paid on a fee-for-service basis. As of April 30, 2000, the Department had expended about $14.4 million to all of the program's medical providers for the first ten months of Fiscal Year 2000, out of total year-to-date expenditures of $18.5 million.

Capitation payments are due to HMOs prior to the month of coverage and are calculated for each month on the basis of the projected number of children that will be enrolled with each HMO the next month. PCP capitation payments are paid one month in arrears; in other words, these payments are based on the known number of children enrolled with the PCP in the prior month.

The Department Needs to Prioritize the Accuracy of Payments to Providers

We reviewed the Department's systems for paying HMOs and physicians serving children in the CBHP Network. We found that HMO payments are not routinely adjusted for retroactive changes to enrollment records, and the reconciliation performed for retroactive changes related to physician payments needs improvement. For example, CHA may learn that a child has been enrolled in the Medicaid program for several months. This will result in a retroactive adjustment to the CBHP enrollment records for those months, and it should also result in a negative adjustment to the next payment to the appropriate provider. However, adequate controls are not in place to ensure retroactive adjustments to enrollment records are identified and necessary adjustments to payments are made.

Overpayments to providers are likely to result from the failure to make retroactive adjustments. During April and May 2000, CHA staff made 61 retroactive disenrollment adjustments that should have resulted in almost $14,000 in reductions to capitation payments. However, staff reported that information regarding these retroactive adjustments was not relayed to network administration staff at CHA. The network administration staff calculate the amount of capitation payments for HMOs and PCPs and any adjustments to these payments. In another instance an error in enrollment records identified by CHA staff that should have resulted in reduction of about $1,500 in capitation payments due to an incorrect birth date for a child was not relayed to network administration staff.

In addition to these communication problems within CHA, we found that there are not adequate procedures in place generally to ensure that retroactive enrollment adjustments are reflected in future payments to providers. For Fiscal Year 2000 the responsibility for identifying these retroactive enrollment adjustments and correcting future payments is as follows:

- **HMO capitation payments.** The Department is responsible for using information from CHA to identify discrepancies between projected and actual enrollments and making the required adjustments to future capitation payments. However, the Department does not have procedures in place to compare the projected enrollments, used as the basis for monthly payments, with actual enrollments, or to otherwise identify retroactive adjustments that should affect future payments.

  Retroactive adjustments can have a significant impact on enrollments. CHA staff reported that in February 2000 they provided the Department with an estimate indicating about $80,300 was overpaid in capitation payments to

HMOs over a three-month period early in Fiscal Year 2000. At the conclusion of our audit four months later Department staff indicated they had not ascertained the accuracy of the information or made any necessary adjustments related to this information.

- **CBHP Network.** CHA network administration staff complete a reconciliation between projected and actual enrollments for the CBHP Network providers; however, the reconciliation is performed quarterly and as a result, the "look-back" period is only from 30 to 90 days. This means that CHA personnel are unlikely to identify retroactive enrollment adjustments made outside of the 30- to 90-day window and to adjust future payments accordingly.

  On the basis of discussions with Medicaid personnel, we believe a more adequate look-back period is at least 120 days. We identified enrollment errors related to CBHP children simultaneously enrolled in Medicaid that were as much as 12 months old (simultaneous enrollment is discussed in the next section of this chapter).

Further, adjustments to capitation payments must be made within a reasonable period of time. The Department's contracts with HMOs and CBHP Network providers do not permit HCPF to recover for adjustments that are more than six months past. Therefore, in some instances it may be too late for the Department to recover amounts related to retroactive disenrollments.

The 61 retroactive enrollment adjustments during April and May alone indicate that such changes are not unusual in the Children's Basic Health Plan. These retroactive adjustments need to be corrected not only because provider payments should be accurate but because the State receives matching funds from the federal government based on these payments. If provider payments are overstated for CBHP, the Department is also drawing more federal funds than is appropriate under the CHIP program. Excess draws of federal funds can result in sanctions and disallowances from the federal government. The Department should take immediate steps to improve controls in this area to ensure funds are spent appropriately.

Recommendation No. 10:

The Department of Health Care Policy and Financing should ensure capitation payments for the Children's Basic Health Plan are accurate by:

a. Performing monthly reconciliations for provider payments that compare enrollment records used as the basis of payment to post-payment enrollment

records for the previous 120 days. Changes identified should be reflected in future payments to providers.

b. Requiring appropriate communication among staff to ensure all adjustments to enrollment records are relayed to staff calculating capitation payments.

Department of Health Care Policy and Financing Response:

a. Agree. Establishment of requirements and procedures to ensure the accurate payment of providers was the Department's top delivery system-related priority during contract renewal negotiations with the contractor during February and March of this year. In the Fiscal Year 2001 contract, the Department has specified its reconciliation expectations in detail. The Department will implement a *monthly* provider payment reconciliation procedure that will account and adjust for *all* retroactive disenrollments. Implementation date: August 15, 2000.

b. Agree. The Department has already taken the following actions to address this problem. These are:

Implementation of a series of monthly enrollment reports that provide a definitive statement of HMO enrollment for the purpose of payment and reconciliation. These reports are symmetrically represented in the Department's contracts with both the contractor and participating HMOs.

Implementation of information system changes at the contractor that will automate the reconciliation of HMO capitation payment. This will reduce opportunity for errors and omissions due to human oversight and miscommunication within the contractor.

Creation of a monthly payment summary report that reflects *all* adjustments for retroactive disenrollments. The amount of capitation adjusted due to retroactive disenrollments will be documented monthly on this summary report, and distributed to both the Department and HMOs. Implementation date: August 1, 2000.

Identify and Correct Duplicate Enrollments in CBHP and the Medicaid Program

Controls over retroactive enrollment adjustments are particularly important because CBHP children are sometimes simultaneously enrolled in the Medicaid program ("dual-enrolled"). Under federal CHIP requirements, Medicaid-eligible children are not allowed to be served in CHIP programs. However, instances of dual enrollment can occur without necessarily being detected by either program. This can occur because eligibility and enrollment for CBHP and Medicaid are tracked through two separate systems. Currently there is no routine exchange of information between the CBHP and Medicaid databases to systematically identify and correct instances of dual enrollment between these programs.

As part of our audit a data match was performed between Medicaid and CBHP enrollment lists for children enrolled in CBHP for part or all of the period from May 1999 through April 2000. As seen in Table 10 below, out of 15,691 children enrolled in CBHP during some portion of that year, there were 1,830 children (11.7 percent) enrolled in Medicaid at the same time for some part of the year. Of these dual enrollments, 423 children had been dual-enrolled between 4 and 12 months. These numbers are likely understated because records for 7,370 additional CBHP children enrolled during part or all of this 12-month period could not be matched against the Medicaid system due to data inconsistencies.

Table 10: Results of Data Match Between Programs: Children's Basic Health Plan (CBHP) and the Medicaid Program
Children Simultaneously Enrolled in CBHP and in Medicaid
Between May 1999 and April 2000

Length of Dual-Enrollment Period	Number of Dual-Enrolled Children[1]	Percent of Total CBHP Children Matched With Medicaid (15,691 Children[2])
1 day to 1 month	372	2.4%
2 to 3 months	1,035	6.6%
4 to 6 months	207	1.3%
7 to 9 months	142	0.9%
10 to 12 months	74	0.5%
Totals	**1,830**	**11.7%**

Source: Office of the State Auditor analysis of agency data.
Notes:
1. "Dual-enrolled" children are those simultaneously enrolled in both the Medicaid program and CBHP.
2. There were 23,061 children enrolled in CBHP for all or part of the 12-month period. Due to data inconsistencies the match could only be performed for 15,691 children at the time of the audit. Agency staff are resolving these inconsistencies.

Double payment of health care coverage is a poor use of funds and not an effective means of reducing the cost of uncompensated care. These kinds of payments also violate federal regulations on two counts:

- Federal regulations prohibit charging the same expenditure to two different grant programs. In this case the federal CHIP and Medicaid programs are both being charged for the same child for health services for the same period of time.

- Federal regulations prohibit enrolling a child in the state CHIP program if the child is eligible for Medicaid. Therefore, any corrections in payments must be made in CBHP rather than in the Medicaid program.

Assuming that children are in the pre-enrollment stage of CBHP for about two months, we estimated that approximately $242,000 in excess CBHP capitation payments were made for dual-enrolled children in the period tested. This estimate is

likely to be low because it does not include payments made for specialized services under the CBHP Network. In addition, it does not include any estimate for the 7,370 CBHP children for whom the data match could not be run because of data problems.

