1996 Annual Reports

Introduction

The Department of Health Care Policy and Financing (HCPF) was created on July 1, 1994. The Office of Medical Assistance administers the state and federally funded Medicaid program and other health care programs. Medicaid is the primary payment source for acute and long-term health care services for Colorado's low-income citizens. The state's Medical Services Board has rule-making authority for the Medicaid, Indigent Care, Adult Foster Care and Home Care Allowance programs. Board members are appointed to four-year terms by the Governor with consent of the Colorado Senate. The department's Office of Public and Private Initiatives researches, designs, and implements market-oriented health reforms and Medicaid program improvements. The office also provides information on the performance of the health care market.

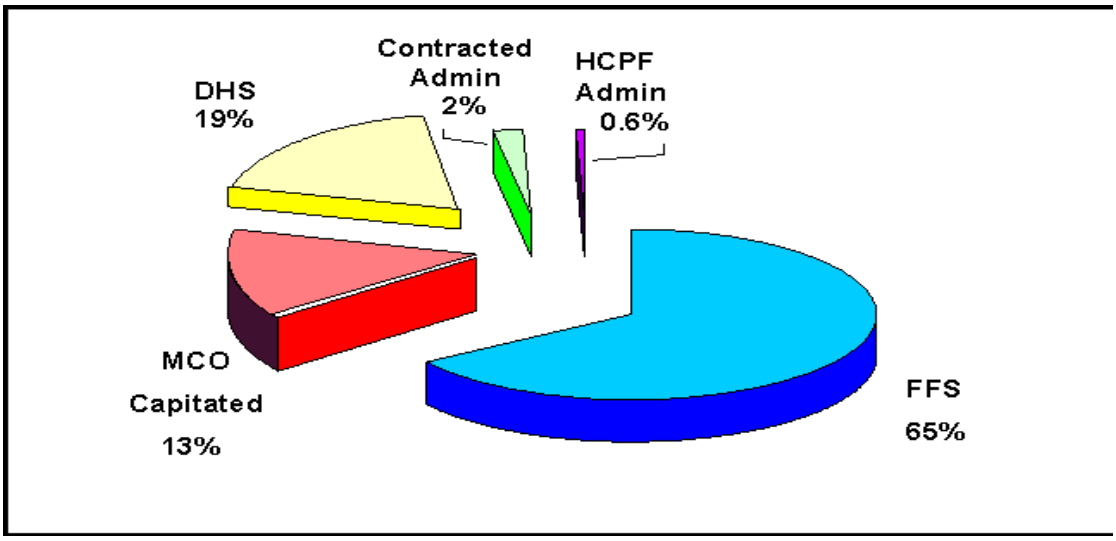
Our Programs

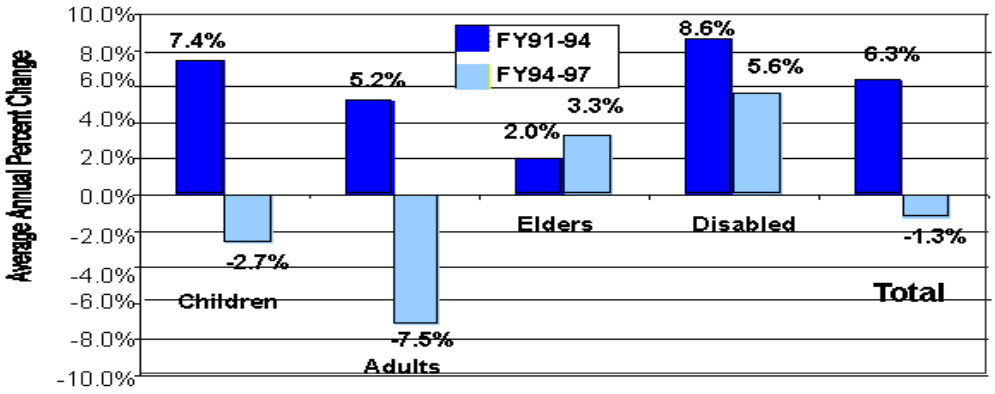
Medicaid is a program for low-income custodial parents, pregnant women, children, persons with disabilities, and elderly persons requiring long-term care services. Figure 1 shows the approximate income limits (as a percentage of the federal poverty level, which was $12,980 in 1996 for a family of 3) for Medicaid program eligibility in each eligibility category. Coloradans who are not eligible for Medicaid coverage, but whose incomes are below 185% of the poverty level, may qualify for partially or fully subsidized hospital and clinic care, through the Colorado Indigent Care Program (CICP). Asset limits also apply for Medicaid and CICP programs. HCPF also administers non-Medicaid health and home care programs and the state's poison control program. Nearly one-half million Coloradans are served by HCPF programs each year.

