Department of Health Care Policy and Financing

Hot Topics

Prepared for the Colorado General Assembly

DECEMBER 16, 2008 VOLUME 4, NUMBER 4

The Mission of the Department of Health Care Policy and Financing is to provide cost-effective, quality health care services to Coloradans.

Alternative Care Facility vs. Institution for Mental Disease

After an audit conducted by the federal Centers for Medicare and Medicaid Services (CMS) earlier this year, the Department of Health Care Policy and Financing (Department) was asked to ensure that Alternative Care Facilities (ACF's) were not operating as Institutes for Mental Disease (IMD's) thereby putting the Department's federal financial participation at risk.

In early August 2008 CMS sent a letter to the Department restating their concerns that some ACF's in the Medicaid program may meet the criteria for being considered an Institute for Mental Disease (IMD), reinforcing that Medicaid payment to any such IMD is in violation of federal law, and notifying the Department that we had until December 31, 2008 to end any such payments

Since September 2007, the Department has been working to complete the necessary assessments of ACF's to refute concerns expressed by CMS that some ACF's in Colorado may meet federal definitions for being an IMD. The Department has been engaged in working with stakeholders to develop some best practices around alternative care facility services, to develop a tool to help determine whether an alternative care facility meets the IMD criteria, to develop a protocol around the relocation of residents, if needed, and to strategize around how best to meet client needs and maintain compliance with Medicaid law and regulations.

On November 18, 2008, due to assurances provided by the State and ACF providers that they do not provide mental health services on the premises of these facilities, CMS rescinded their previous instructions requesting the State to cease claiming federal financial participation (FFP) for ACF's that could have been determined to be IMD's.

The Department, on the advice of the Attorney General, will begin the process of developing an assessment tool to use in the future so we can continue to provide assurance to CMS that the ACFs are not providing services in a way that could be considered an IMD. The tool will be used not only for ACFs but for other types of facilities such as Nursing Facilities, Therapeutic Residential Child Care Facilities and Mental Health residential facilities.

Staff will draft a tool with input from the Attorney General and stakeholders. We expect that will be done around the 1st of February. At the same time we will be working on a rule to take to the Medical Services Board which will provide input for the framework/guidance for how to conduct the assessments as well as provide guidance on the process.

Eligibility Modernization and CBMS Realignment Update

If a client is to access health care, a number of events must occur as part of the health care continuum or as part of the "life cycle of the client" - awareness of a program, the application process, eligibility determination and enrollment, accessing

Department of Health Care Policy and Financing
1570 Grant St.
Denver, CO 80203
303-866-2993
Fax 303-866-3883

Colorado.gov/hcpf

quality services and retention of clients eligible for coverage. One of the goals of eligibility modernization includes a focus on the client experience from beginning to end. States make a tremendous investment in outreach efforts to enroll eligible clients into health care programs, so eligibility modernization focuses on protecting the up-front investment by retaining eligible children and families. The ultimate goal of eligibility modernization is to provide good customer service with low application processing times while leveraging technology to provide consistency and predictability to the eligibility experience for clients.

The health and human services agencies of a number of states are considering or implementing reforms to modernize their eligibility models. The models differ greatly, but national experts propose these common elements of "eligibility modernization":

- Paperless processes supported by Electronic Document Management Systems (EDMS)
- Customer contact centers that move work to the phone instead of face-to-face client interactions
- Web-based access to programs and services to increase flexibility and access to programs
- Moving from caseload-driven to task-based business processes

The Department hired a contractor, Public Knowledge, to gather information and make recommendations as to how best we might organize eligibility activities across the state. Public knowledge visited and reviewed ten county eligibility sites as well as a medical assistance site and the ACS CHP+ call center. They conducted research into best practices and reviewed responses the Department received from vendors on proposed solutions. Their final report is due to the Department on December 17, 2008. Public Knowledge shared some of their preliminary findings with Department staff and stakeholders which include the following:

- The overall model utilized in Colorado is outdated and does not fit current workload and demographic trends
- The current model is confusing to may clients and hinders access to programs
- The current model fosters inconsistencies in the timing and manner in which eligibility determinations are made
- The current model lacks accountability
- Consistent training program does not exist for Medicaid, particularly for new eligibility technicians
- The eligibility model is hindered by a reliance on paper documentation, limiting organizational options for managing the workload
- Counties and medical assistance sites continue to report challenges with CBMS, although there is general agreement that the system has greatly improved since its implementation in 2004
- Eligibility sites use inconsistent methods for tacking case status and workloads
- Medicaid and CHP+ review periods are not aligned with re-determination periods for other types of assistance programs, causing duplicate work for

both eligibility technicians and clients

The Department also contracted with Electronic Data Systems (EDS) to perform a feasibility study to determine whether CBMS could be realigned to streamline front-end screens for users, to reduce or eliminate the adverse impacts the program rules of both the financial and health care programs have on each other within CBMS, and to improve how the client correspondence functionality within CBMS might be improved. The Department is reviewing the results of the feasibility study and preparing an executive summary that will be available in mid-December.

The Department continues to work with Bailit Health Purchasing on strategic planning and outreach initiatives around modernizing our Medicaid and CHP+ eligibility and enrollment processes. The Department has applied to participate in Robert Wood Johnson's Foundation's "Maximizing Enrollment for Kids" grant program. We will hear in December whether we have been selected for participation.

The Eligibility Modernization and CBMS Realignment Projects represent a tremendous opportunity to make the eligibility experience more efficient, cost-effective and more client-centered and position Colorado as one of the visionary and national leaders in this area. It is also an important component of the Governor's building blocks for health care reform.

Colorado Medicaid Global Prior Authorization

In order to protect the health of our most vulnerable Medicaid clients, the Department proposed requirements to exempt qualified clients from any further prior authorization requirements for non-preferred drugs thereby allowing the client's prescriber the freedom to select the most appropriate medication for vulnerable clients. Qualifying clients will also be exempt from prior authorization requirements for non-PDL drugs currently requiring prior authorization. This policy has been known as a Global Prior Authorization.

On February 19, 2008 the Department posted proposed requirements related to this policy and asked for comments. The Department also presented the criteria to the Pharmacy and Therapeutics (P&T) Committee. After considering the comments and recommendations that the Department received, the Department revised the proposed policy.

The previous proposed policy required a client to have a medical home. The term "medical home" seemed to indicate a more involved process for the providers and was confused with the Department's medical home initiative. In order to better clarify what the provider's role is with respect to the individual exemption, the term was changed to "focal point of care" and the qualifying criteria were simplified. The goal is still for a client to have a provider who can monitor the client's medical condition(s) and one who is actively involved in the client's care.

Qualifying Criteria for a Global Prior Authorization:

I. Clients must have a focal point of care

A focal point of care is a provider, or group of providers, from whom a client receives the majority of their scheduled primary care, and is the place where care coordination occurs. Having a focal point of care minimizes risks of medication duplication among multiple prescribers and helps ensure that the prescriber is familiar with the complex needs of the client. In general, the focal point of care conducts medication-reconciliations at least annually and as needed during care transitions, regularly scheduled age-appropriate preventative care visits, and

conducts a complete review of the client's history at least annually.

II. Clients must be at high risk for drug-drug interactions

This includes clients taking four or more medications and/or taking high risk medications. High-risk medications are those that require specific patient education, close monitoring, or special personnel for administration. These high-risk medications will be identified by the Department.

III. Clients must have one of the following diagnoses:

- **HIV/AIDS –** Taking antiretroviral therapy.
- **Severe chronic schizophrenia and severe bipolar disorder –** Diagnosis based on DSM-IV criteria and ICD-9 diagnosis codes.
- **Traumatic Brain Injury –** An injury caused by a blow or jolt to the head, penetration of the head, or violent shaking, that disrupts the function of the brain, resulting in long-term or lifelong need for help in performing activities of daily living.
- **Developmental disability –** Manifested before age 22 and attributable to mental retardation*, cerebral palsy, epilepsy, or autism. Diagnosis includes: life-long disability, inability to live independently, severe communication difficulties and/or profound intellectual disability.

The individual exemption policy is not finalized. We are still collecting feedback from stakeholders and will be updating with information as it becomes available.

* As defined by the American Association of Intellectual and Developmental Disabilities

For more information on these or other topics, please contact Nicole Storm, Legislative Analyst, at 303-866-3180 or Nicole.Storm@state.co.us