In some instances CHA may have made adjustments that corrected some of these overpayments; however, weaknesses in controls over provider payments, discussed in the previous section, suggest that although enrollment records may have been corrected, provider payments may not have been adjusted. In any case, as well as improving controls over provider payments, the Department needs to routinely match information between various systems to ensure instances of dual enrollment are identified and corrected in a timely manner. The fact that some children were dual-enrolled for as much as a year clearly indicates a lack of procedures to ensure dual enrollments are identified and payments corrected.

Recommendation No. 11:

The Department of Health Care Policy and Financing should work with the Department of Human Services to identify on a monthly basis instances in which children are simultaneously enrolled in the Children's Basic Health Plan and in the Medicaid program. Erroneous enrollment records and provider payments should be corrected in a timely manner.

Department of Health Care Policy and Financing Response:

Agree. The Department appreciates the work that the Office of the State Auditor has done in this area. The Department will continue to work with the Department of Human Services to attempt to resolve these cases in the shortest amount of time possible.

The statutory design of the Children's Basic Health Plan program reflects a model common to commercially insured groups (i.e., prospective health plan enrollment and 12-months' continuous eligibility). However, given the recent statutory change that explicitly allows retroactive CBHP eligibility and the fact that Medicaid eligibility is mutually exclusive to CBHP eligibility, the Department may be compelled to implement the complex enrollment status and payment reconciliation procedures that were formerly unique to the Medicaid managed care program. This may have an impact on HMO participation and, potentially, rates.

Reconciliation of Fiscal Year 2000 CBHP files identified as having overlapping Medicaid eligibility spans and payments to participating HMOs and providers will be a very labor intensive effort that will require coordinated work within five (5) entities: the Department, the contractor, Anthem, Horizon Behavioral Services, and Consultec (the Medicaid fiscal agent). Failure of these entities to coordinate retroactive edits of eligibility and enrollment status and process CBHP-to-Medicaid payment reconciliations accurately (most of which will need to be completed manually) will have a *significant adverse impact* on HMOs and providers participating in both programs.

In addition to the operational issues identified above, CBHP-to-Medicaid payment reconciliation for participating HMOs will *not* be possible unless there is a change to Medicaid HMO enrollment rules. Unlike CBHP, Medicaid HMO enrollment rules are very complex and prescriptive. A CBHP applicant's selection of an HMO must be deemed in the rules as an acceptable choice for the purpose of Medicaid enrollment. Failure to implement such a change to the Medicaid enrollment rules will: A) prohibit the Department from maintaining a child's enrollment in his or her original CBHP plan, B) result in a significant financial loss to the HMO, and C) potentially impede continuity of care.

Implementation date: September 15, 2000.

Improve Premium Administration

We have already noted our concerns regarding policy decisions related to premiums for the Children's Basic Health Plan and the costs of collections in Chapter 2. In this section we discuss problems with premium administration as it currently stands.

Background

CHA's premium administration responsibilities include charging and collecting monthly family premiums and maintaining, reconciling, and transferring premium information to the State. On a monthly basis CHA forwards the amount of premiums collected to HCPF. Currently CHA reports indicate about 9,100 families, or 70 percent of the almost 13,000 families enrolled in CBHP, are charged premiums. As noted in Chapter 1, depending on the size and income of the family, premiums range from zero to $30 per family. As of April 30, 2000, the State had recorded fiscal year-

to-date premium revenues of a little over $1.3 million. Also as of that date, CHA reported about $457,200 was outstanding as premiums due from families.

We reviewed CHA's premium collection systems. Because of the history of problems with tracking premiums, subsequent efforts to correct inaccuracies, and lack of adequate controls over the premium administration process generally, we have concerns about the accuracy of the premiums reported as being owed by families to the program. As described below, records contained numerous adjustments and write-offs, some of which were inadequately documented. In addition, the lack of controls over premiums substantially increases the risk of errors and/or irregularities.

Child Health Advocates reports that the information system it inherited for the program is inadequately designed to track premium activity and does not provide accurate reports. Further, premium receivable balances transferred from the previous contractor were considered unreliable. As mentioned earlier, CHA became the administrator for CBHP as of March 1, 1999; however, some key personnel have been with the program since it began operations in April 1998. Recently the Department agreed to contract with CHA to develop a new premium administration system at a cost of $150,000. The new system is scheduled to be in place on August 1, 2000.

Problems with premium accounts are discussed below.

Deficiencies in Accounting for Premiums

The Department reports that because of inaccurate premium records maintained by the prior program administrator for CBHP, it allowed CHA to "archive" all amounts due from families as of February 28, 1999. In archiving these balances, the Department permitted CHA to remove from families' active records outstanding amounts owed on February 28, 1999. As a result, families were not specifically requested to pay these amounts due to the program. The archived amount authorized by the Department represented almost $292,600 that was reported as owed by over 4,600 families, or about 93 percent of premium-paying families in CBHP as of February 1999.

Problems with premiums continued to plague the program, however, and in the fall of 1999, the Department asked CHA to reconcile each policyholder's account. CHA staff subsequently performed a detailed review of individual premium accounts. This review resulted in adjustments to over 3,300 families' accounts, or approximately 38 percent of premium-paying families at that time. During the audit we found that in some cases staff did not detail the basis for these changes. Further, for some accounts, staff deleted premium charges from records altogether.

In other words, CHA staff had the ability to delete activity from families' accounts, and the information system did not maintain evidence of the original entries or the dollar amounts deleted. CHA staff also reported that due to the volume of adjustments, not all adjustments were reviewed by a supervisor. Because of the risk of errors and irregularities, write-offs and deletions are a highly sensitive area that should have been tightly controlled, especially in view of system deficiencies.

During our audit CHA staff began maintaining a listing of manual adjustments made to accounts. This is an improvement; however, this listing lacked evidence of supervisory approval and the dates the adjustments were made. Further, the premium system still permits deletions to records without maintaining evidence of these deletions.

Problems With the Premium Collection System Affect Individual Family Accounts

We reviewed a sample of 67 families' premium accounts. We identified problems in 14 accounts (about 21 percent):

- *Premiums not charged appropriately*. In three accounts families were not charged premiums for a month when they should have been. These same families were charged a premium for a month in which they should not have been.

- *Premiums not charged in a timely manner.* In March 2000, premiums for 11 families' accounts were charged for months as far back as October 1999.

Charging for premiums should be a relatively straightforward process. The number of errors in the sample indicates a lack of adequate systems and controls to ensure ongoing accuracy of accounts.

Department Needs to Ensure That Adequate Controls Exist to Safeguard Program Assets

It is clear that the administration of premiums is an area that has troubled the program from its inception. We found that CHA does not have adequate controls in place to ensure that assets are safeguarded and premiums properly charged. Among some basic controls that should be in place are the following:

- **Policies and procedures.** These should clearly delineate responsibilities and restrict authority. CHA has documented the cash receipt process and outlined staff responsibilities in this area. However, staff have not documented policies

and procedures related to other aspects of premium administration such as charging monthly premiums to accounts and making manual adjustments to premium and enrollment records.

- **Adequate supervision and review.** This is required to ensure entries are appropriate. As noted above, CHA has made some improvements in documenting adjustments to records, but supervisory review needs to be documented as well.

- **Monthly reconciliations.** We found that a basic reconciliation between individual premium account balances and total premiums due has not been done. This reconciliation ensures that all premiums charged, adjustments made, and payments received are posted to families' individual accounts.

  CHA staff report that they perform a "reasonability check" on the overall balance, and they provided us with a spreadsheet identifying differences between the calculated premium receivable balance and the balance generated by the information system. These differences ranged from about $570 to over $37,600 from month to month over the past ten months. CHA staff reported they were unable to determine the reasons for these differences and therefore were not able to resolve them and make corrections to individual accounts that might have been needed.

- **Adequate segregation of duties.** One staff person makes the bank deposit, enters adjustments to individual accounts, and performs the monthly bank reconciliation. In other words, one person has control over cash processing and recording. This combination of duties means that funds could be misappropriated and the action subsequently concealed.

  Placing all these duties with the same person unnecessarily creates risks. CHA staff indicated that beginning in July 2000 they will utilize a bank lock-box for premium payments, significantly lessening the amount of cash receipts to which CHA staff have access. Despite this improvement, adequate segregation of duties should be maintained at CHA.

In addition to these control issues, inadequacies of the present information system likely contributed to some concerns identified in the audit. We noted that the system is not able to perform monthly "cutoffs;" as a result, adjustments to prior accounting periods can and are being made on a continual basis. We also found that the detailed premium receivables report generated from the system showed individual account balances not in agreement with balances in the individual account records within the system.