Fig 1: Medicaid Eligibility Income Limits

Category of Eligibility	Income Limit as % of poverty level, 1996
Pregnant Women	133%
Children 0-5	133%
Children 6-13	100%
AFDC families	39%
Persons with disabilities	73%
Persons qualified for nursing facility level of care	219%

About two-thirds of Medicaid clients are adults and children; one-third are elderly or disabled. Figure 2 shows that the one-third who are elderly or disabled account for more than two-thirds of the department's Medicaid expenditures.

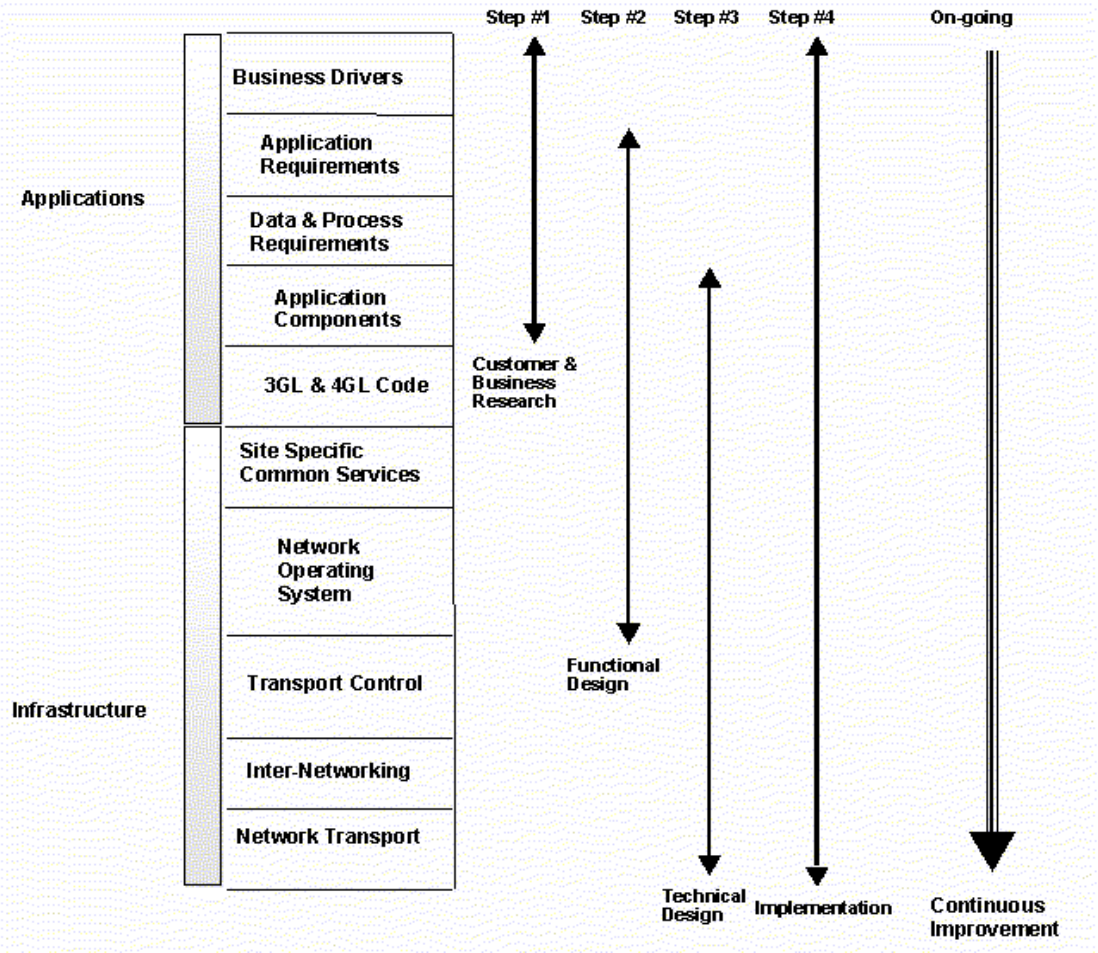




Medicaid covers a broad array of services including physician care, prescription drugs, hospital care, mental health care, long-term nursing facility care, and long-term home and community-based care. Figure 3 shows the distribution of all services paid for by Medicaid in FY 96.