Regardless of the source of the problems found in the audit, all must be addressed. Under the cost sharing rule for CBHP that will go into effect on August 1, 2000, families will be disenrolled from the Children's Basic Health Plan based on nonpayment of premiums. Staff indicate past due amounts as of July 31, 2000, will not be used as a basis for disenrollment. However, it is imperative that families' account balances are accurate and reliable under the new rule; otherwise, the State risks disenrolling families on the basis of erroneous information.

Recommendation No. 12:

The Department of Health Care Policy and Financing should ensure that the contractor for the Children's Basic Health Plan has adequate controls over premium administration by stating expectations clearly in the contract and monitoring compliance. Controls over premium administration should include:

a. Documenting staff responsibilities for all aspects of premium administration, including supervisory review and limitations on authority.

b. Maintaining adequate supporting documentation for all adjustments made to families' accounts. Such support should include at a minimum explanations for the adjustment, date of the adjustment, individual entering the adjustment, and evidence of supervisory review and approval.

c. Completing a monthly reconciliation between individual family account balances and the total premium accounts receivable balance. The sources of discrepancies should be identified and resolved, including appropriate adjustments to individual family accounts.

d. Establishing appropriate segregation of duties over cash receipts.

Department of Health Care Policy and Financing Response:

Agree. The Department is requiring the contractor to correct all of the identified deficiencies, as part of the Fiscal Year 2000 contract closeout. No final payment for the Fiscal Year 2000 contract will be made until full resolution is documented by the contractor and accepted by the Department. Premium information system modifications have been made and will be implemented concurrent with the implementation of the new premium compliance (cost sharing) rule. Segregation of duties over cash receipts has

been implemented. Payment for Fiscal Year 2001 contract year will be made only for accurate, timely and procedurally acceptable premium administration performance. Please refer to the response to Recommendation No. 4 for further information.

Implementation date: part "a," June 30, 2000; part "b," June 20, 2000; part "c," August 1, 2000, and ongoing; and part "d," June 20, 2000.

Recommendation No. 13:

The Department of Health Care Policy and Financing should ensure that the new information system for the Children's Basic Health Plan premium administration is adequate to meet program requirements and addresses problems with the present system. This includes, but is not limited to, ensuring that:

a. Transactions entered in the system cannot be subsequently altered or deleted.

b. Monthly and year-end cutoffs can be performed for accounting and reporting purposes.

c. Reports generated by the system produce information consistent with underlying data in the system.

Department of Health Care Policy and Financing Response:

Agree. Premium information system modifications that were underway at the time of the audit, which are designed to support fully accountable premium administration operations (and that will also resolve the audit's information systems issues in a prospective sense), will be completed and installed by August 1, 2000, concurrent with the implementation of the new premium compliance rule, as discussed in Recommendation Response No. 4. As of mid-July, testing by the Department of the developed system components has been fully satisfactory.

The Department assures that all components of the corrective action process noted above are fully and effectively implemented and maintained, and the Department will pay only for acceptable premium administration performance.

Review Collection Efforts

In Chapter 2, we discuss some of our concerns regarding the impact of the new CBHP cost sharing rule. Nonetheless, once premium requirements are in place, they should be administered appropriately and consistently with other programs.

We found the lack of confidence in information on amounts owed by families for CBHP has also resulted in the Department's being out of compliance with state laws and regulations concerning past due amounts owed to the State. At the time of the audit HCPF had not requested or received a waiver of these requirements; however, staff indicate they are currently working on such a request.

Specific areas of noncompliance with state collection requirements include:

- Premium accounts 30 days or more past due for CBHP have not been turned over to state Central Collections, as required by state law. As of April 30, 2000, almost $381,900 of the total premium receivable reported by CHA of about $457,200 was more than 30 days past due. The amount past due represents almost 84 percent of premiums owed to the State.

  In terms of families, CHA reports for April 30, 2000, indicate that close to 4,800 families, or 37 percent of the almost 13,000 families enrolled in CBHP, were more than 30 days past due. These 4,800 families represent almost 53 percent of the approximately 9,100 families required to pay premiums.

  About 63 percent of the reported receivable, or $289,395, is more than 90 days past due. None of these past due amounts include the $292,600 in balances previously archived by the Department and CHA effective March 1, 1999.

- Past due amounts greater than $50 for individual accounts have in effect been written off without appropriate collection efforts because certain amounts due were "archived" by the program. Regulations permit agencies to write off only amounts of $50 or less, and only after the agency has made an effort to collect; larger amounts can only be written off once Central Collections has determined them uncollectible and with approval of the State Controller and State Treasurer. As mentioned, the Department permitted the contractor to archive balances of almost $292,600 as of March 1, 1999, because information was considered unreliable. The average balance for these accounts was $63 per family. Currently about $67,500 (23 percent) of the archived amount remains outstanding, and no efforts are being made to collect these balances from families.

No families have been disenrolled from CBHP for nonpayment of premiums, because, in addition to lack of confidence in amounts reported as owed to CBHP, until recently no rule had been put into place establishing policies in this regard. Until July 1999, families were not notified of past due amounts.

It is unfortunate that fiscal systems, controls, and policies for the Children's Basic Health Plan have not been adequate to establish a foundation for tracking and enforcing premiums since the inception of CBHP over two years ago. This has resulted not only in noncompliance with state requirements; it also means that families have not been informed from the beginning about the State's expectations of payment and consequences of nonpayment.

In discussions about the new cost sharing rule, there has been some concern among the CBHP Policy Board and HCPF staff that enforcement of state laws and regulations for collections will further hinder enrollment efforts for CBHP. For example, families may be reluctant to enroll if they are uncertain they can maintain premium payments and believe payment problems will affect their credit. However, state statutes and regulations for collections allow agencies some flexibility. For example, each agency defines the due date for payments under its program. Further, an agency may request an extension from the State Controller for more than 30 days to collect past due amounts, prior to turning them over to Central Collections.

The State operates many programs in which families and individuals have low incomes, and all of these programs are required to operate under the same laws and regulations regarding collections of past due amounts. The CBHP Policy Board and Department need to define an appropriate structure for the collection of past due amounts for the program, working with the State Controller's Office as needed. This structure should be designed in a manner that does not have an unduly negative impact on program goals to maximize enrollment, and that at the same time encourages reasonable accountability to the State for amounts owed and achieves compliance with requirements.

Recommendation No. 14:

The CBHP Policy Board and the Department of Health Care Policy and Financing should develop and implement collection requirements for the Children's Basic Health Plan that are reasonable for the program and comply with state laws and regulations regarding the collection of past due amounts.

CBHP Policy Board Response:

Agree. The Board will review the recommendations in the report and respond to the Legislative Audit committee by no later than September 1, 2000.

Department of Health Care Policy and Financing Response:

Agree. The Department is currently working with the State Controller's Office to arrive at a mutually acceptable policy for remitting past due premium accounts to Central Collections. Federal rules prohibit the use of parent's social security numbers, which makes collection efforts difficult. The Department will have an approved waiver in place by August 1, 2000, and will be prepared to amend that waiver in the future as necessary.

Communication Between Program and Accounting Staff at HCPF

Child Health Advocates provides the Department's program staff with monthly reports on aspects of the CBHP program, including premium administration. This information includes a detailed premiums receivable report and information on premiums billed and collected.

We found that program staff do not routinely provide Department accounting staff with all necessary information related to premiums. As a result, several account balances related to premiums for the Children's Basic Health Plan are misstated on COFRS, the State's accounting system. Specifically, accounting staff did not receive the monthly aging report listing the total amount of premiums receivable, and accounting staff were not aware that in some instances families pay premiums in advance. The net effect of this lack of communication on COFRS balances is that as of April 30, 2000, the Accounts Receivable balance was understated by about $56,000 and the Deferred Revenues balance was understated by about $87,000. Although accounting staff were uncertain where the remaining $31,000 misstatement was recorded, it is likely that CBHP revenues were overstated by that amount. Program staff should ensure accounting staff receive information needed to avoid errors on the State's financial records.

Recommendation No. 15:

The Department of Health Care Policy and Financing should ensure that program staff for the Children's Basic Health Plan provide to accounting staff all required information regarding premium administration.

Department of Health Care Policy and Financing Response:

Agree. The program staff and the accounting staff have been communicating this information since the issue was raised in June 2000.

Federal Requirements for CHIP

Under the federal Single Audit Act, the Department is responsible for compliance with requirements for the federal Children's Health Insurance Program, or CHIP. This means that HCPF must have adequate measures to ensure that CHA and other contractors meet these requirements. This is particularly important in the case of CHA, since it is responsible for critical functions of the Children's Basic Health Plan such as eligibility determination. Out of Fiscal Year 2000 year-to-date expenditures of $18.5 million for CBHP as of April 30, 2000, we estimated that CHA directly or indirectly controlled the expenditure of $18.08 million (about 98 percent).

One way for the Department to determine CHA's compliance with federal requirements would be for HCPF to classify CHA as a subrecipient for federal award reporting purposes. Classifying CHA in such a manner would require it to have an annual audit under the Single Audit Act. This type of audit must determine if an entity has adequate controls in place to ensure federal funds received are expended in accordance with applicable federal laws and requirements. By requiring such an audit, the Department would receive an independent assessment of CHA's controls and compliance relative to federal requirements under CHIP.

Another way for the Department to determine if CHA is meeting federal requirements is for HCPF to perform onsite monitoring of CHA operations. Colorado state agencies operating federal programs of comparable size to CHIP typically have established some means of onsite monitoring of subrecipients, in addition to requiring the annual audit under the Single Audit Act. In any case, the Department must implement measures to ensure funds are spent appropriately.

Recommendation No. 16:

The Department of Health Care Policy and Financing should develop and implement a mechanism to ensure the administrative contractor for the Children's Basic Health Plan complies with federal requirements.

Department of Health Care Policy and Financing Response:

Agree. The Department, as part of the Fiscal Year 2000 contract closeout, is requiring the contractor to agree in writing to comply with federal Single Audit procedures, beginning with an audit of the Fiscal Year 2000 contract year. Final payment to the contractor for Fiscal Year 2000 will not be made until this agreement is provided to the Department. The Department is also reviewing its staffing and organizational priorities to determine if modifications to its contract management procedures (including on-site monitoring procedures) are needed and feasible.

Document Policies and Procedures

We found that Child Health Advocates does not have a current, comprehensive manual to document policies and procedures for the various functions it performs, such as eligibility and enrollment, premium administration, marketing and outreach, and network administration for the CBHP Network. The lack of a manual defining program operations may have contributed to some of the problems found during the audit. Some of the areas in which inconsistencies or lack of clear policies and procedures were identified include:

- Lack of a documented policy dictating when refunds for premium overpayments should be made. We identified instances in which families did not receive refunds of overpayments for months after leaving CBHP. For example, we found six families that were owed refunds ranging from almost $60 to over $170; these families left CBHP between 4 and 16 months ago.

- Lack of documented procedures for conducting CHA's internal quality assurance process, including follow-up procedures to ensure all errors identified are addressed in a timely manner. Without this, there can be

misunderstandings concerning what elements are being tested and whether or not errors were corrected.

- Lack of documented accuracy standards to be used for applications submitted through satellite eligibility determination sites. Sites are only paid for applications that CHA determines have been accurately filled out. The standards and definition of what constitutes an error need to be consistent for all sites and from month to month to ensure fairness.

- Lack of adequate documentation describing staff responsibilities in certain areas such as eligibility and enrollment, premium administration, and network administration. We noted some problems related to all of these areas. Documentation should include procedures for appropriate supervisory review, restrictions on authority, and requirements to communicate information needed by other parts of the organization.

- Questions about how to resolve contradictory information regarding family income. For example, sometimes there are discrepancies between self-reported unearned income (e.g., child support, cash assistance, or SSI payments) and documented unearned income (e.g., from bank account statements). This could result in families' being treated in an inconsistent manner.

- Lack of requirements for documentation from families that report they have other coverage and would like a refund for previous months' premium payments to CBHP. Families are not asked to provide documentation verifying the coverage and the date it began.

The Fiscal Year 2000 contract between the Department of Health Care Policy and Financing and Child Health Advocates states that CHA shall develop and maintain a comprehensive policy and procedures manual. In July 1999, CHA published an Eligibility and Enrollment manual; however, this manual was not updated when the eligibility requirements were changed in December 1999. Therefore, the information is not entirely accurate for key elements of this critical process. The Eligibility and Enrollment section has begun compiling the substance of a new manual. However, the new manual had not yet been published by the end of our audit. Further, this manual will not address other components of the administration of CBHP, such as premium administration and network administration.

We recognize that Child Health Advocates has consulted with the Department on numerous occasions to clarify areas of operations and has used informal means to document these discussions. This information needs to be compiled into a manual that serves as a formal agreement between these two entities regarding how CBHP

rules are implemented and how the program operates. Furthermore, documented policies and procedures help ensure that families are treated equitably under the Children's Basic Health Plan. This type of documentation is especially important when a program is new and in transition, as is the case with CBHP.

Recommendation No. 17:

The Department of Health Care Policy and Financing should ensure that the administrative contractor for the Children's Basic Health Plan develops and maintains a comprehensive and current program policy and procedures manual for the program that addresses all areas of operation, as required by contract.

Department of Health Care Policy and Financing Response:

Agree. The Department received from the contractor revised procedure manuals for premium administration, distribution, customer services, and eligibility and enrollment. The marketing plan accepted in June 2000 substantially meets the requirements of a procedures manual for that scope of work area. These manuals are under review and will be accepted or sent back for revision, as part of the Fiscal Year 2000 contract closeout procedures. Any additional manual materials or corrective actions required, or substantive failures to maintain manuals, will be incorporated into contingency payments or payment holdbacks for the appropriate contract fiscal year.

Implementation date: June 30, 2000.

CBHP and Other Children's Health Services Programs

Chapter 5

Introduction

The creation of the Children's Basic Health Plan (CBHP) has introduced a new dynamic among programs providing children's health services in Colorado. As noted earlier, CBHP is Colorado's version of the federal Children's Health Insurance Program (CHIP), and therefore it provides a major new source of federal funds for these children's services.

Similar to other states, Colorado is experiencing the need to reevaluate relationships between this new program and other established programs. Further, state statutes for CBHP indicate that identifying and addressing opportunities for interprogram communication, coordination, and consolidation are all viewed as important aspects of implementing the program (Sec. 26-19-102(3,5), C.R.S.).

Efforts have been made to promote interprogram communication and coordination under CBHP. Specifically:

- The CBHP Policy Board (Board) includes the executive directors of the Departments of Health Care Policy and Financing, Human Services, and Public Health and Environment, as well as the commissioner of the Department of Education. In addition, the Board includes seven members from the private sector. The Board sets policies and rules for the development and implementation of CBHP.

- The Board has established committees and subcommittees open to the public that provide a forum for discussing issues related to CBHP.

- Administratively, CBHP has worked to establish communication and exchange of information, such as efforts with the Health Care Program for Children with Special Needs and with the Medicaid program. CBHP and the Medicaid program have also held joint eligibility training for staff.

- CBHP, the Colorado Indigent Care Program, and Medicaid have developed a more comprehensive joint application to be used to apply for all three programs. The application has been through a pilot test and is undergoing management review.

In general, the Children's Basic Health Plan has developed many relationships with service providers, county health departments, and other community-based organizations, most notably CBHP satellite eligibility determination sites. Nonetheless, while these efforts are important, they do not address more systemic issues, such as coordination and consolidation among state programs that offer health services to children.

Clarifying Interrelationships Among Programs

Table 11 below contains some comparative information about CBHP, the Colorado Indigent Care Program (CICP), and Medicaid programs that serve children.