The state paid $296 million (24% of total expenditures) to nursing facilities, mostly for elderly clients. The state paid $205 million to hospitals (17% of total expenditures), mostly for children, adults, and persons with disabilities. Because Medicare pays for acute care (except prescription drugs) for almost all Coloradans over age 65, Medicaid spends very little on hospital and physician care for these clients. Medicaid transferred $244 million to the Department of Human Services for mental health services and service for people with developmental disabilities. In FY96 Medicaid paid $112 million to health maintenance organizations (HMOs) which provided a comprehensive set of benefits to those Medicaid clients enrolled in them. As HMO enrollment continues to grow, the HMO service line will increase, and the separate lines for services covered by HMOs (e. g., hospital, ambulatory care, prescription drugs) will decrease.

Figure 4 shows Medicaid's portion of total spending in Colorado for several services. Medicaid pays for a large proportion of the state's long-term care services and services to pregnant women and children. Eighty percent of community-based long term care services, such as home health and personal care, and 60% of nursing facility services in Colorado are paid by Medicaid. The state's community-based long-term care programs continue to develop and provide cost-effective, client-preferred alternatives to institutional care; in FY96, more Coloradans received Medicaid long-term care at home or in community-based programs than in nursing facilities.

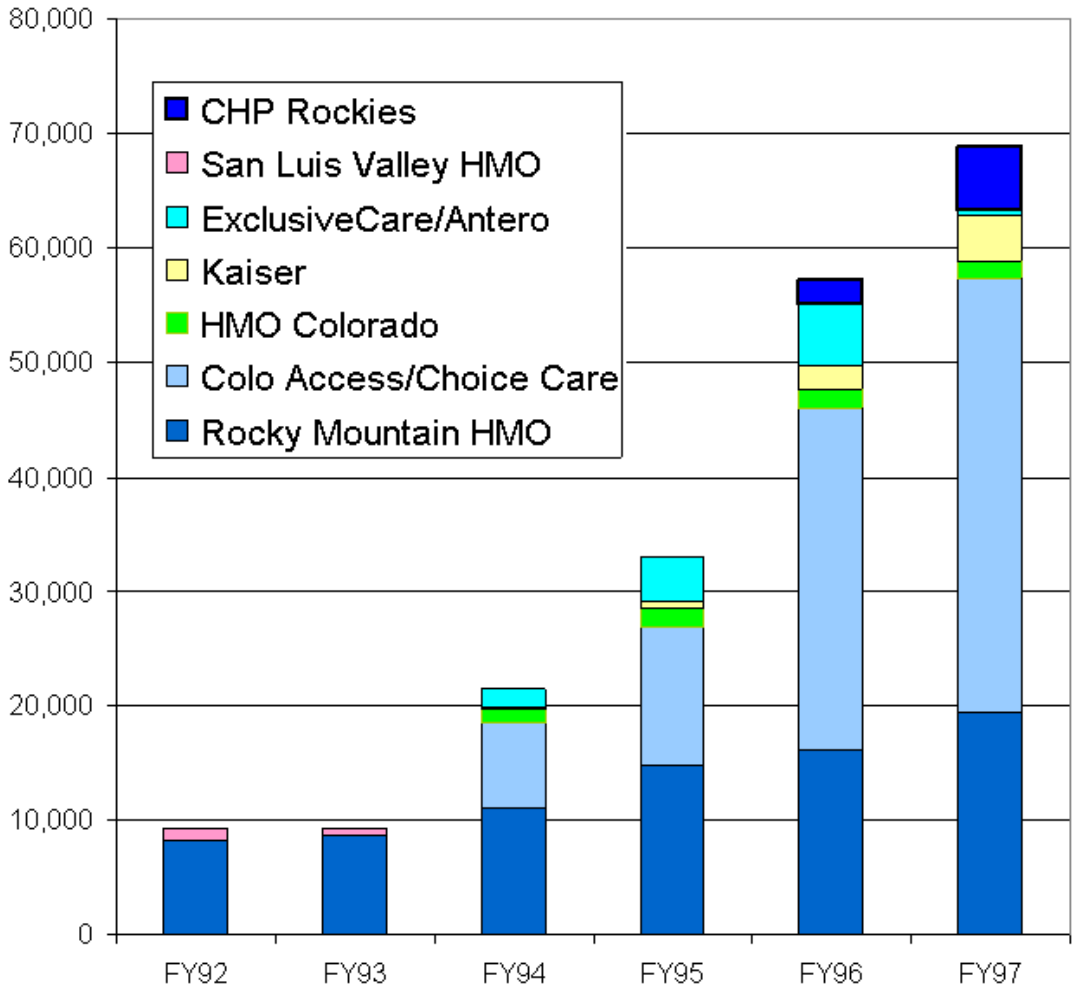


Births are % of total births; all others are % of total expenditures.