Table 11: Comparison Information for the Children's Basic Health Plan, Colorado Indigent Care Program, and Medicaid Program Programs for Children Under 19 Years: Fiscal Year 1999

	Children's Basic Health Plan	Colorado Indigent Care Program	1931, Baby Care/Kid Care (BC/KC), and Ribicoff Medicaid (Children's programs only)[1]
Number of children served[2]	12,825	28,743	112,771
Expenditures[3]	$12,663,772	Not available[4]	$150,656,152
Average cost per child	$987	Not available[4]	$1,336
Funding sources	Federal funds and state general funds (approx. 2:1 match)	State general funds (some Medicaid funds are used to support the program.)	Federal funds and state general funds (approx. 1:1 match)
Entitlement program?	No	No	Yes
Area of availability	Statewide	Primarily urban; limited rural coverage	Statewide
Types of benefits	Inpatient, outpatient, prescription drugs, limited mental health.	Varies by provider.[5]	Inpatient, outpatient, prescription drugs, mental health, long-term care.
Maximum age of children served	18 years old.	None; serves both children and adults.	*BC/KC:* 5 years old. *Ribicoff:* 16 years old as of Fiscal Year 1999. *1931:* None; serves all members of a family with children.
Maximum income of eligible family, based on Federal Poverty Level (FPL)[6]	185 % FPL	185 % FPL (includes excess amount from asset calculation).	*BC/KC:* 133% FPL. *Ribicoff:* 100% FPL. *1931:* AFDC standards on July 16, 1996 (approx. 39% FPL for Fiscal Year 1999).
Asset test for eligibility?	No	Yes; specified base amounts of assets (cars, real property, savings accounts, etc.) are exempt; excess of base is added to income.	*BC/KC and Ribicoff:* Yes; limited to $1000 after $1500 deduction from value of vehicle with highest equity. *1931:* Yes; limited to $2000 after exemption of vehicle with highest equity.
Cost-sharing structure	Families above 100% FPL pay premiums and copayments based on a sliding scale.	Families pay copayments based on a sliding scale.	[There is no cost sharing for children in Medicaid programs.]

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

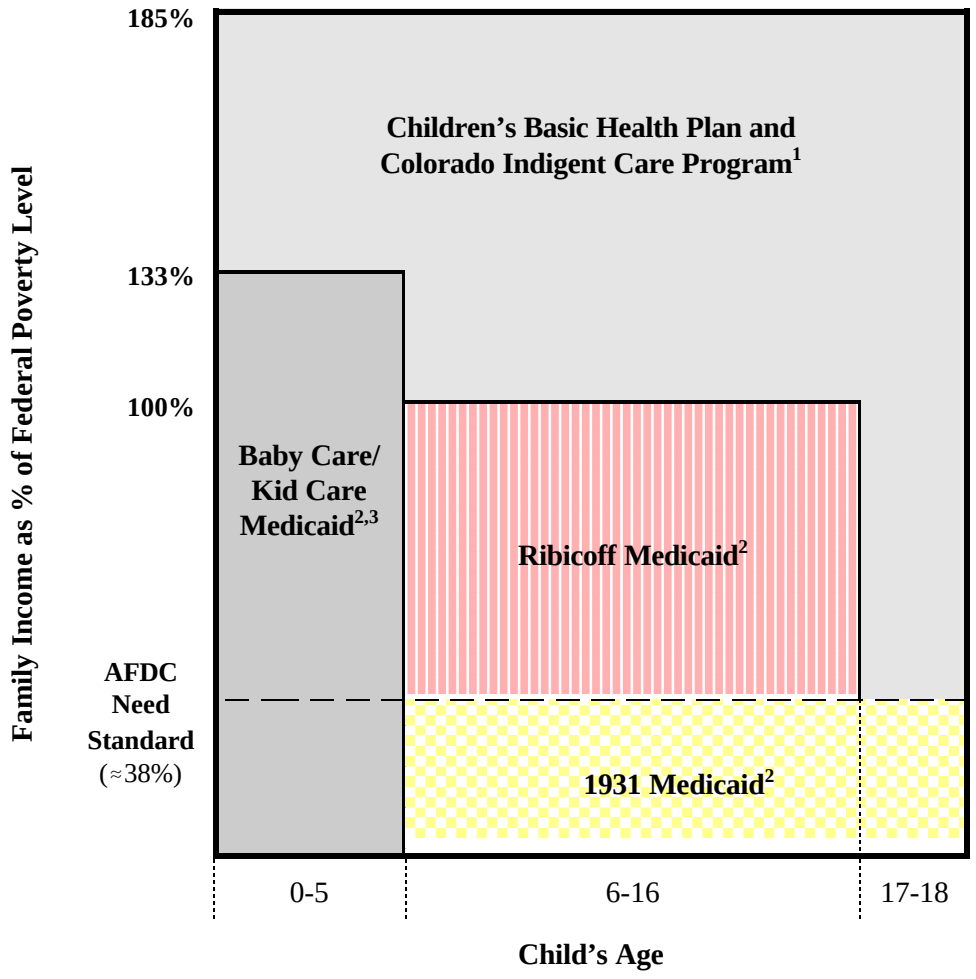
Notes:

1. When requirements for the programs differ, they are described separately. Children also receive Medicaid through Foster Care and Undocumented Immigrants programs.
2. CBHP and Medicaid: Average of the number of children enrolled at the end of each month during Fiscal Year 1999; CICP: Number of children who received services in Fiscal Year 1999.
3. Expenditures do not include administrative costs.
4. CICP serves adults and children and expended approximately $110.3 million in Fiscal Year 1999. The program does not track health care costs by age group.
5. Statutes require providers to prioritize the medical services to be furnished. The highest priority must be the funding of emergency services for the entire year.
6. Each program defines income differently. Therefore, 185% FPL income levels are not the same for CBHP and CICP.

From a budgetary point of view, the most important distinction among the programs is that Medicaid is an entitlement program. This means it must serve all individuals meeting the program's eligibility rules. CBHP and CICP are not entitlements; expenditures are limited to available appropriations, and the State can limit enrollments or costs in order to control expenditures if necessary.

Overall, the three programs work together in a manner that provides health care services to Colorado's low-income families. Table 12, which follows, is a simplified graphic representation of how the Children's Basic Health Plan, the Colorado Indigent Care Program, and the Medicaid program interrelate in terms of income levels and ages of low-income children covered under the programs. However, this is not a comprehensive view of the interrelationships among the programs due to other important aspects of eligibility not shown in the table, as discussed below.

Table 12: State-Subsidized Health Insurance for Children Under 19 Years
Children's Basic Health Plan (CBHP),
Colorado Indigent Care Program (CICP), and Medicaid Program
Fiscal Year 2000
(Table does not reflect the impact of CICP and Medicaid asset tests or differences in program income definitions.)



Source: Office of the State Auditor Analysis of agency data.
Notes:
1. The Colorado Indigent Care Program also serves eligible adults.
2. Only Medicaid programs serving children are included (Baby Care/Kid Care, Ribicoff, and 1931 Medicaid). The 1931 Medicaid program also serves eligible adults.
3. The Baby Care/Kid Care Medicaid program also covers pregnant women; therefore, qualifying pregnant teenagers could receive Medicaid services under this program.

Generally, Table 12 illustrates that Medicaid is structured toward providing coverage to younger children. As a child's age increases, their family income must be lower in order for the child to remain eligible for Medicaid. If the family's income exceeds Medicaid limits but does not exceed 185 percent of the federal poverty level, families typically are eligible to enroll their children in CBHP or CICP. In effect, CBHP and CICP fill in the gaps left by Medicaid limits.

However, there are two key points not shown in the table that add complexity to the relationships among these programs. First, the table does not reflect the impact of the different asset limitations imposed by Medicaid and by CICP. These requirements mean that even if families have the same income, they may be eligible for different programs based on the value of their assets, such as a car or savings account. Second, the table does not reflect differences in how the programs define family income and allocate it among family members. Currently all three programs have different ways of defining and calculating "family income."

Colorado Indigent Care Program and Children's Basic Health Plan

The General Assembly has been concerned since the inception of CBHP about the fact that eligibility rules for CBHP and CICP generally allow for children to qualify for both programs, as long as the families' assets do not exceed limits under CICP. Although specific data are not available, there are indications that families with children qualifying under both programs sometimes use the Colorado Indigent Care Program, even though service levels may be lower under CICP and copayment costs to the family could be higher.

From a policy point of view, this possible underutilization of CBHP is a problem for several reasons:

- **Leveraging of state funds.** CBHP is funded by a 2 to 1 match of federal to state dollars, which enables the State to leverage general fund monies. CICP is a state-funded program, although some Medicaid monies not specifically tied to CICP have been used to support the program. Medicaid is funded by about a 1 to 1 match of federal to state dollars.

- **Target populations.** CBHP's target population is smaller than CICP's because CBHP only covers children through 18 years of age. CICP has no age restrictions.

- **Access to services.** Children generally have access to a greater range of services under CBHP than they do under CICP. This would suggest children

in CBHP would be able to obtain a higher level of services during the critical early years. For example, preventive services are part of CBHP's benefit package. Under CICP, not all providers make these services available. Thus, it appears reasonable to cover qualifying children under CBHP rather than CICP.

Under changes resulting from the passage of Senate Bill 00-223, the CBHP Policy Board has initiated a revised eligibility rule that would incorporate into CBHP the same standards for family income that are in place for CICP. This is an important step because matching eligibility-related definitions helps ensure that children are not inadvertently "lost" between the two programs.

Senate Bill 00-223 charged the Department of Health Care Policy and Financing (HCPF) with evaluating the possibility of eliminating the Colorado Indigent Care Program (CICP) for children eligible for CBHP and requiring families to enroll these children in CBHP. The Department is to issue a report on this option by November 1, 2000, to the Joint Budget Committee and the House and Senate Health, Environment, Welfare, and Institutions Committees.

Streamlining and Standardizing CICP, CBHP, and Medicaid

The Department oversees both CICP and CBHP, and it is therefore the logical entity to identify and recommend ways to facilitate moving children from CICP to CBHP. As the oversight agency for the Medicaid program as well, HCPF can take a broader approach and further work toward the goals of coordination and consolidation among programs required under CBHP statutes. The Department can help achieve these goals by identifying ways to streamline the eligibility requirements and processes, as well as standardizing aspects of all three programs. Recommendations in these areas could also help the State achieve a more "seamless" system for providing benefits to low-income families and children, as well as lessen confusion for families over differing program requirements. As noted earlier in this report, it is not unusual for children to move between CBHP and Medicaid; similar movement may also occur among CICP and the other two programs. Areas that the Department could consider for streamlining and simplification include:

- Exploring ways to make the cost-sharing provisions between CBHP and CICP more similar in order to encourage families to move from CICP to CBHP. The Colorado Indigent Care Program relies on a copayment structure, while CBHP uses both premiums and copayments. Families with little discretionary income may prefer a program in which fees are based on utilization of services, rather than a program in which monthly premiums are required even when services are not used.

Further, as noted earlier in the report, as of April 2000, a significant number of the families required to pay premiums under CBHP are currently more than one month behind with their payments. Once the CBHP disenrollment policy for nonpayment of premiums is enforced, the viability of CBHP may be dependent upon exploring other cost-sharing options.

- Moving toward standardization of benefits among programs in order that families receive more consistency in services among programs.

- Finding ways to ensure continuity of care through maintaining the family's primary care physician, when possible, in instances where families move between programs.

- Extending the effort to align eligibility definitions by reviewing Medicaid rules, specifically for calculation of family income, to identify ways that can simplify program administration among all three programs. This would need to be examined in light of federal requirements for Medicaid and negative impacts on state expenditures.

- Using the Medicaid Management Information System (MMIS) to process claims for all three programs. MMIS is currently used for Medicaid payments to providers and tracks a wealth of other data. The Department is in the process of converting CICP claims payments onto MMIS. Staff report that when CBHP achieves statewide HMO coverage, it may be cost-effective for this program to use MMIS as well.

- Identifying ways in which the separate eligibility and enrollment systems can exchange information in a more timely manner. Some specific recommendations along these lines are made in the next section of this chapter.

The Department reports that efforts to simplify the Medicaid program structure have been attempted in the past; however, these efforts have not been particularly successful because of possible cost implications and the State's budget constraints. However, the implementation of CBHP has added a new element to the network of programs that offer health services to children, and thus a new attempt to streamline the interrelationships between these programs may be appropriate.

The State has already taken significant steps to move toward a seamless eligibility system with its commitment to the development of the Colorado Benefits Management System (CBMS). This system is envisioned as creating a single entry point for many programs, including CBHP, CICP, and Medicaid. Identifying ways to improve the interactions among programs is another means of working toward a

true single entry point approach, and at the same time achieving legislative goals for coordination and consolidation.

Recommendation No. 18:

The Department of Health Care Policy and Financing should promote program coordination and consolidation among the Children's Basic Health Plan, the Colorado Indigent Care Program, and the Medicaid program by identifying ways in which to streamline and standardize eligibility and enrollment processes and requirements, benefits, cost sharing requirements, and other aspects of these programs. Recommendations should be forwarded to the Joint Budget Committee and the House and Senate Health, Environment, Welfare, and Institutions Committees under the same timeline established by the Department in its response to Recommendation No. 1 of this report.

Department of Health Care Policy and Financing Response:

Agree. The Department is in the midst of the statutorily required study under Senate Bill 00-223 identifying ways in which to better integrate the CICP and CBHP programs. A Task Force has been convened and meetings scheduled to focus on those statutorily required functions. We agree with the recommendation that a full analysis of the eligibility and enrollment processes, requirements, benefits, and cost sharing need to be assessed between the CICP program, CBHP, and Medicaid as they relate to children. However, we recommend that the timing be expanded to allow adequate resources to successfully fulfill this task. We will complete the existing study under Senate Bill 00-223 for reporting to the legislature on November 1, 2000. We recommend scheduling the additional analysis subsequent to this study for completion by January 1, 2001.

Improving Eligibility and Enrollment Coordination

Applications and enrollment information frequently need to be exchanged between CBHP, CICP, and Medicaid programs. Improving communication and coordination between eligibility and enrollment systems can lessen administrative duplication, decrease excessive application time lags, avoid simultaneous enrollment in both

programs, and minimize confusion for families. While the implementation of CBMS should address many concerns in this area, until this implementation occurs the State needs to find other means to improve coordination between CBHP and the Medicaid program.

Eligibility Processes and Systems

Similar to other states, Colorado's CHIP program, CBHP, and the Medicaid program have separate eligibility processes and automated systems. The Colorado Indigent Care Program has yet another process for eligibility, which is manual and not centralized. The combination of different points of entry for different programs and related legal requirements are summarized below.

- **Children's Basic Health Plan**: Eligibility is determined by the State's contractor, Child Health Advocates (CHA), a private nonprofit entity. Providers and other community-based organizations function as satellite eligibility determination sites (SED sites) at 67 locations.

- **Colorado Indigent Care Program**: Eligibility is determined by the participating providers, which include local hospitals and clinics at 108 sites.

- **Medicaid**: Eligibility is determined by the county departments of social services.

A variety of other sites provide information about some or all three of these programs. However, with the exception of 35 locations that function as eligibility determination sites for both CBHP and CICP, the "entry points," or locations where families can actually enroll in the programs, are different for each program. Additionally, the automated eligibility systems for CBHP and Medicaid do not interact or exchange information.

The eligibility process is further complicated by several legal requirements:

- CBHP and CICP are required to *screen* applicants for Medicaid eligibility, since neither program is allowed to enroll an individual who is Medicaid-eligible.

- Medicaid eligibility must be *determined* by the county department of social services in which the applicant resides (Sec. 26-4-106(1), C.R.S.). This means only the counties can actually enroll individuals in the Medicaid program.

In cases where an individual applying through CBHP or CICP appears Medicaid-eligible, the application must be sent to the county departments. The county then re-performs the Medicaid eligibility process. If the county does not agree that the child is Medicaid-eligible, the application is sent back to the original program. In addition to these legal requirements, Colorado has a county-administered system for Medicaid and social services, rather than a state-administered system. This means that the State has limited ability to standardize procedures across counties.

Processing Delays Between CBHP and Medicaid

Lack of adequate communication between CBHP and Medicaid eligibility systems can cause processing delays for applicants referred to the other program. In mid-February 2000, CHA began to formally track the length of time it takes to receive information back on applicants referred to the county departments of social services. From mid-February to mid-March 2000, Child Health Advocates sent the counties applications for 536 children who appeared Medicaid-eligible. By late April, CHA had received dispositions from the counties for only 144 of the children, or about 27 percent of the total. For the remaining 392 children (73 percent), we tested a sample of 27 applicants and were only able to determine that 15 of these had been enrolled in Medicaid.

Overall, for the first ten months of Fiscal Year 2000, CHA reports that 5,353 applicants were referred to the counties, or about 14 percent of applicants. As of the end of April 2000, CHA had received dispositions on 1,252 children. Staff report there can be substantial delays in hearing back from the counties, and in some cases the disposition is never received.

Feedback from the counties is important because CHA needs to follow up with families concerning children determined ineligible for Medicaid. These are likely to be children who could be enrolled in CBHP. Out of the 1,252 applicants for whom CHA had received information back from the counties, 395 children (32 percent) had been denied Medicaid. This suggests that a substantial number of applicants referred to the counties may ultimately end up being eligible for CBHP.

There are several ways in which the Department could address these delays:

- ✓ Place Medicaid eligibility technicians at Child Health Advocates. This is the most straightforward solution from the viewpoint of processing these potentially Medicaid-eligible children in the quickest manner. This would require a change in the state law requiring county departments of social services to determine Medicaid eligibility. However, discussions are already

under way to change this law in order for the proposed Colorado Benefits Management System to be effective as a single entry point system.