Medicaid continues to cover about one-third of the state's births, including pre-natal, delivery and post-partum care. Expanded Medicaid coverage to children supports preventive care such as immunizations and early treatment of potentially disabling conditions. Medicaid pays a somewhat smaller share of the state's hospital and physician services, and a very small share of dental services. Medicaid covers dental services for children only.

The Budget

The department's budget was $1.5 billion in FY 96, of which $1.2 billion was for HCPF-administered, Medicaid-related services. Federal funds account for 51% of this total, with the balance coming from state and some grant funds. The department manages more than 17% of the state's annual budget.



Figures 5 and 6 show Medicaid enrollment and per capita costs by eligibility category. In the early 1990s federal law changes brought many new low-income pregnant women and children into the program. This large increase in the number of pregnant women covered by Medicaid also increased the average cost of services for adult Medicaid clients. The growth in per capita costs for elders is largely due to annual increases in average nursing facility rates.

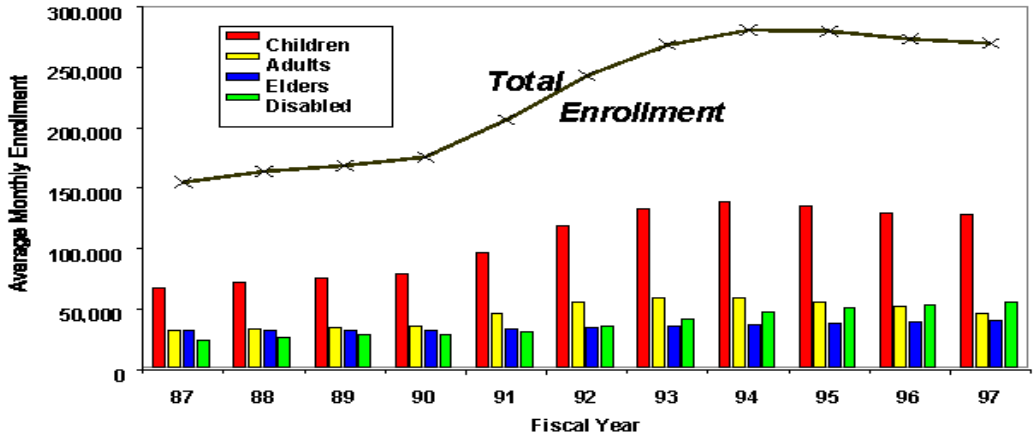
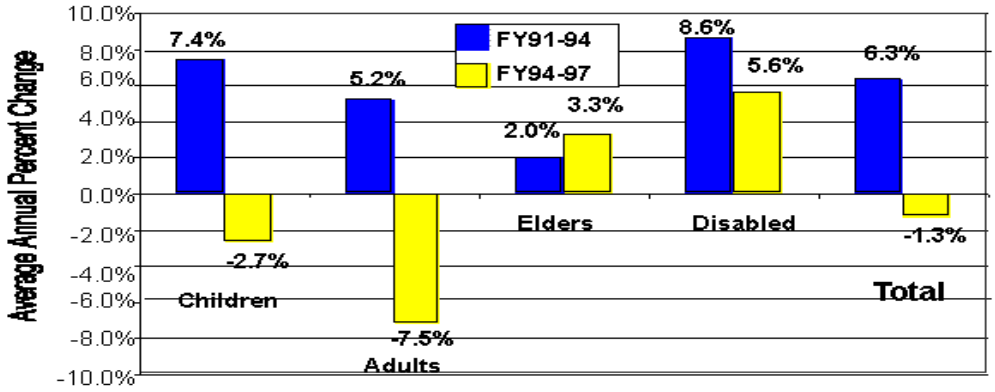
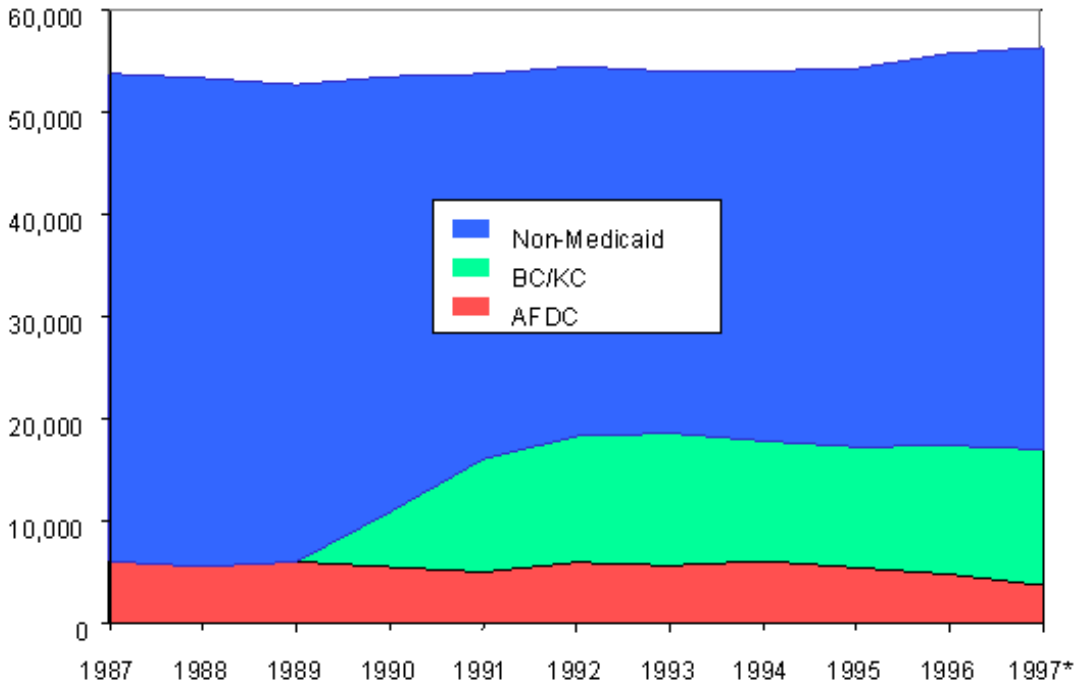


Figure 7 shows total Medicaid expenditures by eligibility category. In recent years, total expenditures for adults and children have grown fairly slowly. Total costs for people with disabilities have grown primarily because of increased enrollment. While the number of elders served by Medicaid is fairly stable, total Medicaid expenditure growth for the elderly population has been rapid because of nursing facility rate increases.



Administration

At a staffing level of 133 full-time equivalent (FTE) personnel, HCPF is one of the smallest departments in staff size -- about one-half of one percent of the state's employees. State staffing costs account for less than one-half of one percent of the department's budget. Total administrative costs, including public and private sector contracts and eligibility determination at the county level, are about 2.3% of the department's budget. Figure 8 shows the department's total administrative costs compared to those of the state's three largest health insurance companies. Even when administrative costs are shown on a per member per month basis, the department's administrative costs are the lowest.



Other Activities

The Office of Public and Private Initiatives engages in projects to reduce the cost and improve the accessibility, quality, and effectiveness of health care services for all Coloradans. The major projects are:

- Certification of and technical assistance to employer health insurance purchasing pools designed to give employers and employees more health care choices, better quality, lower prices, and more information about their choices
- Studying and reporting on the number of Coloradans lacking health insurance coverage, the effects of uninsurance, and policy options for covering or delivering services to more of the uninsured
- Collaborating with large private employers and purchasing cooperatives to collect performance data from HMOs and to use the data to improve purchasing and inform consumers
- Collaborating with other state and federal government agencies to streamline current managed care

regulation and monitoring while increasing consumer protection
- Designing methods for risk adjusting HMO premium payments to encourage plans to enroll high-need populations and discourage risk-skimming behavior
- Reporting on the status of the health care market, including how much different health care payers in Colorado spend on different health care services, and on the amount of competition for delivering health care services and insurance in different parts of the state