- ✓ Arrange in larger counties for Medicaid eligibility technicians to spend some portion of time on a weekly basis at one of the satellite eligibility determination (SED) sites for CBHP. This would require that access to the Medicaid eligibility system be made available at these sites. This type of arrangement is currently in place at one of the SED sites in Denver.

- ✓ Establish specific time frames for counties to report on the status of applicants to CBHP. In cases where a disposition has not occurred, require an explanation of the nature of the delay. This would require the least change in the current process and probably be the least effective in reducing time frames.

Additionally, CHA reports that applications originating with the counties are not necessarily forwarded in a timely manner, although CHA does not formally track these delays. During the first ten months of Fiscal Year 2000, almost 7,000 applicants, or nearly 18 percent, came through county departments of social services. To expedite these applications, SED sites could be required to pick up applications from the counties on a weekly basis.

The Department should ensure that the exchange of applications and eligibility information between CBHP and the Medicaid program occurs in a timely manner. This will reduce excessive delays in processing time that could discourage families from participating in the programs and also could cause families to delay needed medical care for their children.

Recommendation No. 19:

The Department of Health Care Policy and Financing should ensure applications referred between the Children's Basic Health Plan and Medicaid program are processed timely. Options include:

a. Locating Medicaid eligibility technicians at eligibility sites for the Children's Basic Health Plan.

b. Requiring satellite eligibility determination sites for the Children's Basic Health Plan to collect referred applications from the county departments of social services on a regular basis.

c. Establishing specific time frames for counties to report on the status of applicants to CBHP and on the nature of any delays.

Department of Health Care Policy and Financing Response:

Agree. The Department agrees that a system that allows more timely determination of Medicaid eligibility would benefit applicants to both Medicaid and CBHP. The Medicaid eligibility system is devolved to the counties. Placing Medicaid eligibility technicians at Child Health Advocates would require statutory change. Placing Medicaid eligibility technicians at SED sites has received limited support from the counties (other than Denver) because of volume issues. To date, counties have not found this recommendation to be cost effective. We will continue to meet with counties to discuss the possibility of this option. The Department has been working with the counties and plans to issue an agency letter to the county departments of social services by September 30, 2000, that will specifically address referral of applications between CBHP and Medicaid, as well as other communications and procedural issues. The Department will continue to stress the need for timely referrals in future meetings with the counties.

Information on CBHP for Families Leaving Medicaid

Families disenrolled from Medicaid programs may not always be referred to or receive information about CBHP. At least annually Medicaid enrollees are required to have their eligibility redetermined through verification of key information to the local county department of social services. This process allows the counties to update the family's data and reassess their eligibility under the program.

Currently counties have the following procedures in place:

- If the family submits an initial application and is determined ineligible for Medicaid, the county forwards the application to the Children's Basic Health Plan.

- If the family submits the redetermination form and is found ineligible for Medicaid, the county does not forward information to CBHP, because the redetermination form is not designed so that it can be used as a referral form to CBHP.

Additionally, the Medicaid "denial" letter that is automatically sent to families informing them that they are no longer eligible for the Medicaid program does not inform families that their children may be eligible for CBHP or tell them how to apply for the program.

The Department reports that it plans to include CBHP information in Medicaid denial letters. This will help ensure that all families ineligible for Medicaid either are referred to CBHP or receive information about the program.

Recommendation No. 20:

The Department of Health Care Policy and Financing should ensure that families determined to be ineligible for the Medicaid program receive information on how to apply for the Children's Basic Health Plan by including information about CBHP in denial letters sent to these families and by other appropriate means.

Department of Health Care Policy and Financing Response:

Agree. Currently, cases denied for Medicaid are referred to CBHP sites. Changes to Medicaid notice information on denial letters to inform applicants of CBHP (including an information phone number) are scheduled to be in place by August 2000.

CBHP Network Claims Audit

Chapter 6

Background

As part of our audit of the Children's Basic Health Plan (CBHP), the Office of the State Auditor contracted with Buck Consultants to evaluate the payment of health insurance claims under the program. The following is a summary, prepared by Buck Consultants, of the results of the claims audit. A copy of the full report is available upon request from the Office of the State Auditor *(Children's Basic Health Plan Claims Audit,* Report No. 1225B).

Summary of Findings and Recommendations: Claims Audit

Introduction

The primary goal of CBHP is to maximize enrollment of Colorado's low-income, uninsured children in order to increase their access to health care. As of April 30, 2000, there were 24,410 children enrolled in CBHP; of these, 16,640 (68 percent) were served through HMOs, and 7,770 (32 percent) were served through the CBHP Network.

The Department of Health Care Policy and Financing (HCPF) contracts with Child Health Advocates (CHA) to determine eligibility for all program applicants. Once enrolled in CBHP, children receive health care primarily through HMOs. However, in some rural areas where HMO coverage is not available, CBHP maintains a network of providers referred to as the CBHP Network (Network). Designated physicians in the Network serve as Primary Care Physicians (PCPs) and as gatekeepers for referrals to other services (e.g., ancillary and specialty services, hospital services) in the Network. Claims resulting from these referrals are paid on a fee-for-service basis. The claims filed under the CBHP Network are the focus of this audit.

HCPF contracts with Anthem (formerly Blue Cross Blue Shield of Colorado) to process claims submitted under the CBHP Network.

Audit Objectives

In order to thoroughly evaluate the administration and management of the CBHP program, we conducted on-site audits at CHA's and Anthem's offices. Our review of applications at CHA was based on a sample of 20 enrollment applications and focused on three key performance indicators:

- Enrollment application accuracy.
- Enrollment application eligibility timeliness.
- Eligibility rule compliance.

At Anthem our review of claims focused on three key performance indicators:

- Claim payment accuracy.
- Timeliness of claim payments.
- Compliance with CBHP schedule of benefits and other requirements.

In addition, our review included internal controls and procedures, claim cost controls, eligibility, claims payment system, and data collection capabilities.

Our investigation covered all aspects of claim administration. We verified the eligibility of the claimant at the time services or supplies were rendered. All claims were recalculated to confirm that benefit payments were reimbursed accurately. All claims were reviewed for medical necessity. Procedural and diagnostic codes were validated to ensure accuracy of payments. Fee allowances were reviewed and verified for each claim. The date received and the date paid were recorded for each claim to calculate the processing time.

In determining the capability of Anthem's operation to effectively support CBHP, we made comparisons wherever possible to industry standards of performance for claim administration.

Audit Results

Child Health Advocates

During our review we noted that CHA forwards eligibility information, such as additions, deletions, and changes, to Anthem on a regular basis. However, there is no reconciliation between the eligibility information maintained by CHA and by Anthem.

Eligibility File Reconciliation

As an integral part of our review, we compared the CHA and Anthem eligibility files. A sample of files for 20 families was compared to eligibility information maintained at Anthem for these same families. We found discrepancies in 4 out of the 20 families tested (20 percent); these families involved a total of 9 children. The following discrepancies were noted:

- For 7 children, Anthem and CHA had different termination dates on file. For 6 children, Anthem had later termination dates on file than CHA, which could result in claims being erroneously paid by Anthem. For the other child, Anthem had an earlier termination date than CHA, which could result in claims being erroneously denied by Anthem. In all instances, CHA stated it had previously communicated the corrected termination dates to Anthem.

- For 2 children, Anthem had no eligibility files, while CHA had both children listed as currently enrolled. This could have resulted in claims being erroneously denied by Anthem if CHA's records are accurate and the children are enrolled.

Recommendation No. 21:

The Department of Health Care Policy and Financing should ensure that consistent and accurate eligibility data for the Children's Basic Health Plan are reflected on-line at Anthem and Child Health Advocates by:

a. Requiring that eligibility discrepancies identified during the claims audit and any resulting claims issues are resolved.

b. Establishing a reconciliation process on eligibility data to be performed by Anthem and Child Health Advocates on a monthly basis.

Department of Health Care Policy and Financing Response:

Agree. The Department has established formal processes in the Fiscal Year 2001 Anthem and Child Health Advocates agreements for adherence to a prioritized work agenda and corrective action plans. Monthly eligibility reconciliation procedures are being prioritized and implemented. Implementation date: October 1, 2000.

Anthem

Claim Payment Accuracy

A random sample of 150 claims was selected from CBHP claims paid by Anthem between March 1, 1999, and February 29, 2000. During this period 34,310 claim records were filed with Anthem on behalf of CBHP for a total of $2,651,050.