Trends and Highlights

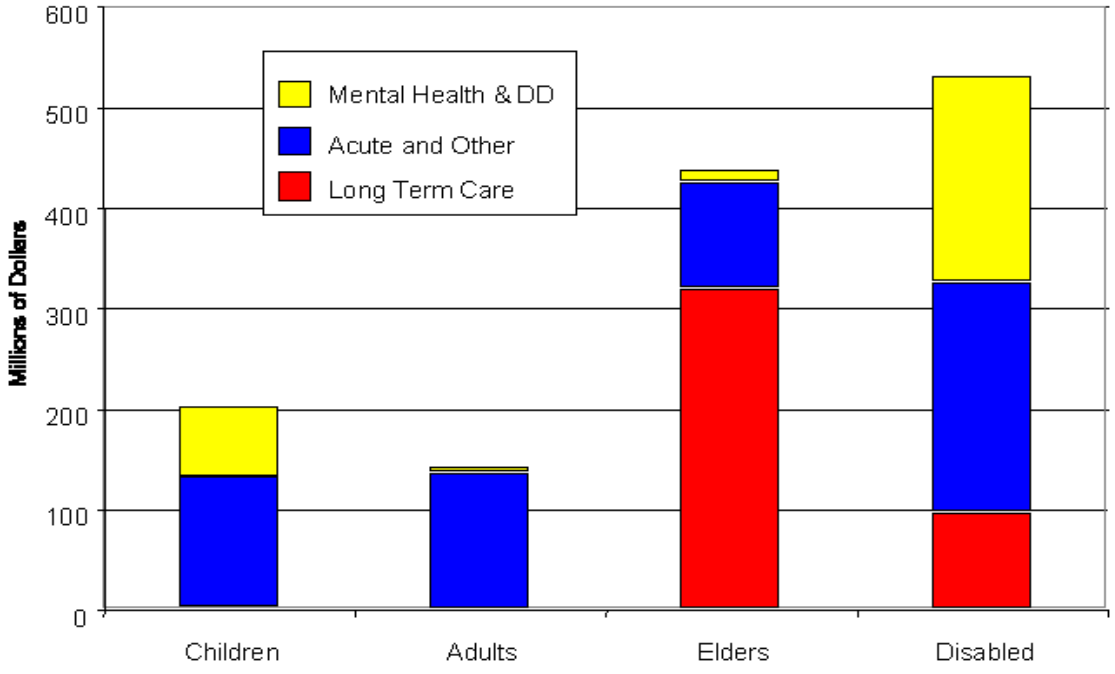
This section highlights four areas of focus for the department in 1996. These are:

- Managed Care
- Welfare Reform
- Customer Service and Consumer Involvement
- Information Systems Development

These high-priority projects and development efforts involve staff from throughout the department working in cooperation with many other public and private sector agencies and individuals.

Managed Care

More than 1 million Coloradans (about 30% of the state's population) are enrolled in Health Maintenance Organizations (HMOs), making this state one of the most active managed care markets in the country. There are 20 licensed HMOs in Colorado, seven of which were licensed in 1995 or 1996. Medicare, Medicaid, and the small group market have seen major HMO enrollment growth. HMOs are also developing new products, such as point-of-service plans, and entering new geographic areas, especially in rural regions of the state. Figure 9 shows that, in December 1996, Colorado Medicaid had contracts with 5 plans covering 70,000 enrollees or about 30% of all Medicaid clients. In



January 1994, Medicaid had only one HMO contract covering 10,000 clients.

In addition to HMO contracts, the department administers the Primary Care Physician Program (PCPP) which served 61,000 clients in December 1996. The PCPP provides an effective form of managed care for clients with complex health care needs who may not find that the care system in an HMO meets their needs.

Capitated managed health care integrates the financing and delivery of health care services to a specific group of clients through a variety of arrangements between payers and providers. A payer (such as an employer, or the Medicaid program) pays an HMO a fixed dollar amount per enrollee per month (a "capitated " rate), and the HMO is responsible for providing that enrollee with all medically-necessary care.

While an increasing reliance on capitated managed care (HMOs) in Colorado brings opportunities for cost control and for more efficient and effective care delivery systems, it also raises new problems. Some consumers are concerned that financial incentives to control costs may cause HMOs to restrict access to care or reduce quality.

As a large managed care purchaser, Medicaid needs to balance the cost control incentives inherent in capitated managed care with access and quality safeguards. Unlike private health care purchasers, Medicaid buys HMO services for large numbers of disabled and special-needs clients. Concerns about access, quality, and appropriate care management are even greater for persons with disabilities, because these clients often require extensive and varied health care resources.

Preparing well for rapid growth of HMO-based services is one of the department's top priorities. The department is working with Medicaid clients and HMOs in a variety of ways to ensure that the products purchased by Medicaid meet enrollees' needs, that contracting HMOs have an incentive to provide the most appropriate levels of care, and that Medicaid clients are informed consumers of managed care. Some of the department's projects are:

- **Medicaid HMO Risk Adjustment** - This rate-setting plan pays HMOs more for enrolling people with high health care needs and less for those likely to require less health care. This creates an incentive for plans to become expert at caring for disabled and other special-needs populations and removes the disincentive to serve these clients.