Based on the findings of the random sample audit at the Anthem claim office, the ratio of the number of claims processed incorrectly to the total number of claims audited (the sample error rate) was determined. The error rates are based on a population of individual claim transactions rather than complete claim histories. An error is defined as a claim transaction containing one or more mistakes in the calculation of amounts payable, or in procedures that potentially affect the calculation or management reporting of data. Multiple errors on the same claim transaction are counted only once. Claim transactions containing both a procedural and financial error are counted as a financial error.

- The **financial error rate** for the sample is 1.4 percent. The financial error rate is the incorrect dollars paid in the sample, divided by the total dollars paid in the sample. It includes the absolute value of both overpayments and underpayments identified by the audit. This is the most substantive measurement of claim administration, since it directly impacts plan dollars. One percent (1 percent) of paid dollars is considered by most major administrators as the maximum acceptable financial error rate; this is also Anthem's internal standard. Compared with both industry's and Anthem's standard, the 1.4 percent financial error rate identified by the audit is unacceptable.

- The **payment incidence error rate** for the sample is 21.3 percent; this represents the number of incorrect sample payments divided by the total number of sample payments. Compared with the maximum acceptable industry error rate of 3 percent, the error rate in the audit is significantly above the acceptable rate. Anthem does not internally measure the payment incident error rate. The majority of these errors were caused by a systemic problem related to incorrect copayments.

- The **procedural error rate** for the sample is 0.7 percent; there was one procedural error identified in the random sample. The procedural error rate is the number of sample claims containing an error with an unknown or no monetary effect divided by the total number of sample claims. Acceptable industry standards for procedural error rate in an automated environment is

5 percent. Anthem's internal standard is 2 percent. The procedural error rate in the audit was better than both industry's and Anthem's standard.

Table 13 summarizes the industry standards for error rates, Anthem's stated standards, and the audit results:

Table 13: Children's Basic Health Plan Claims Audit
Summary of Claims Payment Errors

Measurement Criteria	Industry Standard	Anthem Standard	Audit Result
Financial Error	≤ 1.0%	≤ 1.0%	1.4%
Payment Incidence Error	≤ 3.0%	Not measured	21.3%
Procedural Error	≤ 5.0%	≤ 2.0%	0.7%

Source: Buck Consultants analysis of claims data.

The relatively high financial and payment incident error rates were largely the result of incorrectly applied copayments. The audit identified numerous errors where a $2 and zero copayment were incorrectly applied.

Anthem reports that in September 1998 it entered certain claimant files on-line using an incorrect benefit package. The benefit package defines the amount of copayment to be applied when reimbursing providers. Anthem states the claim system was corrected in September 1999 to reflect accurate benefit package data. Therefore, for 12 months claim payments to providers were based on erroneous data. Anthem did not correct past payments to providers once the error was discovered. Adjustments were limited to instances where the family or provider complained.

Anthem's results for financial errors in the random sample fall outside the acceptable range. The numerous payment incidence errors are systemic due to the incorrect programming of the benefit package onto the claim payment system. The impact of these errors must be quantified by Anthem. The Department should determine if correction of erroneously paid amounts related to the mistakes is feasible. In addition, error rates should be improved.

Recommendation No. 22:

The Department of Health Care Policy and Financing should require that Anthem execute a utility report to quantify the error amount caused by the installation of the incorrect benefit package for the Children's Basic Health Plan and determine the cost-benefit of correcting erroneous payments.

Department of Health Care Policy and Financing Response:

Agree. The Department will request quantification of copayment-related claims errors by August 1, 2000. However, results may indicate that the cost of reprocessing claims to correct payments may exceed the associated financial benefit.

Recommendation No. 23:

The Department of Health Care Policy and Financing should require that Anthem improve the poor financial and payment incidence error rate results for the Children's Basic Health Plan by including performance guarantees and remedies for nonperformance in future contracts. Guarantees should be based on industry standards.

Department of Health Care Policy and Financing Response:

Agree. The Department will specify improvement via the corrective action process noted above in Recommendation No. 21. Additionally, liquidated damages may be applied if corrective action plans are not implemented or completed satisfactorily. Implementation date: October 1, 2000.

Timeliness of claim payments

Turnaround time (TAT) studies were performed on the random sample. Most carriers and claim administrators strive to process 85 percent to 90 percent of all claims within 10 work or 14 calendar days. Anthem's goal for TAT exceeds industry objectives; Anthem aims to process 98 percent of all claims within 14 calendar days and 98 percent of investigated claims within 45 calendar days. Our study revealed 64.7

percent of the sample claims were processed within 14 calendar days and 82.7 percent of the sample claims were processed within 45 days. Thus, Anthem failed to satisfy both its internal standard and the industry standard for TAT.

Table 14 summarizes the audit results for turnaround times:

Table 14: Children's Basic Health Plan Claims Audit Turnaround Time Results

Measurement Criteria	Paid Within 14 Days
Industry Standard	85% - 90%
Anthem Standard	98.0%
Audit Result	64.7%

Source: Buck Consultants analysis of claims data.

Recommendation No. 24:

The Department of Health Care Policy and Financing should require that Anthem improve timeliness of claims payments (turnaround time) for the Children's Basic Health Plan by including performance guarantees and remedies for nonperformance in future contracts. Guarantees should be based on industry standards.

Department of Health Care Policy and Financing Response:

Agree. The Department will specify improvement via the corrective action process noted above in Recommendation No. 21. Additionally, liquidated damages may be applied if corrective action plans are not implemented or completed satisfactorily. Implementation date: October 1, 2000.

Internal Controls and Procedures

The Quality Unit at Anthem performs daily audits by ordering reports of all the claims processed by the firm and reviewing a statistically valid sample of claims. The claims

that appear on the itemized report represent all plans that contract with Anthem for claims processing. Consequently, an internal audit is not conducted that is specific to the requirements of CBHP, although CBHP claims are included in the overall sample.

Internal audit activities should be specific to CBHP and should be expanded to target the issues identified by this claims audit. If a CBHP-specific internal audit program were in place, any programming errors, such as the error described earlier related to incorrect copayments, would have been identified and corrected in a timely manner and with minimal plan exposure.

Recommendation No. 25:

The Department of Health Care Policy and Financing should require that Anthem restructure its internal audit program to specifically target the Children's Basic Health Plan and ensure all plan components receive adequate review.

Department of Health Care Policy and Financing Response:

Partially agree. The Department will conduct a program needs assessment with Anthem to identify changes in its current internal audit procedures (which are applied for all lines of business) that may be necessary to ensure compliance with plan requirements that are unique to the Children's Basic Health Plan (e.g., retroactive eligibility). Once necessary changes are identified, the Department will develop an implementation plan with Anthem.

However, it is important to note that it may not be cost-effective to mandate a fundamental change to Anthem business processes given the relatively small size of the CBHP group. The Department is striving to minimize administrative and operational costs in all areas. Anthem has contracted to provide services for the CBHP during Fiscal Year 2001 at a fee that is 20 - 40 percent below the market rate. Implementation of internal audit changes solely for the purpose of compliance with all CBHP-specific program requirements may result in increased administrative costs.

Depending upon the cost (if any) associated with changes to Anthem audit procedures, the Department may attempt to identify a more cost-effective alternative to verify compliance with program requirements. Implementation date: October 15, 2000.

Improving Future Performance

After Anthem has had the opportunity to develop an action plan to address the programming and internal audit initiatives necessary to effectively handle the CBHP program, the Department should perform another focused audit. The follow-up audit should target the application of copayments. On the basis of the unfavorable audit findings resulting from Anthem's copayment application, the cost of any follow-up audit activities should be borne by Anthem.

Recommendation No. 26:

The Department of Health Care Policy and Financing should require that Anthem develop an action plan to address the internal issues identified by the claims audit on the Children's Basic Health Plan.

Department of Health Care Policy and Financing Response:

Agree. The Department will specify improvement via the corrective action process noted above in Recommendation No. 21. Additionally, liquidated damages may be applied if corrective action plans are not implemented or completed satisfactorily. Implementation date: October 1, 2000.

Recommendation No. 27:

The Department of Health Care Policy and Financing should perform a follow-up audit to test the effectiveness of Anthem's action plan with regard to the Children's Basic Health Plan claims audit.

Department of Health Care Policy and Financing Response:

Agree. The Department will conduct a follow-up audit to assess changes in performance in the areas cited in this audit, and the effectiveness of the corrective action plan implemented in accordance with contractual procedures. As noted above, a follow-up audit specific to the CBHP is preferable to mandating overall Anthem business systems changes that may not be cost effective. Implementation date: April 1, 2001.

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