- **Enhanced HMO Contract Standards -** New quality and access standards developed in FY 96 and implemented in FY 97 address issues such as provider network adequacy, care coordination, utilization management, and enrollee grievance procedures. The department will ensure compliance with these standards through annual HMO evaluations, tracking of complaints and grievances, customer satisfaction surveys, and focused studies of particular clinical and service delivery topics.

- **Interagency Collaboration on Health System Accountability** - Although Medicaid clients may have needs that are different from those of some commercial HMO members, all managed care consumers are concerned about issues such as appropriate and fair utilization review practices and access to needed care. HCPF is working with the Department of Public Health and Environment and the Division of Insurance to ensure that Medicaid's HMO contract requirements and regulatory and accountability systems are as integrated as possible with those of other purchasers and regulators.

- **Public/Private Data Partnership** - HCPF is sharing resources with the Colorado Business Group on Health (a large-employer coalition) and The Alliance (a small-employer coalition) in an unprecedented partnership to collect health plan quality measures from HMOs and to publish those measures for use by Medicaid and private-sector consumers.

- **Medicaid Enrollment Re-design** - During FY 96 the department created a project to improve client and HMO satisfaction with managed care enrollments by streamlining the process and by providing clients with more useful information about their HMO choices.

- **Competitive Procurement of HMOs** - All of the quality-enhancement techniques described above come together in the department's HMO competitive procurement project. A competitive bid process allows the department to specify the quality, access, marketing, customer service, reporting, and enrollment standards that plans must meet. Plans would compete against each other by offering lower prices or by showing how they can exceed the specifications. The department plans to implement competitive bidding for HMO contracts in FY 99.

Welfare Reform

Federal welfare reform (the Personal Responsibility and Work Opportunity Act of 1996) has three major effects on Medicaid. First, the client eligibility link between cash assistance and medical assistance is broken. That is, the state may make major changes in eligibility for cash assistance, but clients would keep Medicaid eligibility based upon previous cash assistance eligibility even if they lose cash assistance. Some of the effects on Medicaid client eligibility and coverage will depend upon the approach Colorado takes to welfare reform.

Second, the welfare reform bill bars certain immigrants from Medicaid eligibility, and makes coverage for some other immigrants optional on the part of the state. The changes are complex and are still being evaluated by state and federal officials. Early analysis shows that about 5% of the approximately 14,500 legal immigrant

Colorado Medicaid beneficiaries will be barred by federal law from Medicaid eligibility. Most future legal immigrants will also be barred from Medicaid coverage for five years after entry. The state has the option of providing a Medicaid-like benefit package to the populations barred from Medicaid, but no federal matching funds will be available for such a program. The vast majority of the legal immigrant population served by Medicaid may continue to be eligible at the option of the state. Medicaid providers will continue to be reimbursed for services rendered to any alien, regardless of immigration status, in emergency situations.

Third, the bill modifies the eligibility criteria for children with disabilities. Approximately 2,000 children in Colorado will have their eligibility reviewed to see if they meet the new disability criteria. Based upon national estimates, most of these children are likely to remain eligible for Medicaid coverage.

The department anticipates that the Colorado General Assembly and the Governor will take action during the 1997 Legislative Session to interpret and implement provisions of the federal welfare reform act. Many leaders see welfare changes as an opportunity to make Medicaid a more effective tool in moving welfare recipients into the work force. These initiatives are likely to require a significant response by the department to modify and restructure Medicaid and other health care programs.

Customer Service IMPROVEMENTS

HCPF is pursuing a number of policy, program, and operational initiatives to maintain and improve its ability to provide effective and efficient customer service. HCPF staff are collecting customer feedback on what services are needed and how they can best be delivered, and are then acting upon those inputs to develop systems that respond faster and meet more customer needs. Major department projects to improve services to clients, providers, and the public are outlined below.

Client Services and Consumer Involvement

- **Customer Information Line -** In 1995 the department identified its telephone communications system as a major source of problems for customers and staff. Poor telephone technology caused long wait times, lost calls, and customer complaints. The department developed and implemented an automated system with the capacity to meet customers' telephone service needs effectively. A new system was installed in September 1996. The new system was immediately successful in more than doubling the volume of calls handled per day and in slashing wait times and customer complaints. The department plans to expand the system in early 1997 to function 24 hours per day and 7 days per week.

- **Client Education and Enrollment -** Medicaid clients are required to choose and enroll with an HMO or the Primary Care Physician Program. Clients need information about providers and HMOs to make a choice that serves their needs. Clients receive most of this information at the time they enroll in the Medicaid program, at the local county department of social services. However, local departments of social services have had very limited training and staffing for this function.

  The department is providing a range of supports to local agencies and directly to clients, including providing managed care information in printed and video formats, assistance in streamlining local agency operations and processes, and statewide telephone access systems to handle client information and enrollment needs. One major addition to direct telephone assistance is the Triage Line, which provides 24-hour access to health care advice and referral to Medicaid clients.

- **Consumer Involvement** - In FY 96 the department dramatically expanded consumers' opportunities for input into program decisions. For example, the Medicaid Managed Care Disability Working Group, formed in February 1996, addressed issues of access and quality of care in the managed care environment as these issues affected persons with disabilities. The group recommended about 200 changes to Medicaid HMO contracts and quality management systems. The Consumer Involvement and Report Card Projects address quality and access issues by involving consumers in identifying problem areas and developing effective methods of assuring quality service delivery. The department also analyzes consumer inputs received in telephone and written communications and from customer satisfaction surveys and uses the information to improve program policy and procedures.

Information Systems DEVELOPMENT

Achievement of department goals and objectives depends upon an information technology (IT) infrastructure that provides complete, accurate, useful and up-to-date information at a reasonable cost. HCPF is implementing a number of IT initiatives that will enable the department to provide services more effectively and efficiently. The

developing IT infrastructure consists of an integrated departmental local area network (LAN) with appropriate software and access to external data. The systems will be partially managed by the department's staff and partially outsourced to private corporations. To build this infrastructure HCPF is carrying out four information technology projects:

- a new Colorado Medicaid Management Information System (MMIS);
- the Automated Medicaid Payment System (AMPS);
- the Colorado Benefits Management System (CBMS); and,
- a new Technical Architecture.

New Colorado Medicaid Management Information System (MMIS)

The department recently issued a Request for Proposal (RFP) and awarded a contract for the design and development of a new MMIS. HCPF staff and contractors researched and documented the general and detailed requirements of the system, state and contractor responsibilities, deliverables, and milestones for the implementation phase of the contract, and linked the performance expectations for the system to the requirements analysis. The contract for the new MMIS was awarded to Consultec Inc. The new MMIS will be fully operational on July 1, 1998.

Automated Medicaid Payment System (AMPS)

AMPS was installed in FY 95 and expanded in FY 96. Almost all Colorado Medicaid providers can now access the on-line billing and electronic payment system, which has substantially reduced the time between billing and payment and streamlined the billing process for providers and for the department. Figure 10 shows that processing times for prescription drug claims dropped from an average of 22 days in January 1995 to an average of 6 days in July 1995 after AMPS implementation. HCPF processes more than 200,000 pharmacy claims per month (about 30% of total claims.) With the success of AMPS, Medicaid is one of the fastest and most customer-friendly health care payers in the state.

Colorado Benefits Management System

The Department of Human Services (DHS) is currently assessing the feasibility of developing an integrated client information management system, called the Colorado Benefits Management System (CBMS). HCPF is a major stakeholder in this project because the department's programs and systems rely upon a well-functioning DHS system for accurate and timely client eligibility information. The current eligibility and enrollment system does not accommodate HCPF program needs given the movement to managed care and the development of a state of the art MMIS system.

New Technical Architecture

HCPF has initiated a project to design, develop, and maintain its own technical architecture. The focus of the project is to establish a technology foundation that can be exploited to meet the long-term business needs of the department. The new LAN system now in development is expected to be operational by July 1, 1997.

Additional Information

Additional information is available on the programs and activities of the Department of Health Care Policy and Financing. Questions on health care policy, financing, programs, or services may be directed to the HCPF Customer Service Information Line - 303-866-3513 or 1-800-221-3943. Copies of the 1997 HCPF Reference Manual, the Annual Report, and other Department publications can be obtained from the Office of Public and Private Initiatives, HCPF, 1575 Sherman Street, Denver, Colorado 80203, or FAX: 303-866-2803.

Website access for the HCPF Annual Report and other HCPF information and publications is available through the HCPF home page (www.state.co.us, then page down to "State Government-Executive Branch/ Agencies/ HCPF").

Joan Henneberry, Executive Director

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